

June 26, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1410-P, Medicare Program; Skilled Nursing Facility Prospective Payment System for Federal Fiscal Year 2010; Proposed Rule (Vol. 74, No. 86), May 12, 2009.***

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members – including approximately 1,200 hospital-based skilled nursing facilities (SNF), the American Hospital Association (AHA) appreciates the opportunity to comment on the fiscal year (FY) 2010 proposed rule for the SNF prospective payment system (PPS). This regulation proposes changes for both 2010 and 2011.

CMS proposes a FY 2010 SNF market basket update of 2.1 percent. However, CMS also proposes to recalibrate the SNF PPS case-mix weights, which would reduce payments by 3.3 percent resulting in a net decrease of \$390 million in Medicare payments from FY 2009 to FY 2010. CMS also proposes two significant SNF PPS changes that would take effect in FY 2011: implementing refined versions of the SNF case-mix system and updating the SNF patient assessment instrument. CMS proposes implementation of these two major changes on October 1, 2010 to provide stakeholders with adequate time to update systems and train staff for the change.

#### **HOSPITAL-BASED SNF PERFORMANCE**

In its March 2009 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that the Medicare margin for hospital-based



SNFs in 2007 was *negative* 80 percent. While a variety of factors contribute to this margin, one central factor is that hospital-based SNFs treat more complex patients, provide more intensive care, have much shorter lengths of stay (half the freestanding SNF average), use a greater volume of registered nurse care, and use more non-therapy ancillary services such as respiratory therapy and intravenous drug therapy than free-standing SNFs. The March report also notes that the overall number of hospital-based SNFs continues to decline rapidly, as the number of freestanding facilities has grown. Despite the unique contributions provided by hospital-based SNFs, the continued pattern of closure is not surprising given their challenges with under-reimbursement of non-therapy ancillary costs, which disproportionately harms hospital-based SNFs.

Proportionally, the under-reimbursed hospital-based SNFs are more reliant on Medicare funding than freestanding SNFs. As a result, the proposed 2010 cut would have a disproportionate impact on hospital-based SNFs. In 2007, the median share of Medicare days in hospital-based SNFs was 62 percent; and 1 in 10 had 91 percent or more total Medicare days. In comparison, Medicare paid for just over 12 percent of patient days in freestanding facilities; with 1 in 10 having 29 percent or more Medicare days.

MedPAC's March 2009 report also found notably stronger quality outcomes for hospital-based SNFs, relative to free-standing SNFs, for the two risk-adjusted quality measures tracked by the Commission:

*Hospital-based facilities performed comparatively well, with community discharge rates more than 14 percentage points higher and potentially avoidable rehospitalization rates more than 4 percentage points lower than those for freestanding facilities, after controlling for differences in case mix, ownership, and location. Hospital-based SNFs may have lower rehospitalization rates in part because they have higher staffing levels and skill mix, and their proximity to the hospital facilitates physician visits. (Page 172)*

## **PROPOSED CALIBRATION AND PAYMENT REDUCTION**

On January 1, 2006, CMS increased the number of SNF payment units – known as resource utilization groups (RUG) – in the RUG-III payment system from 44 to 53 to better account for the higher cost of treating medically complex patients who also need rehabilitation. Using claims data from 2001, CMS projected that 19 percent of SNF cases would fall into the nine new RUGs. However, CMS' analysis of 2006 payments found that the new RUGs accounted for more than 30 percent of SNF cases. CMS' intention when introducing the new RUGs in 2006 was to implement a budget-neutral change to the SNF PPS, relative to what Medicare would have paid under the prior 44-RUG model. In FY 2009, CMS proposed to recalibrate the SNF PPS weights to adjust for the difference between proposed and actual utilization of the new RUGs added in 2006, which would have produced a FY 2009 cut of \$770 million for SNFs. CMS did not implement this proposal in the FY 2009 final rule for the SNF PPS. For FY 2010, CMS

is re-proposing this recalibration of the RUG-III case-mix weights, which would produce a reduction of RUGs payments that CMS estimates would reduce FY 2010 SNF payments by 3.3 percent – a \$1.05 billion cut.

As noted when this proposal was recommended for FY 2009, the AHA remains concerned that CMS' proposal adjusts for greater-than-expected utilization of the nine RUGs without first quantifying the portion of the change driven by a rise in real case mix. The nine RUGs provided a new tier of SNF payment for medically complex patients who also require rehabilitation and are the highest paid of the 53 RUGs. It is reasonable to expect that as a direct result of the introduction of these new payment categories, SNFs began treating more rehabilitation cases with higher overall severity levels. SNFs and their referring providers and case managers likely viewed the new RUGs as an expansion by Medicare of the scope of services provided by SNFs – and SNF admissions changed accordingly both in volume and case mix. The new RUGs also represented more accurate payment for those medically complex SNF patients who receive rehabilitation.

In 2006, other Medicare policy changes also led to greater utilization of SNF services by sicker patients who fit well in these new RUGs, such as patients dislocated by the inpatient rehabilitation 75% Rule and heightened medical necessity review and denials. These factors caused many Medicare beneficiaries who would otherwise have received medical management plus intensive rehabilitation in an inpatient rehabilitation facility to seek care in a less-intensive setting, usually a SNF. To put this dislocation into perspective, a December 2007 report by The Moran Company on inpatient rehabilitation trends estimated that IRF utilization dropped 11 percent from 2005 to 2006.

In the FY 2009 final rule, CMS acknowledged that real case mix did change in 2006 over prior years, but did not discuss its case mix analysis or quantify the scale of this real case mix change. Instead, CMS is re-proposing the \$1.05 billion cut through re-weighting as if the sole reason for the difference between projected and actual utilization of the new RUGs was the agency's error in its initial forecast of utilization and the scale of the related budget-neutrality adjustment. While a forecast error adjustment can be reasonably applied to wage index changes and market basket increases, it is inappropriate to apply this concept to case-mix measurement because Medicare has always, as it should, paid for real case mix change to the extent that CMS can and has measured it.

**We urge CMS to reduce the size of the proposed recalibration cut to eliminate the portion caused by real case-mix change that occurred when the RUGs were expanded in 2006. In addition, given the size of the reduction, it would be appropriate for the agency to allocate the reduction over a two-year period to minimize instability for SNF providers, especially hospital-based SNFs that already struggle with extremely negative Medicare margins.**

## **PROPOSED IMPLEMENTATION OF RUG-IV CASE MIX MODEL**

CMS proposes to refine the RUG-III system in FY 2010 by, among other changes, increasing the payment groups from 53 to 66 RUGs. The proposed new RUG-IV case mix model is based on new data from CMS' 2005-2007 time study, known as the Staff Time and Resource Intensity Verification (STRIVE) project. This study collected patient, nursing and therapy resource data from 205 SNFs in 2006 and 2007. Participating SNF therapists and nurses logged the type and volume of therapy and other services and resources provided to SNF patients.

STRIVE Data Concerns. Given the scope of the proposed change, we have concerns about the STRIVE study method and its findings. First, the STRIVE study collected data from a small sample of providers – 205 sites with approximately 2,000 patients. There are more than 15,000 SNFs and more than 1.6 million SNF patients per year. In addition, as discussed with the March 2009 STRIVE Technical Expert Panel and in the proposed rule, the process for collecting therapy data from the participating sites resulted in several problems highlighting inconsistencies in training, data-collection methods, and oversight for the therapists submitting data. CMS is proposing retroactive adjustments to the therapy data to attempt to address data inaccuracies and reliability concerns. While we understand the need to adjust the therapy minutes data, the proposed retroactive therapy data adjustments bring into question the accuracy and usefulness of the STRIVE data – especially in light of the small sample size. Also, retroactively adjusting the therapy minutes collected directly from therapists treating SNF patients seems to be contrary to the purpose and design of the time study – which was real time, bed-side measurement of the resources provided to SNF patients.

Very little final STRIVE data disseminated so far provide information about the study's findings on resource utilization by provider type, size, and case mix. Not surprisingly, the AHA is especially interested in the STRIVE data that might provide insights on hospital-based SNF patients, services, and resource utilization and how these findings compare relative to those of freestanding SNFs. Given the limited access to STRIVE findings, which are the basis of CMS' refinements to the RUG system, it is difficult to fully understand the implications of CMS' proposed move to the RUG-IV system and to confidently endorse the proposal to implement RUG-IV in 2011.

Proposed Fiscal Impact for RUG-IV. The proposed rule includes fiscal impact projections for the FY 2011 implementation of the RUG-IV system. For hospital-based providers, CMS projects that RUG-IV payments in 2011 for urban hospital-based SNFs would drop by 2.2 percent, with rural hospital-based SNF payments reduced by 1.8 percent.

We are concerned that the impact analysis does not include the 2011 market basket or wage index changes. In addition, the reliability of CMS' fiscal impact projection for FY 2011 under RUG-IV is unclear, given the scope of the change and the greater than one-year lag between the projection and the October 2010 implementation date. It is

reasonable for providers to have access to and formally comment on a more complete and reliable fiscal impact estimate before completing plans to implement RUG-IV.

Another concern related to CMS' projected 2011 fiscal impact is that, while CMS states that the overall introduction of the new RUGs model is intended to be budget neutral, it is unclear why a proposed RUG-IV adjustment to achieve budget neutrality – referred to in the proposed rule as a “parity adjustment” – as only applied to the nursing case-mix index. We do not understand why this parity adjustment was not also applied to the therapy case-mix index, or to the overall, proposed 2011 payments under RUG-IV. And we question whether spending parity between RUG-III and RUG-IV payments can be achieved without these additional adjustments..

Based on the concerns and questions raised above, **the AHA recommends that CMS extend the comment period and postpone implementation of the RUG-IV system in 2011. We also recommend a staged approach for implementing MDS 3.0 and RUG-IV, which would be less burdensome and confusing to implement.** Under an incremental phase-in, CMS would proceed in FY 2011 with the implementation of the updated version of the MDS 3.0 to be followed in FY 2012 with the implementation of the RUG-IV. To proceed with both changes concurrently would be premature, overly burdensome and detrimental to hospital-based providers, given their vulnerable financial standing. A gradual approach such as this would also allow for additional dissemination and analysis of STRIVE data and its application to RUG-IV.

#### **OTHER PROPOSED POLICY CHANGES**

CMS Research on Non-therapy Ancillary Services. The AHA looks forward to CMS' pending research on the use of non-therapy ancillary (NTA) services. This has long been an area of concern for hospital-based SNFs, which on average use more of these services than free-standing SNFs due to variety of reasons, including treating a more medically complex case-mix. We share these concerns noted by CMS in the proposed rule:

*“... the present system could underestimate NTA costs for the patients with the highest NTA needs, and that inadequate reimbursement could lead to restricted access to care for those patients who require them.”*

The proposed rule notes that the agency is considering a wide array of alternative methods to better capture non-therapy ancillary costs in the payment system. Of the possible ideas noted in the proposed rule, adding an outlier payment and/or a payment add-on for non-therapy ancillary costs seem worthy of exploration. In fact, MedPAC's March 2009 recommendations to Congress called for both of these changes. Together they would improve the SNF PPS by accounting for high cost non-therapy ancillaries such as intravenous medications, respiratory therapy and drugs. While we recognize these additions would require statutory approval, we encourage CMS to explore these

options expeditiously to provide a foundation for a legislative effort to make these needed SNF PPS improvements.

Concurrent Therapy. In this regulation, CMS proposes to change the method for counting and paying for concurrent therapy. Concurrent therapy is the practice of one professional therapist treating multiple patients at the same time while the patients are performing different activities. CMS estimates that based on STRIVE data, 90 percent of SNF patients receive therapy, and of those, two-thirds receive concurrent therapy. In light of this greater than expected utilization of concurrent therapy, CMS recommends that for the purpose of assigning SNF patients to the appropriate RUG, the therapy minutes provided through concurrent therapy be allocated among the patients being treated. Our concerns about the impact of CMS' retroactive adjustments to the STRIVE therapy minutes on data reliability are relevant here, as well.

The proposed FY 2010 re-weighting of the RUGs case-mix weights is based on 2007 therapy utilization patterns, which include the concurrent therapy provided to SNF patients at that time. The proposed new method for pro-rating concurrent therapy minutes per patient may result in a wide variety of changes. It may increase the use of individualized therapy which may raise SNF case mix as physicians and case managers become aware of the greater availability of individualized therapy in SNFs, and as a result begin to refer patients with more advanced therapy needs. To the extent that concurrent therapy is provided and the minutes prorated per patient, patients are likely to be assigned to lower-level RUGs. Any resulting changes in therapy resources, case mix, RUG assignments, and billing will need to be monitored closely by CMS and accounted for accordingly in future SNF PPS updates. In addition, the MDS 3.0 tool may need adjustment to assist with the accurate recording of concurrent therapy minutes that would now be divided among the participating patients. Finally, it's important to note that implementing this change may be difficult for SNFs in communities facing therapist shortages, such as many rural communities.

Assessments for Swing Bed Patients. Under Medicare, 481 hospitals have Medicare-certified swing-beds that provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished in a swing-bed; and for non-CAH rural hospitals, swing bed care is reimbursed under the SNF PPS. The proposed rule states that it is CMS' "intention" to include swing beds in the FY 2011 transition to the RUG-IV system and the MDS 3.0.

Today, full MDS 2.0 assessments are not required of SNF patients treated in swing-beds based on the presumption that swing-beds are incorporated in the overall quality review process of the rural hospital. Furthermore, the average length of stay in swing-bed facilities is significantly lower than in either hospital-based or free-standing SNFs, and the MDS 2.0 is not well suited to assessing short-stay patients. So instead, the clinical status and progress of swing-bed patients is assessed using abbreviated MDS assessments. CMS is considering replacing the current swing-bed MDS reporting

requirements with an MDS 3.0 equivalent, and including the items needed to evaluate quality in the same way as for other SNFs.

The AHA supports the intent of these proposed changes and would be pleased to engage in CMS' efforts to improve patient assessments for swing bed patients. However, we urge CMS to proceed cautiously and consult with swing bed providers prior to expanding the current patient assessment requirements. Many rural hospitals operate a small volume of swing beds and at any given time treat only a handful of SNF patients in these beds. As such, hospital nursing staff capacity available for swing-bed patient assessments is limited. Given their small volume of swing-bed patients, without further rationale from CMS and details about possible changes, it is unreasonable to expect these hospitals to dedicate additional nursing staff resources to complete expanded patient assessment instruments.

Short-Stay Patients. Given that hospital-based SNFs have an average length of stay that is half that of freestanding SNFs, approximately 15 days versus 30 days, respectively, we strongly support CMS' proposed changes to more accurately capture the actual volume of therapy provided to SNF patients – regardless of when the patient is discharged. The accurate counting of therapy minutes is key to correctly assigning a Medicare patient to a RUG, which affects the accuracy of the resulting payment. Today, the amount of therapy and other care provided to many short-stay patient's is not accurately captured by the MDS 2.0 when a patient is discharged before the assessments on 5<sup>th</sup> and 14<sup>th</sup> day of a SNF stay. This can unfairly reduce Medicare payments and skew quality data for hospital-based SNFs. Therefore, AHA supports CMS' proposed changes to more accurately capture therapy minutes and related resources provided to short-stay patients.

If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack  
Executive Vice President