American Hospital Association

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Submitted Electronically

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Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS–1351–P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations – including approximately 1,000 hospital-based skilled nursing facilities (SNF) – and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2012 proposed rule for the SNF prospective payment system (PPS).

The AHA urges CMS to conduct a more thorough analysis of its proposed recalibration of the "parity adjustment," the mechanism used by CMS to achieve the budget neutral implementation of the new SNF PPS refinements that took effect in October 2010. Given the scope and complexity of these changes, we urge CMS to move slowly in implementing the recalibrated parity adjustment and encourage the agency to phase in this provision. We also encourage the agency to revise its group therapy proposal by setting a cap on the number of patients eligible for group therapy rather than limiting this modality to one group size. Finally, we support CMS' proposals to allocate group therapy minutes and to clarify the guidelines on how SNF therapy minutes are reported to CMS for the purpose of setting per diem payment amounts.

FY 2012 SNF PPS UPDATE

CMS' proposed regulation includes two options for the FY 2012 payment update to the SNF PPS. The first option is the traditional market basket update, which would produce a net increase of 1.5 percent. It reflects a market basket increase of 2.7 percent minus a 1.2 percent productivity adjustment as mandated by the *Patient Protection and Affordable Care Act*. The second update option would add an additional reduction to recalibrate the parity adjustment used for the FY 2011 transition from the Resource Utilization Group (RUG) 53, which was the former version of the SNF PPS, to the RUG-IV version. The parity adjustment was made in the FY 2011 final rule to implement the RUG-IV change in a budget neutral manner. Under this proposal, the FY 2012 Medicare payment for SNFs would be reduced 11.3 percent.

CMS' parity adjustment proposal is based on only one quarter of claims (October-December 2010) paid under the new RUG-IV PPS. Based on this analysis, CMS found that the proportion of SNF patients grouped into the highest-paying RUG-IV therapy categories greatly exceeded the agency's expectations. The analysis indicates that under RUG-IV, the use of concurrent therapy decreased while individual and group therapy increased, contributing to a greater proportion of SNF patients being assigned to higher rehabilitation RUG categories. This finding is the basis for CMS' proposed update option to recalibrate the parity adjustment.

The AHA urges CMS to conduct a more thorough analysis of the parity adjustment. The American Health Care Association and LeadingAge analyzed CMS' proposed methodology and both identified possible errors with CMS' analysis. LeadingAge's analysis, specifically, indicates that the methodology proposed for recalibrating the parity adjustment would disproportionately affect medically complex patients, both those receiving therapy and those not receiving therapy. The Medicare Payment Advisory Commission has reported on several occasions that medically complex patients experience the most difficulty accessing SNF care. We are concerned CMS' proposal may unintentionally limit SNF access for medically complex patients, and we urge CMS to correct problems in its methodology.

If CMS elects to implement the revised parity adjustment for FY 2012, then AHA urges CMS to implement the adjustment using a multi-year, phase-in approach with a much smaller adjustment applied in FY 2012. Payment cuts as large as CMS proposed would create significant financial pressure on SNFs and could force reductions in access to SNF services for the sickest patients. Given the complexity of the parity analysis, errors in the parity adjustment methodology, the limited availability of data and the dramatic scale of the proposed cuts, we strongly encourage CMS to address potential problems through a multi-year approach. In addition, the need for additional modifications to the amount of the parity adjustment in the future is unknown. A phase-in approach is especially critical for hospital-based SNFs, which have highly negative Medicare SNF margins. Hospital-

based SNFs are not financially equipped to bear a cut of this magnitude. If implemented, many SNFs' ability to continue to operate would be threatened.

The phase-in approach also provides an opportunity for CMS to assess ongoing behavior changes as providers adjust to the new RUG-IV and the refined SNF patient assessment instrument, MDS 3.0. Continued study of the impact of a recalibrated parity adjustment will be needed to ensure that the transition to RUG-IV is fair and incorporates any real increases in patient severity. In addition, the phase-in approach allows CMS to monitor and adjust for any changes in utilization and payment that occur as the SNF field responds to the final version of this regulation.

PROPOSED THERAPY CHANGES

Group Therapy. The proposed rule discusses CMS' concerns that there was a significant increase in the provision of individual and group therapy services after the agency in October 2010 implemented limits on concurrent therapy. The SNF PPS FY 2011 final rule required that concurrent therapy minutes be allocated by the number of patients receiving this mode of therapy, which generally results in patients being assigned to lower level RUGs. In response to the increase in group therapy that occurred during the first quarter under RUG-IV, CMS proposes to restrict group therapy to only groups of four patients and to allocate group therapy minutes across the four patients. However, the proposed rule does not provide an adequate clinical rationale for limiting the size of therapy groups in this manner. Contrary to the statements in the proposed rule, therapists report that patients in groups of two or three experience meaningful clinical benefit when they engage in similar therapy activities. **Therefore, the AHA urges CMS to allow groups of two, three or four patients for group therapy and cap it at a maximum of four patients.** In addition, we support CMS' proposal to allocate group therapy minutes by the actual number of patients receiving therapy. These changes would allow therapists to retain more flexible use of the group therapy modality, while also addressing CMS' concerns that therapists should "receive one hour's salary for the hour of therapy provided."

MDS 3.0 Clarifications. **The AHA supports setting clear guidelines that help ensure payment levels accurately match services provided.** The proposed rule clarifies and tightens several instructions related to how therapy minutes are counted per beneficiary, which affects how a patient is assigned to a RUG category for SNF PPS per diem payment. Without these clarifications, the problems associated with unclear guidelines for counting therapy minutes will persist, as will the need for ongoing payment adjustments by CMS. Because the clarifications are substantial, they may result in material change in the modes and volume of therapy services provided by SNFs. If this occurs, it is important for CMS to account for any such change in its future assessments of the budget neutral implementation of RUG-IV.

Thank you for your consideration of our comments. 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,

/s/

Rick Pollack
Executive Vice President