Rec 6-8-05

1-9

Submitter : **Mr. nathan Lake** **Date: 05/18/2005**

Organization : **American HealthTech**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Comments contained in attachment

CMS-1282-P-1-Attach-1.DOC

Attachment #1
Comments **Docket: CMS-1282-P - Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Case-Mix Adjustment and Other Clinical Issues

Table 3a - There appears to be a type in the New Groups column. The new groups within Rehab High, Medium, and Low have an "RUX" designator. I think they should be RHX, RMX and RLX respectively.

Proposed new RUG score - Excellent plan

Proposed Refinements to the Case-Mix Classification System

Grace Days - I agree with the proposal to eliminate grace days. Not because they were a bad idea, but because of the confusion that surrounds their use. However, in order to continue to give facilities the flexibility they require to accurately code the MDS, I would suggest that the grace days be added to the allowable date range. In other words, the Medicare 5 Day, effectively becomes an 8 day assessment.

Assessment	Allowable ARD Date Range	
Medicare 5 Day	Day 1 to 8	It is particularly important to maintain the 8 day range on the first Medicare assessment. Limiting this to 5 days will have a significantly negative impact on a facility's ability to accurately classify a resident when large amounts of therapy are involved, but perhaps not delivered during the first couple days of the admission. Extending the date range as far as day 10 might be given some consideration as it allows users to better represent the care actually being given.
Medicare 14 Day	Day 11 - 19	
Medicare 30 Day	Day 21 - 34	
Medicare 60 Day	Day 50 - 64	
Medicare 90 Day	Day 80 - 94	

Projection of Anticipated Therapy - The primary purpose of projected therapy minutes was to capture therapy that was going to be delivered, but might not begin immediately upon admission. The ability to project minutes becomes less important if the allowable date range for the Medicare 5 day is extended to day 8 (or maybe even day 10) as I have proposed above. Eliminating projected therapy minutes **AND** limiting the first Medicare assessment to 5 days would create a significant hardship for the facilities since many true rehabilitation residents would fail to qualify for a rehab RUG score.

Implementation Issues

Implementation Date - Software vendors will require at least 3 months from the time the rule is finalized to update programs and deliver them to customers. Any implementation date that is at least 3 months after finalization would be acceptable to them.

Implementation Date - I would suggest that the rule be worded such that the new RUG system is implemented and used for payment for any Medicare assessment with an Assessment Reference Date of January 1, 2006 or later. Assessments with earlier ARDs will be paid entirely under the old system regardless of the days being paid. This will eliminate the need to split payments under two systems.

Submitter : **Ms. Sara Hayden** **Date: 05/18/2005**

Organization : **Ms. Sara Hayden**

Category : **Nurse**

Issue Areas/Comments

Issue

Issue

The proposed changes in the RUGs groupers will be devastating to long term care facilities. Medication prices continue to soar and facilities are making budget cuts left and right. The most educated staff are being pulled from resident care activities to paper compliance. By proposing these cuts, the facility will not be able to afford to provide post-hospital cares for the acutely ill, multiple diagnosis patients. Residents in highly acute phases of illness will no longer have places to go, but will remain hospitalized for longer periods. Please leave section P of the MDS unchanged when determining RUG groups for acute patients (within the first 8 days after admission or hospital return).

Submitter : **Date: 05/19/2005**

Organization :

Category : **Nurse**

Issue Areas/Comments

Issue

Issue

Eliminate grace day usage on 5 day Assessments. Routine usage is rampant.

Submitter : **Mrs. Laura Loftis** **Date: 05/20/2005**

Organization : **Sun Healthcare**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1282-P-4-Attach-1.DOC

Attachment #4

COMMENTS REGARDING CMS-1282-P

While the overall changes of the establishment of the 9 additional RUG levels is a great improvement, there are some refinements that are concerning:

1. The changes in the MDS items and look back period. This would be a mistake. The MDS drives the RAPS and care plan. If a resident was sick enough to be in the hospital and to receive IV meds/fluids, these should be counted on the MDS if appropriate. The fact that the resident received these indicates that the resident was ill and required these in order to get well or at least stabilized. This is something that we want to capture to make sure it is rapped and care planned.
2. The deletion of the grace days. This would be inappropriate for the five-day MDS. I can understand it for the others, but not for this one. The whole idea set forth in the first final rule allowed grace days to the benefit of the resident who may not be physically able on the first one or two days to participate effectively in therapy. If a resident is appropriate for rehab ultra high or very high, requiring the five days of therapy directly after admission will potentially decrease the resident's ability to participate. Transfer day to a SNF is a tiring proposition for a resident.
3. The deletion of Section T. How is this going to help? Section T is only good to capture Rehab Medium or Rehab High. The usage of Section T decreases the need for grace days. Taking away Section T will not help residents or SNF'S. It may negatively impact revenue.

As a nurse, I always hated to talk about dollars when it came to resident/patient care. I never understood it completely until I became a case mix specialist. I always tell the facilities that if we are documenting needed care appropriately, we will be paid appropriately. A change in ADL scores, captured appropriately, will pay for a shower chair, etc. Please keep in mind when making decisions that may radically change the way that we are reimbursed can negatively affect resident care. The cost-of-living for our employees has not decreased at all and we are required and desire to hire enough quality employees to care for our residents-many of whom do not have families that are able or desire to care for them at home. Our costs are also increasing for supplies. The suppliers do not need to decrease their prices for the items that are purchased by us.

In a country where health care is supposed to be above all other countries-and this is proved, I believe, every day-reverting to low dollar reimbursement for both SNF'S, LTC facilities and hospitals will bring us down to the level of third world countries. We have the most dedicated nursing aides, nurses, and physicians that you will find. Remember them as well as the resident/patient when these important decisions are made.

Respectfully,

Laura L Loftis, RN, RAC-C
Sunhealthcare Corp

Submitter : **Mr. James Wickline** **Date: 05/25/2005**

Organization : **Bellbrook Rehab and Healthcare Center**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I believe the creation of the RUG III extensive category would decrease the discrepency that exists currently between facilities that produce high amounts of therapy with low nursing needs and facilities like ours that produce high levels of therapy in conjunction with patients that require highly skilled staff (I.e. ventilator, TPN, wound VAC, etc patients).

I also support the elimination of the 5 day assessment period, as this time is typically a poor representation as to what the patient will actually be doing with therapies. Typically there is an adjustment period that the patients at our facility go through. I have found that there is little variance between RUG's obtained during the 5 and 14th day. This would eliminate redundency from multiple facets. There is, however, generally a diffence in the RUG levels between the 14 day and 30 day assessments.

I would also agree with the elimination of grace days. Our facility choses not to use grace days, with the exception of the five day. Currently grace days are used on the 5 day to account for adjustment time for the patient or as a feeling out process for staff and patient. The elmination of the 5 day, however, would also reduce the necessity of grace days.
thanks you
J. eric wickline ,MPT

Submitter : **Date: 05/25/2005**

Organization :

Category : **Nurse**

Issue Areas/Comments

Issue

Issue

Please reconsider the disallowance of credit for skilled services provided by hospitals prior the resident's admission to SNF. We in SNF's have taken many hits to reduce compensation for taking care of our elderly population while also being ladened with more and more regulation. The increase or more stringent review of current regulations will place a huge burden on facilities that are already financially unable to provide the staff needed to meet basic activities of daily living let alone have to suffer the potential for further loss of income.

We, care providers, take great provide in the work we do with what we are allowed by Government to have. However, we do object to the premise that we can work miracles! It takes time to meet the needs of our elderly population. We need to provide them a safe environment, nurtishious meals/snacks, entertainment that is appropriate for their level, professional staff and caring care givers. We are to ensure their Rights are protected and provide Respect and guarantee their Dignity. All in, on average, less that 2 hours per person per day and less than $200.00 per day. We challenge you to walk a day in our shoes. Shoes that are wearing out and with little funding to replace them.

Please, please show your support of our elderly population and for those who make it our life's work to care for them.

Submitter : Jan Shenkenberg **Date:** 05/26/2005

Organization : Todd Shenkenberg, MD, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-7-Attach-1.DOC

Todd Shenkenberg, MD, PA

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Harlingen, TX 78550
Phone # (956)364-2131
Fax # (956)364-2141

June 9, 2005

Attachment #7
Centers for Medicare & Medicaid Services

Attn: CMS-1282-P
Re: SNF Consolidated billing

The rules regarding SNF consolidated billing have had many unintended negative consequences for cancer patients. While many high dollar chemotherapy agents and most forms of chemo administration are excluded from consolidated billing, most supportive therapies and medications are not, even if given concurrently with the chemo. Therefore we are forced to bill the nursing home for anti-emetics, synthetic erythropoietin alpha, hydration, and other pre-medications and their administration. Some low cost chemo drugs are not excluded, e.g. fluorouracil, even though nursing homes do not employ chemotherapy nurses. In other situations the drug is covered by part B, such as aldesleukin, but the administration, chemo IM or SQ, is not. Hormonal treatments, leuprolide acetate or goserelin implants, must be billed to the SNF. Other supportive medications, such as zoledronic acid for bone metastasis or octreotide acetate for carcinoid tumors, are not excluded from consolidated billing, in spite of their high cost. New chemotherapy agents, like bevacizumab, which are usually the most costly, are generally not excluded. PET imaging, used for staging or restaging several cancers, must be billed to the nursing home. Radiation therapy is excluded, but only in the hospital outpatient setting. There are no hospital based radiation centers in the Rio Grande Valley of Texas, so radiation done here must be billed to the nursing home. Labs must be done frequently to monitor the patient's well being. This adds up to a bill that the nursing homes do not want to pay.

As a direct result of this policy, **local nursing homes are refusing to accept oncology patients**. In some cases, patients have been required to forgo all treatment during their nursing home stay. Nursing homes refuse to authorize treatment when it is needed. When the doctor orders an expensive injection, such as erythropoietin alpha, to be given at the home, we get a call from the director of the home complaining, or refusing to give the drug. In at least one case, a patient's family was told to bring the patient to our office "to get a shot", even though the director was well aware that we would not be able to bill Medicare Part B for reimbursement.

Billing the nursing homes for services rendered is a difficult and frustrating process. First, we have to identify those patients that are under Part A at the home. The nursing homes do not cooperate with this procedure and identify those patients before hand, so we have to have procedures to catch those who might slip by. In some cases, we do make a mistake and bill Part B, only to have to refund the money later. We try to order the labs at the home prior to the patient's visit, and try to order medications to be given at the home, but we have difficulty ensuring that the orders are carried out. Once treatment is authorized by the nursing home, the charges have to be carefully sorted out, so that the nursing home and the carrier each get the appropriate bill. Even then, when everything is done exactly by the book, the nursing home may take months, or even a year to pay us for expenses we have incurred.

Clearly skilled nursing facility consolidated billing rules have compromised Medicare patients' access to care, both cancer treatment and nursing home care. Thank you for your attention to this problem.

Sincerely,

Jan Shenkenberg
Office Manager
Todd Shenkenberg M D P A

Submitter : **Mr. Charles Harris** **Date: 05/31/2005**

Organization : **Aloha Nursing & Rehab Centre**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-8-Attach-1.DOC

Aloha Nursing & Rehab Centre

Memo

Attachment #8

To: CMS

From: Charles Harris Executive Director

CC: Hawaii Long Term Care Association

Date: June 9, 2005

Re: CMS 1282-P http://www.cms.hhs.gov/regulations/ecomments

COLA:

With the implementation of the Balanced Budget Act (BBA) of 1997 Hawaii and Alaska lost the cost of living adjustment that was included in our Medicare rate prior to BBA. For whatever reason or oversight, the cost of living adjustment was left out of the BBA for Hawaii and Alaska. The Medicare program has historically recognized the unique circumstances of hospitals and nursing facilities located in Hawaii and Alaska. DRG payment amounts and inpatient hospital capital costs still contain COLA under Section 1886(d)(5)(H) of the Social Security Act and Section 412.312 of the Code of the Federal Registry, respectively. The reason for these provisions is that Alaska and Hawaii are geographically remote, face atypical challenges in providing health care services to Medicare beneficiaries, and are so small as to have virtually no impact on the national averages. Previously, the calculation of SNF's routine cost limits (RCLs) recognized the unique situation of nursing facilities in Hawaii and Alaska through a COLA adjustment. Because BBA did not specifically direct CMS to continue providing COLA for SNFs in Alaska and Hawaii, the SNF PPS CFR contains no such provisions.

I feel to avoid continuing to disadvantage nursing facilities in Alaska and Hawaii a COLA adjustment should be reinstated. Currently our facility receives a wage adjustment for Hawaii of 1.1014. This in no way makes up for my additional cost of living than say a facility in Lexington KY who has a wage index of .9219. The non-labor related costs are much different for Alaska and Hawaii as compared to Lexington KY for such things as employee benefits, supplies and food which all has to be shipped by air or ocean barge, land cost that are some of the highest in the nation and very high building costs. This adjustment should be applied to the federal percentage of the adjusted federal per diem rate based on the amount of the most recently determined cost-of-living differentials provided by the Office of Personnel Management (OPM). These OPM cost differentials are based on surveys used to determine COLAs for federal wages in our states. The Federal COLA adjustment for Honolulu County is 25%, Kauai County is 23.25%, Maui County is 23.75% and Hawaii County is 16.5%. We believe that this COLA adjustment should be added back to our non-labor portion of the PPS rate.

3 DAY HOSPITAL STAY:

It is my belief this is an archaic requirement that does not fit with a RUGs based system in place. I do not believe the 3 day hospital stay is needed as a gatekeeper any longer and does not reduce cost or improve quality of care for our residents. If the resident's MDS meets at least the minimum RUGs

levels then, in my opinion, they should qualify for a Medicare stay in a SNF assuming everything else is in order.

Catastrophic Care:

There needs to be some type of relief for facilities who provide costly care that is way and above the normal cost for a RUGs catagory. There is no mechanism to ever recover this costly error in admitting this type of expensive resident to our facility. Is it the preference of CMS that we not take this type of patient and for them to continue to be waitlisted in a hospital where the cost per day for Medicare is much more than in a SNF setting? I do not believe that it is fair to expect nursing facilities to just eat this extraordinary cost. For example, we took a difficult patient to improve our goodwill to a particular hospital and to help them out with their waitlisted patients. Our charges for this particular resident amounted to $36,970 for 100 days of care and our reimbursement was $27,283. We will never recover this loss and it is wrong to think that we win some and lose some. I feel that we win very few and there is no way to recover the losses.

Submitter : **Ms. sue wakeland** **Date: 06/01/2005**

Organization : **Ms. sue wakeland**

Category : **Speech-Language Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Please do not retract the grace period on the 5 day MDS. This retraction would require 7 days per week therapy which is difficult to staff and difficult for patients to maintain. The grace period allows some flexibility in patient treatment schedules but still produces excellent patient outcomes. Thank you for this consideration.

Sue Anne Wakeland
Speech-Language Pathologist, MEDCCCSLP

CMS-1282-P-10 **Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter : **Mr. James stansel** **Date & Time:** **06/09/2005**

Organization : **Mr. James stansel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

This must be taken care of now, not later

Issue

Case-Mix Adjustment and Other Clinical Issues

This must be taken care of now, not later

Concurrent Therapy

This must be taken care of now, not later

Implementation Issues

This must be taken care of now, not later

Issue

This must be taken care of now, not later

Proposed Refinements to the Case-Mix Classification System

This must be taken care of now, not later

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

This must be taken care of now, not later

Wage Index Data

This must be taken care of now, not later

CMS-1282-P-11 **Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter : **Mr. Paul Ercolini** **Date & Time:** **06/15/2005**

Organization : **Mr. Paul Ercolini**

Category : **Individual**

Issue Areas/Comments

Issue

Proposed Revisions to the SNF PPS Labor Market Areas

70 to 75% of nursing home expenditures are for labor. Nursing home jobs account for a living wage for many just starting in the labor force or workers who have come to this country to start a new life. In Lawrence Massachusetts these facts are especially true.

As an employee of a nursing home in Lawrence, in Essex County, to hear that the wage index is proposed to drop by 2.3% seems to make no sense. By reducing the wage index this proposed regulation makes attacting employess from outside the County more dfficult. Also, for those employees and potential employees who live in Lawrence lower wages make working at our nursing facility less attactive. For many, a job at our facility is thier first and sometimes their only option if they do not own a car or public trasportation is not available to similar jobs outside the county that may be higher paying. By basing wage indexes on existing data, this proposed revision perpetuates existing wage differences between countys in Massachusetts, makes it harder to keep and attract employees, and limits potential wage increases for those employees who cannot travel to better paying jobs.

As a member of a not for profit association of church sponsored nursing and other health care facilities we are as a group committed to providing a 'just' wage to all our employees. Also, as a nursing facility with a 120 year history of providing services to the poor and new emigrant in the City of Lawrence we are not about to abandon our mission. I expect Congress had no intention that this proposed revision would make it harder to continue to provide a just wage or continue our mission.

Focusing on one factor like the hospital wage index in Essex County alone is very shortsighted. These proposed revsions should also take into account the reach of our recruiting efforts, our just wage initiative, current inequities in wage rates that would only be perpetuated by this proposed revision, lack of public trasportation, employee family committments that may mean employees must work close to home, and ability to speak english, just to name a few factors.

I realize it is easier to use the hospital wage index and ignore all the above factors and more, but it does not make it right. Those individuals who provide this type of information to Congress and make these kind of recommendations should also be charged with providing a complete and rigorous presentation of facts and consequences of their recommendations.

CMS-1282-P-12 **Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter : **Mr. Paul Groseclose** **Date & Time:** **06/19/2005**

Organization : **Mr. Paul Groseclose**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

There needs to be some work on adding another Rug level between Rehab medium and Rehab High. We have many patients who are unable to tolerate RH (65 minutes / day) but for whom RM (30 minutes / day) is not enough to meet their needs, therefore requiring that they be seen for an extended period of time. This new level would shorten the stay and decrease costs. I would suggest something in the range of 225 -230 minutes per week. (45-46 minutes per day)

CMS-1282-P-13 **Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter : **Mr. Terri Land** **Date & Time:** **06/17/2005**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

file code CMS-1282-P
I don't know who to contact about this, but maybe you can forward it to the appropriate person. I'm in Charleston, SC and one of our nursing home here, Driftwood, is in my opinion extorting money from its residents. Here's what the current administrator is doing: He is charging each patient in the room a charge for the phone and a charge for the cable tv.I know the cable alone is $16 a month for EACH person in the room. That's $32 a month for just one of the rooms. Multiply that times the number of rooms in the facility and the man is making a killing off these poor people who have no money! Then the phone is a separate charge each month. One individual has been in the facility and never has there been a charge for those things until this particular administrator took charge. I feel something should be done. The TV and/or phone could be considered therapy for these people. That's sometimes their only contact with the world and keeps their minds active. Is there anything that can be done to change things there? How can this man take Federal money and then charge these people additional charges? Phone and TV should be part of the room in this day and age. I can see charging a fee if they make long distance calls, but local charges is a different story. TV should just be included in the room fee. Please forward this to someone who can check on this.

Submitter : **Mrs. Rhonda Ferren** **Date: 06/25/2005**

Organization : **Trilogy Health Services**

Category : **Nurse**

Issue Areas/Comments

Issue

Issue

'proposed refinements to the case-mix classification system'
I am in agreement with the new proposed 53-grouper. We provide services to the clinically challenged resident, but only receive rehabilitation reimbursement. I have been an MDS Coordinator for 14 years. I have been around since the evolution of the PPS system. I am concerned regarding the elimination of the grace days with PPS and projected anticipated therapy services on the MDS. It is fair and completely acceptable not capture the IV that was provided in the hospital on the SNF level. Why would we get reimbursed for a service we did not provide? The 5-day grace period and therapy days/minute projections are needed for several reasons. I will list some; 1. The resident may decline therapy treatment due to having an ill day, doctor's appointment, or just NOT wanting to participate on days 1-5 due to pain, etc (if new rule applies, we have ONLY five days with no room for resident-specific circumstances, if they arise. These five days are required to place resident in category above rehab medium/high if projection is eliminated), 2. Flexibility in staffing with regards to the therapy department (our SNF rehab facility does approximately 28 admissions monthly.) The recommendation of eliminating grace days and projection would force our therapy department to work every weekend to qualify the resident for a rehab RUG. (Remember the 5 day MDS assessment pays for the first 14 days of the Medicare recipient's stay), 3. A service may be rendered on days 6-10 (for which we would not have an assessment reference date) that needs to be captured on the MDS for proper reimbursement and reflection of the resident's status through the RUGS/MDS system, 4. If the look back period is eliminated into the hospital, it would be more appropriate to use ONLY assessment reference days 5-8 rather that days 1-4. We wouldn't have the option of days 6, 7, or 8 if grace days were taken away. Please strongly consider not eliminating or decreasing the grace days for the PPS MDS assessment as this would impede our efforts of accurately reflecting the services being provided to the resident on the MDS. Projection of anticipated therapy services is needed so the therapy department has some staffing flexibility and will not be required to work every weekend in an effort to reflect the actual therapy the Medicare recipient is going to receive for the first 14 days of their admission. Thank you for allowing the opportunity for concerns to be expressed.

Submitter : **Mrs. Donna Elston** **Date: 06/27/2005**

Organization : **Spectrum Health Continuing Care Center**

Category : **Individual**

Issue Areas/Comments

Issue

Proposed Revisions to the SNF PPS Labor Market Areas

I appreciate the fact that you are considering the use of observation days in a hospital when calculating the 3-day hospital stay. As you have stated in the interim final rule, when the initial guidelines were established observation days were not part of an acute care setting. As that part of the industry has changed we need to modify our requirements to adequately provide services for the Medicare population. Often potential admissions are kept an additional day or two at the hospital in order to meet the Medicare requirement because dischare home is not a viable option. Or the patient is discharged with as much support as possible but fails at home requiring another hospitalization. Changing the definition for the 3-day stay would eliminate these scenarios and probably result in an overall savings to the Medicare system.

Case-Mix Adjustment and Other Clinical Issues

I agree with limiting the ability to capture items to those that occur during the SNF stay - IV, IV medications, transfusions, etc. However, if this is done, taking away the grace days and/ or section T greatly limits the SNF ability to capture a time period that adequately reflects payment type. Grace days are needed to allow the SNF patient to become stable enough to participate fully in therapy. If grace days are eliminated, please look at re-defining the window for each assessment. For example, instead of day 1-5 for the 5-day MDS assessment, change it to 3-8. If grace days and section T are removed it will be very difficult to achieve a Rehab category higher than a rehab medium unless a patient receives a significant amount of therapy on the day of admission, which is usually not in the patient's best interest. Furthermore, if the minutes/ days cannot be obtained by day 5, the SNF will not be adequately reimbursed for therapy services provided above a rehab medium category during the payment days covered by that assessment.

Submitter : **Mr. Brian Hickman** **Date: 06/30/2005**

Organization : **BKD, LLP**

Category : **Other**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-16-Attach-1.PDF

Attachment #16

June 29, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: File Code CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

We appreciate the opportunity to comment on the proposed rule to update the payment rates in the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for the 2006 fiscal year and implement refinements in the RUG-III case-mix classification system, published in the May 19, 2005, *Federal Register*.

BKD, LLP is one of the 10 largest CPA firms in the United States. We specialize in the long term care industry, serving over 1,000 skilled nursing facilities throughout the nation. We employ a number of nurses and nursing home administrators who help SNFs provide services and obtain reimbursement according the Medicare (and Medicaid) program rules and regulations. Our experience working with SNFs (and many other health care providers) gives us a unique perspective on the practical impacts of the proposed changes.

The following comments are relative to "Proposed Refinements to the Case-Mix Classification System." The comments herein are specific to the proposed possible modifications to the Resident Assessment Instrument (RAI) Manual. We have significant concerns about each of the potential modifications to the current system including the look-back period, the use of grace days and projecting therapy minutes. The elimination of the look-back period, grace days and estimated therapy minutes from the RAI Manual will negatively affect the quality of services to the most acutely ill of the nation's SNF patients – the post-acute-stay Medicare-covered patients. It appears the changes could be especially damaging to patients in rural America reducing access to quality SNF services.

We believe the three day qualifying hospital stay requirement should be modified to include observation stay time.

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bkd.com

Look-Back Period

Elimination of the "look-back" into the hospital stay will reduce access to Medicare benefits for many individuals and reduce payments to SNFs for the most critical portion of the patients' SNF stay – the initial few days.

The look-back period as it is currently implemented, allows the facility to "look back" into the hospital stay of any Medicare Part A eligible beneficiary to gather certain information pertinent to level of care necessary once the patient has been admitted to the skilled nursing facility. The accumulation of this data is necessary to adequately plan for the provision of the appropriate care (and determine the appropriate RUG group). As stated in the SNF PPS final rule, "the characteristic tendency for a SNF patient's condition to be at its most unstable and intensive state is at the outset of the SNF stay." This requires the SNF to commit its greatest amount of resources to the care of the post-acute patient within the first few days after admission to the SNF. The look back allows the SNF to properly analyze the patient's conditions and develop a plan of treatment that addresses the critical needs of the patient. This is crucial to the patient's improvement.

As patients transition from IV feeding and IV medications provided in the hospital, the SNF's nurses must be actively involved to allow the patient's recovery to progress appropriately or to take action if the transition does not proceed as planned. When the PPS was created, the Medicare program recognized the difficulties involved in the transition and allowed the look-back to acknowledge the required SNF level of care. If the look-back is removed, the SNF will be required to give the same care to the Medicare Part A patient, but will be paid substantially less in many circumstances. This action will reduce the SNF provider's resources available to provide the quality services expected by the patient and the Medicare program.

The RUG categories that will be affected to the greatest extent will be Extensive Services. It should be a matter of record that the most common defining service during the hospital stay that creates the SE category at the sub-acute level is IV medications. Many Medicare Part A eligible patients, who are admitted to a hospital (either through the ER or with a planned admission), have an IV started in the hospital. By not being able to utilize the look-back period, it appears that patients transferred to skilled nursing facilities will not be able to appropriately utilize one of the proposed new upper nine RUG-53 groups due to the lack of accessible data to properly code the patient into an extensive services level of care along with rehab therapy minutes and activities of daily living.

Many patients are admitted to the SNF mere hours after the IV has been discontinued at the hospital. If the IV was, for example, to deliver chemotherapy, antibiotic therapy, heparin therapy, or blood transfusions, the patient will require a significant level of skilled nursing care

for monitoring and treatment of symptoms associated with the causative medical condition. As it currently stands, the sickest of elderly patients are those in the first week after admission following a hospitalization for infections, chronic disease exacerbations (Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), cancer, etc.) and surgeries. These patients also debilitate quickly under those circumstances and may benefit from rehabilitation services, but often are not able to participate in any meaningful therapy program within the first week to 10 days at the SNF. If the hospital look-back for IV meds is not allowed, it is possible the sickest patients will not have an appropriate RUG pathway to care.

If the look-back is limited to only include those services furnished by a SNF after a patient's admission or re-admission, and eliminates the potential to capture treatments performed by the hospital prior to the SNF admission, overall SNF Medicare expenditures will be reduced. However, we disagree that this reduction in payment would be better aligned with services actually provided.

As noted on page 29076 of the May 19, 2005, proposed rule (section II.B.2.a.), data analysis performed by the Urban Institute "...again verified that non-therapy ancillary costs are higher for Medicare beneficiaries who classify into the Extensive Services category than for those who classify to other categories." CMS's research appears to indicate that a reduction in payment is not warranted because of the correlation between Extensive Services and higher cost. If the look back is eliminated, the number of patients qualifying for Extensive Services is significantly reduced, but the research indicates these patients have higher non-therapy ancillary costs than other categories.

The analysis cited in the proposed rule contends that the addition of nine new categories that combine Rehabilitation and Extensive Services improves the predictive power of the RUG-III model. However, revising the RAI Manual to only include special treatments and procedures furnished by the SNF would significantly reduce the number of residents that would be classified into the Extensive Services category. Adding nine new RUG-III categories that combine Extensive Services with Rehabilitation, when patients would not be able to qualify for Extensive Services, would seem to defeat the purpose of the RUG refinements and undermine the predictive power of the new RUG-53 model because many patients presently qualifying as Extensive Services would not be classified into the new levels (nor the present Extensive Services categories).

Decrease or Elimination of the Grace Period

A reduction or elimination of the grace day period used to set the assessment reference date, specifically for the five-day PPS MDS assessment, would have negative patient care implications.

Used appropriately, grace days allow a SNF to better serve the patient's needs, allowing therapy evaluation and services to be provided to generate the greatest health benefit to the patient and provide appropriate reimbursement to the facility. Grace days allow the evaluation and services to occur according to the clinically best time-frame, rather than requiring an artificial regulation-imposed time-frame for the services.

In the July 30, 1999, final rule CMS stated that the use of grace days may be appropriate, especially in cases when, "the beneficiary is not physically able to begin therapy services until he or she has been in the facility for a few days." The final rule goes on to say that the use of grace days for the five-day MDS "make it possible for beneficiaries to classify into the two highest RUG-III rehabilitation sub-categories. Classification into the Ultra High and Very High Rehabilitation sub-categories is not possible unless the beneficiary receives the sub-category's minimum level of services during the first seven days of the stay." Both of these arguments in favor of the use of grace days remain valid.

When PPS was initially developed, the use of grace days for rehabilitation patients on the five-Day assessment was legitimately expected for a number of reasons associated with both the availability of the therapist and the patient. The reality of the five-Day Assessment, without the use of grace days, is that patients must be evaluated by a licensed professional therapist on the day of admission. In order to achieve any RUG group at a level higher than Rehab Medium, the patient will have to be treated on all of the first five days in the SNF, which includes weekends.

Discharges from the hospital setting are not under the control of the SNF. It is the experience of many SNFs, that many hospitals are prone to discharge patients on Fridays (typically in the afternoon). Regardless of the day of discharge, patients usually arrive at the SNF after 1:00 pm. It is inappropriate to expect the new Medicare Part A patient to be able to tolerate all the assessments required by the SNF nursing and rehabilitation therapy staff within the first few hours of admission to the SNF. The ambulance ride alone, often 30 minutes or more to the SNF (especially in a rural setting), can be a traumatic experience for the patient.

Most patients are not physically able to appropriately participate in an effective rehabilitation therapy evaluation on the afternoon of the admission to the SNF. In many facilities, rehabilitation therapy services are often not available seven days per week, thus patients cannot be evaluated for rehab therapy needs until the Monday following the "common Friday afternoon

admission." Thus, if grace days are eliminated, the average days that can be included in the assessment reference window for rehab therapy will be two (2). This will inappropriately restrict the Medicare beneficiary's access to the Medicare Part A covered benefits (especially for rural Medicare Part A patients where therapist availability is even more limited).

The current availability of therapists in most markets will not allow for seven day per week schedules or weekend coverage. Many SNFs do not have sufficient utilization to support a full time therapist, so they must "share" therapists with other providers. The coordination of available therapists with an unpredictable hospital discharge time-table could result in poor coverage and personnel crises, particularly in rural areas.

Elimination of the latitude for a SNF to use grace days on the initial five-day assessment could result in patients whose condition primarily warrants skilled rehabilitation, such as hip fracture or CVA, not even being classified into a rehabilitation category. In the July 1999, SNF PPS final rule, CMS commented their intent was "to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it, to stabilize from the acute care setting and be prepared for the beginning of rehabilitation in the SNF." Reduction or elimination of the grace days for the five-day PPS MDS assessment creates incentives to prematurely initiate therapy before a resident is physically able to tolerate and benefit from it. The result of accelerated initiation of therapy is reduced improvement in health of the patient, which is not the goal of the patient, CMS, or the SNF. Used appropriately, grace days help improve the quality of services.

Patients are now discharged from the acute level in fewer days, resulting in sicker, less hearty patients at the time of the SNF admission. Often, there is little value in a therapy evaluation taking place in the late afternoon or evening of the first day for a frail, elderly patient who has experienced upheaval, ambulance travel and who is emotionally and physically exhausted. It is not appropriate for a medical system policy to mandate that a patient be required to endure such adverse, and often inappropriate, program requirements. A good clinical model is one that allows patients a day or so to adjust to their new reality and surroundings without compromising their recovery. The use of grace days on the five-Day MDS accomplishes this end. The use of grace days on any assessment should be for the provision of the appropriate clinical program for the patient that results in appropriate reimbursement to the provider. The same reasons exist today which existed in 1997, when the Balanced Budget Act of 1997 created the SNF PPS.

Elimination of Projected Therapy Minutes

Elimination of the projection of anticipated therapy services during the five-day PPS assessment could negatively affect the quality of services and the benefits derived by the patients.

Elimination could result in inappropriate incentives to either provide too much therapy too soon or delay therapy beyond when it would be best initiated for the patient's health.

Elimination of the projection of anticipated therapy services will restrict the SNF's ability to appropriately classify patients into rehabilitation RUG-III categories when their condition clearly warrants the need for therapy services. Often, therapy is not initiated until after the end of the initial assessment, but is provided prior to the 14-day assessment. By allowing a beneficiary to classify into an appropriate RUG–III rehabilitation group based on anticipated receipt of therapy, a SNF can be paid for the therapy services being provided during the first 14 days after admission.

There are legitimate reasons to project a therapy RUG on the five-Day MDS. The ability to do so financially protects a Medicare Part A provider who, in good faith, has assessed the needs of a patient and developed a plan of rehabilitation that is interfered with in unforeseen ways, including *unplanned* discharges prior to the planned five-Day assessment reference date.

Currently, if any unforeseen or uncontrollable issue arises in the first five days of a SNF rehab stay, the only options to maintain a rehab reimbursement category are the use of grace days or projected minutes. If both of these options are eliminated, quality of care becomes an issue for the majority of the SNFs – especially those located in rural communities (due to therapist availability.) Once again, the same circumstances exist now that existed when the SNF PPS payment system was initially created.

By eliminating the ability to capture ordered and scheduled therapy services, there may be a tendency for providers to hasten to provide therapy services prematurely or at a level that is too rigorous for the individual's health status. On the other hand, if starting therapy early is not possible, there may be an incentive to forgo or at least postpone therapy services that could be very beneficial to improving a patient's function. In either case, there is an incentive to schedule the onset of therapy services based upon whether the provider will be paid at a rehabilitation level, rather than what is the most appropriate for the beneficiary's care.

We realize there may be situations where estimated therapy minutes have been overstated, resulting in higher than appropriate therapy minutes allocation and potentially higher rehabilitation RUG categories. However, these cases should be handled the same way all inappropriate coding errors are addressed.

Qualifying Three-Day Inpatient Hospital Stay Requirement

We believe observation days should be counted toward the technical three-day acute care stay requirement for eligibility for skilled care.

As noted by CMS, the care furnished during a hospital observation period is frequently undistinguishable from the care provided after a Medicare patient has been admitted to an acute care bed.

In a case where a hospital admits a patient for observation and that patient is ultimately admitted to acute care but is discharged prior to the third "acute" day, the patient could be deprived of their SNF benefit merely because the hospital was judicious in observing a patient to ensure admission to acute care was warranted.

Allowing observation days to count toward the required three-day hospital stay will require a change to the "Common Working File" (CWF), because even though hospitals are required to "bundle" observation services with inpatient services, the formal acute admission date (not the date the patient is admitted for observation) is the date reported on the hospital's claim, which is ultimately recorded in the CWF as the actual admission date. There would need to be some mechanism to distinguish acute hospital stays that are actually less than three days from those that would be (at least) three days by allowing observation days, in determining whether there has actually been a qualifying hospital stay.

Since the implementation of SNF PPS, there have been situations when SNFs have inadvertently counted an observation stay period as a part of an acute care inpatient admission, resulting in a non-qualifying three midnight acute care period. Counting observation midnights will assist with assuring appropriate payment for subsequent post-acute care and will not compromise services for the beneficiary. We appreciate CMS's consideration for this proposed change.

We believe there is a clinical basis to totally remove the three-day hospital stay as a requirement for skilled nursing care eligibility. The SNF environment and the types of patients treated are totally different in 2005 from 1965 when this requirement was implemented. There have been phenomenal changes in the health care delivery system over the last 40 years since the Medicare legislation was enacted and Congress imposed this requirement. In section III.M. of the July 1999, final rule, CMS discusses "presumption of coverage" when a beneficiary scores in the top 26 RUG-III categories and they are deemed to qualify for skilled care. Often, residents are admitted to SNFs that meet these requirements without ever having been admitted to an acute care hospital. We encourage CMS to consider the impact on the Medicare program of reducing or eliminating the three-day qualifying stay. Such a change could save the Medicare program

significant dollars for eliminated hospital stays and allow beneficiaries placement in a less intensive setting.

Summary

Generally, the SNF PPS program has allowed Medicare Part A patients to continue to receive quality care, while reducing costs and risk to the Medicare Trust Fund. We believe strongly that the proposed changes in the look-back period, use of grace days, and projecting therapy minutes would be very damaging to the SNF's ability to provide the quality post-acute care for Medicare Part A patients desired by all. Beneficiaries have earned the right to utilize the Medicare program through their payment of payroll taxes throughout their work lives. The proposed RAI Manual changes could be damaging to many Medicare Part A patients (especially those living in rural communities) by potentially limiting access to coverage and services. The proposed changes could result in increased costs through increased re-hospitalizations and less rehabilitated SNF population ultimately requiring more, not less, services.

We respectfully submit our comments and appreciate your consideration when deciding on the proposed changes. Should you have any questions or if we can be of further assistance, please feel free to contact Mr. Darryl Bueker, Partner, **BKD, LLP** at 417 865-8701.

BKD, LLP

BKD, LLP

Transmitted via e-mail to: http://www.cms.hhs.gov/regulations/ecomments

Submitter : Mrs. Linda Scott **Date: 06/30/2005**

Organization : Cypress Glen Retirement Center

Category : Nurse

Issue Areas/Comments

Issue

Issue

Have heard that the use of grace days may be discontinued. Do not agree with that idea. Grace days help facilities to capture a more accurate picture of that resident. Without them we could miss important health issues and changes.

Submitter : **Mr. Fred Kagarise** **Date: 07/01/2005**

Organization : **MidMichigan Health**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issue

Wage Index Data

See Attached

CMS-1282-P-18-Attach-1.DOC

MidMichigan
Health

July 1, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: Medicare Program; Prospective Payment System
And Consolidated Billing for Skilled Nursing Facilities for FY 2006
Proposed Rule
CMS-1282-P

I am submitting these comments for consideration in the finalization of Policy on behalf of MidMichigan Health ("MH"). MidMichigan Health provides a cross section of medical services to Medicare Beneficiaries from mainly Midland, Gratiot, Clare, Isabella, and Gladwin Counties, including skilled nursing care.

Implementation of the Revised Labor Market Designations

CMS should use its regulatory authority to provide for a transition in applying the Core Based Statistical Area ("CBSA") changes for those counties that were, but are no longer a part of a Metropolitan Statistical Area ("MSA").

The change to the CBSA grouping was first implemented for the Inpatient Prospective Payment System ("IPPS") effective for FY 2005. As stated in the August 11, 2004 Federal Register, Page 49032:

> "We have in the past provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts."

Because of the large negative impact on some providers, from the county it is in being moved from a MSA to a rural area, the final IPPS rule adopted a three-year period where the provider's wage index would be based on the prior MSAs new index and not on the rural area's new index. The Proposed SNF Wage Index for FY 2006 makes no allowance for this type of large negative impact. Midland County Michigan is one of these effected counties.

Because the hospital wage data is used for the SNF Wage Index, the same large negative impact will happen to the skilled nursing services provided in Midland County. The FY 2006 change is an 8.5% decline in the Wage Index value from FY 2005 based on the

Proposed Wage Index values. This is too drastic a change for our service to endure in such a short time period. We anticipated a similar transition or hold-harmless provision for the other Prospective Payment Systems when they switched to CBSAs as the IPPS included.

Your explanation for not including such a transition/hold-harmless provision is un-rational. You reason it is better that almost all facilities benefit on the backs of an "extremely small number" of SNFs that are very negatively impacted. This benefit must be so small that it will not be noticed, given the comparative number of facilities. But, on the "extremely small number", it is a very large negative impact. Or is the negative impact on such an "extremely small number" that large that it is so noticeable when spread over the vast majority of facilities? That proves all the more for the need to transition between the two labor area groupings for those negatively impacted. Your stated position goes completely counter to past practice of minimizing "large negative impacts". Our labor competition will not be any different on October 1, 2005 than it is on September 30, 2005. Our labor competition will still come from the Saginaw and Bay County facilities. This change to CBSAs cries out for a geographic reclassification rule like the hospitals have.

There should be a transition/hold-harmless provision in the applicable Wage Index value used for providers that experience this same shift to rural from urban wage area situation as the hospitals are. The same three-year delay would give us time to try to adjust salary levels to the lower rural wage index adjusters, even though out labor competition will not be changing.

As proposed, the SNF Wage Index for 2006 would leave providers whose county is switching from a MSA to a rural area under CBSAs with a large negative change in payments. An abrupt decrease in payments will damage our ability to provide care. A transition period between the two Wage Index values is needed in the final rule.

Submitted on behalf of MidMichigan Health,

Fred Kagarise

Fred Kagarise
Manager of Corporate Reimbursement
4005 Orchard Drive
Midland, MI 48670
989-839-3336

Submitter : **Mrs. Kathy Brannon** **Date: 07/01/2005**

Organization : **East Jefferson General Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

1. Counting observation days in the "three-day stay" requirement is fair and reasonable.
2. Dialysis charges should be excluded regardless of provider status (Contract company licensed as an inpatient or outpatient provider). As a hospital based SNF unit we send our patients to our dialysis unit on site as opposed to sending patient by ambulance to an OP provider. Providing care on site is "the right thing to do" but we are penalized by receiving no reimbursement.

Issue

Concurrent Therapy

Don't feel there is a need to further dictate how professionals with robust practice acts deliver care.

Submitter : **Ms. Mark Jaeckle** **Date: 07/05/2005**

Organization : **Catholic Health System**

Category : **Physical Therapist**

Issue Areas/Comments

Issue

Concurrent Therapy

There has certainly been some confusion with differentiating Group Therapy and Concurrent Therapy for Medicare beneficiaries. In the proposed rule, I am in agreement with the statement "Concurrent therapy can have a legitimate place in the specturm of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations". I also agree with the statement that "it is inappropriate for a facility to require, as a condition of employment that a therapist agree to treat more than one beneficiary at a time in situations where providing treatment in such a manner would compromise the therapist's professional judgment."

It is my professional belief that the clinical judgment of the therapist should be the determining factor in deciding whether concurrent therapy is appropriate. We need to continue to consider the patient's time spent in therapy, not the therapist's time. There are many different types of patients that are treated in SNF's, and many of these patients are appropriate for concurrent therapy. Licensed clinical staff including Physical Therapists, Occupational Therapists, and Speech-Language Pathologists have the assessment skills necessary to determine on an individual basis when concurrent therapy is appropriate. I also believe that it is very beneficial in enhancing motivation for patients when they participate in therapy in conjunction with other patients. As licensed clinicians, therapists should continue to develop patient treatment plans, incorporating individual, concurrent, or group therapy interventions - as deemed necessary to achieve each patient's individualized goals.

It is my strong recommendation that Concurrent Therapy services should continue for Medicare beneficiaries in the SNF environment.

Proposed Refinements to the Case-Mix Classification System

I would like to comment on (3) specific areas in this section:

1. Elimination of MDS look back period prior to SNF Admission:

Currently using the 14-day look back period into pre-SNF admission may capture services provided in the Acute setting (IV medications, suctioning, tracheostomy care, and use of ventilator/respirator) that will classify a patient into Extensive Services. While these services may not have been directly provided in the SNF after admission, they represent significant clinical criteria that will require ongoing skilled nursing intervention to assess, monitor, and observe these patients for any adverse affects from recent discontinuation of these treatments. This will rquire a great amount of clinical hours for these patients from skilled nursing personnel. The majority of the follow-up interventions for these patients will occur early in the SNF stay and only affect the 5-day MDS (and days 1-14 of the beneficiaries' stay). With that in mind, I recommend to continue to allow the look back period into pre-SNF admission.

2. Elimination of Grace Days:

The use of grace days for Medicare beneficiaries is a critical piece to accurately reflect the types and amounts of services that the patients are receiving in the SNF setting. For the 5-day MDS, the grace days (6-8) are required if patients are going to be provided a Very High or Ultra High level of Therapy services (to allow the acutal days and minutes to be completed). Without the grace days on the 5-day MDS, patients would not be able to score into the Very High or Ultra High RUG groups, even if that level of intensity of therapy is provided. Grace days on the other Medicare assessments (14, 30, 60, 90 day) are also beneficial and appropriate at times. For instance, if a patient misses scheduled therapy minutes on a given day (for an MD follow-up, if the patient is ill), grace days are essential to score the patient into the most appropriate RUG group that reflects the level and intensity of therapy services that patient is receiving. I strongly recommend continuation of the current Grace Day system.

3. Elimination of the Projection of Anticipated Therapy Services during the 5-day PPS Assessment:

The use of section T of the MDS to project patients into the High, Medium, and Low Rehab RUG groups is not essential to accurately reflect the level and intensity of rehab services for Medicare beneficiaries. If the actual therapy days and minutes from Section P of the MDS are used to categorize patients into these RUG groups (similar to Very High and Ultra High), this could eliminate the need for using Section T for projection of RUG groups. The only potential change in practice that I could foresee is there will be more of a need to use Grace Days on the 5-day MDS. I feel that elimination of the projection of anticipated therapy services for the 5-day MDS assessment is reasonable.

Submitter : **Mr. Kenneth Daily** **Date: 07/05/2005**

Organization : **OHCA**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Issue

Issue

Section: P1a, IV medications, suctioning, tracheostomy care and use of ventilator/respirator that classify residents into Extensive Services.

The proposal to eliminate the 14-day look back period for the items in P1a that cause a resident to group in Extensive Services will greatly affect the number of residents who attain that category and may affect the quality of care those residents receive if those items are not addressed on the Minimum Data Set (MDS). We respectfully ask that CMS remember the original reason for the MDS assessment, which is to provide a standardized assessment tool to improve quality of care in the long-term care setting. A comprehensive assessment requires that information be obtained from a variety of sources, thus eliminating the 14-day look back period for these items would compromise the resident?s assessment. Proposing to eliminate the look back period would not identify special needs of the resident and would negatively impact the care planning process and level of quality care. Residents who are transferred to a long term care facility and who have experienced IV medications, suctioning, tracheostomy care and/or use of a ventilator/ respirator during their hospital stay have special care requirements upon admission, requiring more acute monitoring for possible infections and complications following those treatments. Respiratory care residents are often known to have frequent relapses after receiving suctioning or if they have had a tracheostomy or have had ventilator/respiratory care.

5-Day Grace Day Period

Eliminating the grace day period for the 5-day PPS MDS assessment would have a clinically negative impact for long term care residents. Frequently newly admitted residents cannot tolerate therapy on the day of admission because many are admitted in the afternoon or evening and they are extremely tired. If residents are evaluated on the day of admission their rehabilitation potential may be misinterpreted because of admission anxiety or fatigue. Requiring therapy evaluations on the day of admission would in most cases not be wise and done only for reimbursement purposes. It would be done because the MDS must reflect therapy actually given in the facility for a seven-day period. Residents who are experiencing anxiety or extreme fatigue on admission will be asked to participate in therapy in order to maintain their Medicare Part A status regardless of their physical and emotional ability.

In addition, we respectfully encourage CMS to consider the information found on page 2-28 of the Resident Assessment Instrument Version 2.0 manual which specifically states,
?Grace days can be added to the Assessment Reference Date (ARD) in situations such as absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting the ARDs, and should be used sparingly.? We would ask that CMS remember that there is a severe nursing shortage in this country which effects staffing in long term care facilities. Further, there is a shortage of physical therapist as well that impact the start dates of therapies, especially related to weekends, holidays and evenings.

Case-Mix Adjustment and Other Clinical Issues

Elimination of the Projected Therapy on the 5-day Assessment in Section T of the MDS

We encourage CMS to maintain the current policy for Section T of the MDS. Often within the ARD of the 5-day assessment it is not possible to attain the 5-days of therapy required to classify in the Rehab category. The projection of days and minutes allows for this consideration and permits facilities to capture payment that is provided on the remaining days of this payment period. Without the projected days, facilities will not be compensated. More importantly the Medicare beneficiary may not receive the services at a level they require or can benefit from when there is inadequate compensation for the services. The projected therapy should remain to capture a situation where the beneficiary does not start out strong in therapy, but is assessed to have a good potential for an aggressive program.

We would like to thank you for the opportunity to submit comments and suggestions.

Submitter : **Ms. Ann Roberts** **Date: 07/05/2005**

Organization : **Jackson County Medical Care Facility**

Category : **Long-term Care**

Issue Areas/Comments

Issue

Issue

As the Director of Therapy Services in a Skilled Nursing Facility, I wish to comment on the proposed reduction or elimination of grace days & section T projections. Grace days are not required for many of the residents, however there are some residents who require their use during an illness. If the grace days were eliminated, & the window could not be moved, then the therapist is under extreme pressure to make someone who is vomiting have a session of therapy. I certainly don't want anyone bothering me when I don't feel well. Also, it is not fair to make the facility take a lower payment for the next period of time when the resident has been sick for only a couple of days, but can normally tolerate treatment well. During the first assessment, it is ridiculous to expect that a 90 year old woman who has been in the hospital for 2-3 weeks & has been transferred to the nursing home in the afternoon would have any energy to participate in a therapy evaluation after the nursing assessment is completed. By climating grace days & section T projections, you would have to force this woman to complete therapy on the first day in order to get the days/minutes criteria as outlined on the MDS. I don't see how this would be quality of care for the residents. I think the resident needs that first day to rest & become acclaimated to the new environment & staff. You are able to get a much better assessment of function on the residents second day. Also, this elimination would require therapists to be available 7 days/wk & into the evening hours which will be difficult for all facilities to find someone to fill this need. Without the grace days & projections, if a resident was unable to participate every day of days 1-5, then they would most likely fall into a lower category than what they truly require. Please reconsider making any changes at this time. Thank you.

Submitter : **Mr. Timothy Hager** **Date: 07/05/2005**

Organization : **Elim Homes**

Category : **Long-term Care**

Issue Areas/Comments

Issue

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

These comments are made about the interpretation of 'Qualifying Three-Day Inpatient Hospital Stay Requirement.'

The current interpretation of excluding observation days has at least five serious flaws and harsh negative outcomes:

1. The original regulation was never intended to exclude entitlement because of a 'paper determination' of the kind of hospital stay. It simply stated that the hospital stay began the calendar day of the admission. Later interpretation excluded many entitled patients.

2. Current interpretation is confusing to physicians, hospitals, patients and long-term care & rehabilitation facilities. There is inconsistency among physicians within a hospital system and inconsistencies between hospitals. Patients often are not aware that their three-day hospital stay was non-qualifying because they received full hospital care. Facilities will often admit a patient being told that the patient had a qualifying three-day or MORE length of stay only to find that the patient was in observation for many days.

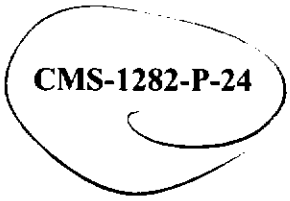
3. This confusion over arbitrary rules produces inconsistency in receiving entitled benefits. Depending on the physician, hospital or region of the country, similar hospital stays may be considered either acute or observation resulting in dramatic differences in care and the cost to the patient for the rehabilitation care.

4. Patients are being robbed of paid entitlements because of these inconsistencies in interpretation. Many have paid into the Medicare system for years only to find that when they need the entitlement, that due to an arbitrary interpretation, they are denied help.

5. Most tragic is the fact that without the Medicare payment system, facilities cannot provide the high levels of therapy needed to bring the person to their highest practicable level of functioning.

It is for these reasons that the interpretation needs to be corrected to the original intent. A qualifying hospital stay needs to be a stay of three days regardless of what terminology the hospital gives the stay. Observation days and acute days need to be regarded as the same for purposes of Medicare qualification requirements.

Timothy C. Hager, CNHA, CAS, CALA, Fellow of ACHCA
Campus Administrator of Elim Rehabilitation & Care Center



Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006

Submitter : **Cynthia Reich** **Date & Time:** **07/06/2005**

Organization : **Crest Haven Nursing and Rehabilitation Center**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1282-P-24-Attach-1.DOC

ATTACHMENT #24

ELECTRONIC COMMENT TO FILE CODE CMS-1282-P

DATE: 7/6/05

TO: CMS, DEPARTMENT OF HEALTH AND HUMAN RESOURCES

FROM: CINDY REICH

As a healthcare provider I would like to thank CMS for the opportunity to comment on the newly released proposed RUG changes for 2006. It is a positive step to recognize that the industry is in need of a combination category that would more appropriately address those patients needing both a high level of skilled nursing and rehabilitation services. The higher reimbursement, however, for the new categories is negatively off set by the significant reduction in reimbursement for the rehab categories and other nursing categories. For our facility the combination category would have affected only 10% of our Medicare A patients in 2004 with 90% being negatively impacted by the significantly reduced rates of the other categories.

The decision to "carve out" Cape May County from the combination Atlantic County/Cape May County rates will have a profoundly negative affect on the facilities in Cape May County. We are a rural/tourist area that has only one hospital in our county on which to base the RUG rate changes. However, we compete with Atlantic County for our job pool and patient population. The proposed rate changes reduces Cape May County Facilities by 20-60 dollars/day below Atlantic County. Because we compete with Atlantic County for staff, wages have increased accordingly and salaries are comparable. Also, rates for pharmacy, laboratory and other services are the same as Atlantic County, yet the patients will see a reduction in reimbursement rates to cover those services.

The remaining points I wish to touch on I will summarize in order to be brief:

- By proposing to eliminate the look-back period into the hospital stay for IV therapy, a category is eliminated that more accurately reflects the higher level of skilled nursing intervention that accompanies those more complicated patients in the first five days of their post acute stay.

- By proposing to eliminate the grace days on the 5-day MDS, you will negatively impact Rehabilitation services available to the patient. If this is eliminated in combination with the predication of minutes in section T, the patient may not be eligible for the higher rehab category, which they require to maximize their potential. Very often the patient is not medically stable in the first few days to benefit from rehab services and section T enables the facility to more appropriately begin therapy on day 3 and still be reimbursed at the level of services that are being delivered.

- By proposing to eliminate concurrent therapy, this will also negatively impact the patient and the industry as a whole. Therapists are educated and trained to deliver a high level of care even when delivering that care concurrently. Concurrent therapy enables the therapist to

24-E

give the patient adequate time and services to maximize their potential. Eliminating concurrent services will negatively impact quality of care that is being delivered to the patient and may ultimately drive up Medicare costs in the future.

- Cape May County has the second highest elderly population in the State of New Jersey, yet the proposed RUG changes would put us at one of the lowest reimbursement levels in the State. The facilities in Cape May County need the resources to deliver services to this fast growing population. The proposed changes will jeopardize the Medicare recipients in this county.

I worry that in an industry that is already highly regulated; there will be even further restriction. Changes in recent years have resulted in facility closings and a decline in care secondary to lower staffing levels due to cuts in reimbursement. It is hoped that CMS will consider these factors when setting the reimbursement rates.

In conclusion I would suggest that we do not eliminate:

1. Grace days on the 5-day MDS.
2. Projected minutes for Rehab on the 5 day MDS.
3. The ability for Rehab to treat concurrently.
4. The look-back into the hospital stay for IV therapy
5. And that the RUG level increases for 2006 for Cape May County, NJ be combined with Atlantic County, NJ as they have been since the beginning of PPS.

Thank you,

Cindy Reich, PT, Director of Rehabilitation and Clinical Reimbursement

CMS-1282-P-25

Submitter : Mrs. Linda Cornell

Date: 07/06/2005

Organization : Mercy St John's

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issue

Issue

Form letter

CMS-1282-P-25-Attach-1.DOC

CMS-1282-P-25-Attach-2.TXT

CMS-1282-P-26

Submitter : **Ms. Linda Berndt** **Date: 07/06/2005**

Organization : **Kansas Health Care Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

July 7, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: File Code CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

Comments to the proposed rule published in the May 19, 2005 Federal Register

We appreciate the opportunity to comment on the proposed rule to update the payment rates in the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for FY 2006 and refinements to the RUG-III case-mix classification system.

The Kansas Health Care Association is the largest long-term care trade association in Kansas. We represent over 200 long-term care providers including long-term care units of hospitals, skilled nursing facilities and nursing facilities. On behalf of our membership, owners and administrators who participate in the Medicare and Medicaid programs, we submit the following comments relative to the ?Proposed Refinements to the Case-Mix Classification System?. Our comments and concerns center around changes to the current system re: the look-back period, use of grace days, and projecting therapy minutes. We believe that the elimination of the look-back period, grace days and estimated therapy minutes from the RAI Manual will adversely affect the quality of services to the post-acute-stay Medicare covered patient. Many of our providers deliver services in rural Kansas. We believe these changes could also reduce access to SNF services in rural areas of our state.

1. The Look-Back Period should not be eliminated from the RAI Manual

Our providers currently utilize the look-back period in order to determine the appropriate RUG classification of a SNF patient so that the patient will receive quality care and an adequate plan of treatment. If this look-back period is eliminated, we believe that the SNF will still provide the same care to the Medicare Part A patient however the provider will be paid substantially less in many circumstances. We believe that many patients who are transferred from hospitals to skilled nursing facilities will not be allowed to use one of the new upper nine RUG-53 groups because of lack of data to properly code patients at the extensive services level.

2. The Grace Day Period should not be reduced or eliminated, specifically for the 5-day PPS MDS Assessment

We believe that reducing or eliminating the grace day period, which is used to set the assessment reference date, would have a negative impact on patient care. We believe Grace Days allow for an adequate evaluation of therapy services to generate the best outcome for the patient. In order for a patient to be assessed higher than a Rehab Medium, the patient will have to be treated on all of the first 5 days in the SNF, including weekends, if grace days are eliminated. We believe this will restrict the Medicare patients access to Medicare Part A covered benefits in rural Kansas where therapists availability are already limited.

3. Projection of anticipated therapy services during the 5-day PPS assessment should not be eliminated

We believe that SNF providers act in the best interests of their patients when they project anticipated therapy services after the needs of the patient have been assessed and a rehab plan developed. We believe that again with therapists in short supply in rural areas of our state, that eliminating projection of therapy services is not in the patients best interest. We believe that any situations where estimated therapy is or has been overstated, should be dealt with on an individual basis.

On behalf of our membership in the state of Kansas, we respectfully submit our comments. If you have any questions please contact Nancy Pierce at the Kansas Health Care Association at 785-267-6003.

Sincerely,

Linda Berndt
Executive President, Kansas Health Care Association

CMS-1282-P-27

Submitter : **Dr. Sheila Abood** **Date: 07/06/2005**

Organization : **American Nurses Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Issue

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

July 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

The American Nurses Association (ANA) appreciates the opportunity to comment on the proposed clarification of the requirement for physician signature as it relates to nurse practitioners (NPs) and clinical nurse specialists (CNSs). ANA is the only full service organization representing the interests of the nation?s registered nurses. Through our 54 constituent member associations, we represent nurses in all practice settings including skilled nursing facilities (SNFs) and also advanced practice registered nurses providing services to SNF residents.

First, ANA understands that under federal law a NP/CNS who is directly or indirectly employed by a skilled nursing facility (SNF) may not certify a resident?s need for skilled care and that ?direct? employment has been defined using the traditional common law test. However, the CMS current proposal to define as an ?indirect? employee any NP/CNS who provides nursing services part of the time and NP services part of the time, no matter who employs them, raises serious concerns related to the possible impact of such a restrictive definition. Therefore, we consider this definition to be a very broad interpretation of an already restrictive provision inhibiting the full scope of practice for advanced practice registered nurses as well as reducing access to hands on expert care for SNF residents. As the providers, who may see the residents on a more regular basis than the physician, this proposed definition would further limit the use of the clinical information obtained during routine NP/CNS resident encounters which are essential for determining resident status.

Additionally, the proposed definition of ?indirect employment? for NPs/CNSs and the conflict of interest argument appear to be applying a double standard to this group of providers since the definition does not apply to physicians (employed or otherwise). If applied to physicians, it would appear that physicians also would have a conflict of interest if they met the definition of ?indirect? employment. In the absence of significant evidence that there have been inappropriate certifications/recertifications performed by NPs/CNSs, we find it difficult to rationalize the broad brush approach that this rule takes.

At a time when we in the profession are encouraging more advanced practice registered nurses to specialize in geriatric care, the adoption of rules and regulations that further restrict their nursing practice is discouraging and disappointing. The end result will be decreased access to the quality care provided by NPs/CNSs for SNF residents.

Thank you for the opportunity to express our concerns. We hope that CMS will reconsider the proposed interpretation of the term ?indirect? employment and ANA stands ready to assist in this process.

Rose Gonzalez, MPS, RN
Director Government Affairs
American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910
301-628-5098

Submitter : **Mr. James Collins** **Date: 07/07/2005**

Organization : **Friends Services for the Aging**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-28-Attach-1.DOC

July 7, 2005

28-E

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-12282-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

These comments are respectfully submitted with regard to the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006 regulation published in the Federal Register on May 19, 2005.

With regard to Section IV, Consolidated Billing, we appreciate the attempt to continuously keep the list of services not subject to consolidated billing up to date to account for new procedures and refinements in the delivery of care. However, the current system has some inequities that need to be addressed. For example, an MRI may be an excluded service; however, this designation is dependent upon the location of the service. Currently, if the service is not performed in a hospital setting the SNF must absorb the cost of the procedure. There are many situations where it is more beneficial and convenient to send the resident to a freestanding diagnostic center, but reimbursement limitations inhibits the ease and convenience to the patient. There are a few other situations with which this limitation also applies. Please consider revising the rules to eliminate this place of service limitation. In addition, treatments such as erythropoietin treatment for those patients receiving chemotherapy are costly to the SNF but are included in consolidated billing.

With regard to Section VI, Qualifying Three-Day Inpatient Hospital Stay Requirement, Congress when establishing the rule in 1965 could not have envisioned the changes in the delivery of care that are in place today. The changes in technology have resulted in shorter hospital stays, thus depriving many beneficiaries from taking advantage of the Skilled Nursing Facility benefit. Many procedures which required extended hospital stays in the past, now may be done on an outpatient basis or require as little as two days in the hospital. These same procedures still require that the elderly patient be monitored and perhaps receive therapy before returning to their full functioning status that they enjoyed prior to the procedure. Furthermore, reduction in hospital beds is forcing an extended emergency room stay, which will negatively impact the qualifying three day hospital stay requirement. These factors should be taken into account when considering any refinement to the three-day hospitalization requirement.

I thank you for your consideration with regard to these matters.

Sincerely,

James F. Collins, MBA
Senior Director of Compliance

CMS-1282-P-29

Submitter : **Mr. Shane Craycraft** **Date: 07/07/2005**

Organization : **Garden Manor Retirement Village**

Category : **Other Health Care Professional**

Issue Areas/Comments

Issue

Issue

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016
Attention: CMS 1282-P
Date: July 7, 2005

My name is Shane Craycraft and I am writing on behalf of Garden Manor Retirement Village to offer testimony for the proposed Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006.
My comments are specific to possible changes that CMS might consider in the future.
Section: P1a, IV medications, suctioning, tracheostomy care and use of ventilator/respirator that classify residents into Extensive Services.
The proposal to eliminate the 14-day look back period for the items in P1a that cause a resident to group in Extensive Services will greatly affect the number of residents who attain that category and may affect the quality of care those residents receive if those items are not addressed on the Minimum Data Set (MDS). I respectfully ask that CMS remember the original reason for the MDS assessment, which is to provide a standardized assessment tool to improve quality of care in the long-term care setting. A comprehensive assessment requires that information be obtained from a variety of sources, thus eliminating the 14-day look back period for these items would compromise the resident?s assessment. Proposing to eliminate the look back period would not identify special needs of the resident and would negatively impact the care planning process and level of quality care. Residents who are transferred to a long term care facility and who have experienced IV medications, suctioning, tracheostomy care and/or use of a ventilator/ respirator during their hospital stay have special care requirements upon admission, requiring more acute monitoring for possible infections and complications following those treatments. Respiratory care residents are often known to have frequent relapses after receiving suctioning or if they have had a tracheostomy or have had ventilator/respiratory care.
5-Day Grace Day Period
Eliminating the grace day period for the 5-day PPS MDS assessment would have a clinically negative impact for long t4erm care residents. Frequently, newly admitted residents cannot tolerate therapy on the day of admission because many are admitted in the afternoon or evening and they are extremely tired. If residents are required to be evaluated on the day of admission their abilities and potential may be misinterpreted because of admission anxiety or fatigue. Requiring therapy evaluation on the day of admission would in most cases not be wise and done only for reimbursement purposes. It would be done because the MDS must reflect therapy actually given in the facility for a seven-day period. Residents who are experiencing anxiety or extreme fatigue on admission will be asked to participate in therapy in order to maintain their Medicare Part A status regardless of their physical and emotional ability.
See Next Section.

Case-Mix Adjustment and Other Clinical Issues

Continued from Previous Section.

In addition, I respectfully encourage CMS to consider the information found on page 2-28 of the Resident Assessment Instrument Version 2.0 manual which specifically states, ?Grace days can be added to the Assessment Reference Date (ARD) in situations such as absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting the ARDs, and should be used sparingly.? I would ask that CMS remember that there is a severe nursing shortage in this country which effects staffing in long term care facilities. Further, there is a shortage of physical therapist as well that impact the start dates of therapies, especially related to weekends, holidays and evenings.
Elimination of the Projected Therapy on the 5-day Assessment in Section T of the MDS
I encourage CMS to maintain the current policy for Section T of the MDS. Often within the ARD of the 5-day assessment it is not possible to attain the 5-days of therapy required to classify in the Rehab category. The projection of days and minutes allows for this consideration and permits facilities to capture payment that is provided on the remaining days of this payment period. Without the projected days, facilities will not be compensated. More importantly the Medicare beneficiary may not receive the services at a level they require or can benefit from when there is inadequate compensation for the services. The projected therapy should remain to capture a situation where the beneficiary does not start out strong in therapy, but is assessed to have a good potential for an aggressive program.
I would like to thank you for the opportunity to submit comments and suggestions.
Respectfully,
Shane Craycraft

Submitter : **Mrs. Laura Sparrer** **Date: 07/07/2005**

Organization : **Catholic Health System - McAuley Residence**

Category : **Physical Therapist**

Issue Areas/Comments

Issue

Issue

I am very concerned regarding the proposal to eliminate the look back period, grace days, and and the projection of therapy services with regards to the 5 day MDS. It would result in SNF/Subacute facilities not being reimbursed for the level of therapy which they are providing. Clinicians work very hard to provide the level and intensity of therapy which is needed to promote the highest level of function for their patients. They deserve to be reimbursed for the quality of service they provide. The flexibility which grace days and the projection of therapy allows facilities to provide the best care possible on an individual basis. Thank you for considering my comment.
Laura Sparrer, PT
Rehab Manager
Partners in Rehab

Concurrent Therapy

In response to the SNF PPS proposed rule for FY 2002 (66 FR 23991, May 2001), as it relates to ?Concurrent Therapy?, I would like to comment on this topic.

The matter of concurrent therapy vs. Group therapy has been an issue for some time. I feel that either type of therapy can be appropriate, and it should be left to the therapist?s judgement how to proceed for each individual patient. I agree that an employer should not require a therapist to treat more than one patient at a time if the therapist feels that it compromises their patient care. I believe that licensed therapists have the skill set and judgement to determine what is best for their patients.

It has been my experience that patients within the LTC/subacute setting often require rest breaks, during which their therapist is monitoring them. At these times the therapist could also be working one on one with another patient, or completing other tasks pertinent to the provision of therapy services. Limiting a therapist?s ability to do this would create inefficiency within our facilities, and could possibly lead to provision of therapy in a more aggressive manner (less rest breaks) which is not advantageous to this population. I also find that patients benefit from participating in therapy sessions where they are able to see their peers perform tasks as it provides motivation for them.

I believe it is more important to look at the patient?s overall treatment time received, rather than debating whether concurrent therapy is appropriate. As licensed clinicians, therapists should continue to develop patient treatment plans, incorporating individual, concurrent, or group therapy interventions as appropriate to achieve patient?s individualized goals.

Thank you for considering my feedback.

Sincerely,

_____
Laura Sparrer, PT
Rehab Manager
Partners in Rehab

CMS-1282-P-31

Form Letter

Submitter : **Mr. Daniel Zawadzki** **Date: 07/07/2005**

Organization : **Self-employed**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Issue

Issue

See attached

Proposed Refinements to the Case-Mix Classification System

See attached

CMS-1282-P-31-Attach-1.DOC

CMS-1282-P-31-Attach-2.DOC

31-E

evaluated on the day of admission their abilities and potential may be misinterpreted because of admission anxiety or fatigue. Requiring therapy evaluations on the day of admission would in most cases not be wise and done only for reimbursement purposes. It would be done because the MDS must reflect therapy actually given in the facility for a seven-day period. Residents who are experiencing anxiety or extreme fatigue on admission will be asked to participate in therapy in order to maintain their Medicare Part A status regardless of their physical and emotional ability.

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In addition, I respectfully encourage CMS to consider the information found on page 2-28 of the Resident Assessment Instrument Version 2.0 manual which specifically states, "Grace days can be added to the Assessment Reference Date (ARD) in situations such as absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting the ARDs, and should be used sparingly." I would ask that CMS remember that there is a severe nursing shortage in this country which effects staffing in long term care facilities. Further, there is a shortage of physical therapist as well that impact the start dates of therapies, especially related to weekends, holidays and evenings.

Elimination of the Projected Therapy on the 5-day Assessment in Section T of the MDS

I encourage CMS to maintain the current policy for Section T of the MDS. Often within the ARD of the 5-day assessment it is not possible to attain the 5-days of therapy required to classify in the Rehab category. The projection of days and minutes allows for this consideration and permits facilities to capture payment that is provided on the remaining days of this payment period. Without the projected days, facilities will not be compensated. More importantly the Medicare beneficiary may not receive the services at a level they require or can benefit from when there is inadequate compensation for the services. The projected therapy should remain to capture a situation where the beneficiary does not start out strong in therapy, but is assessed to have a good potential for an aggressive program.

I would like to thank you for the opportunity to submit comments and suggestions.

Sincerely,

Daniel Zawadzki, NHA, LSW

18910 Mallard Cove, Middleburg Hts., OH 44130

31-E

Centers for Medicare and Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8016

Attention: CMS 1282-P

Date: July 7, 2005

Deleted: http://www.cms.hhs.gov/regulations/ecomments/

My name is Daniel Zawadzki and I am writing on behalf of those who will be negatively effected by the proposed changes to offer testimony for the proposed Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006.

My comments are specific to possible changes that CMS might consider in the future.

Section: P1a, IV medications, suctioning, tracheostomy care and use of ventilator/respirator that classify residents into Extensive Services.

The proposal to eliminate the 14-day look back period for the items in P1a that cause a resident to group in Extensive Services will greatly affect the number of residents who attain that category and may affect the quality of care those residents receive if those items are not addressed on the Minimum Data Set (MDS). I respectfully ask that CMS remember the original reason for the MDS assessment, which is to provide a standardized assessment tool to improve quality of care in the long-term care setting. A comprehensive assessment requires that information be obtained from a variety of sources, thus eliminating the 14-day look back period for these items would compromise the resident's assessment. Proposing to eliminate the look back period would not identify special needs of the resident and would negatively impact the care planning process and level of quality care. Residents who are transferred to a long term care facility and who have experienced IV medications, suctioning, tracheostomy care and/or use of a ventilator/ respirator during their hospital stay have special care requirements upon admission, requiring more acute monitoring for possible infections and complications following those treatments. Respiratory care residents are often known to have frequent relapses after receiving suctioning or if they have had a tracheostomy or have had ventilator/respiratory care.

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5-Day Grace Day Period

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I would like to thank you for the opportunity to submit comments and suggestions.

Sincerely,

Daniel Zawadzki, NHA, LSW

18910 Mallard Cove, Middleburg Hts., OH 44130

Submitter : **Mr. Scott Plumb** **Date: 07/08/2005**

Organization : **Massachusetts Extended Care Federation**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1282-P-32-Attach-1.DOC

32-E

July 12, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P

Dear Sirs,

Enclosed please find comments on your proposal to update Medicare prospective payment system (PPS) rates for skilled nursing facilities (SNFs) effective with October 1, 2005 dates of service. We appreciate greatly the opportunity to testify, and hope that you will give our comments serious consideration when making your final decisions.

The Massachusetts Extended Care Federation is the state's oldest and largest long-term care provider organization. Our 500 member facilities care for and employ more than 100,000 citizens of the Commonwealth of Massachusetts. Increasingly, our members have been specializing in short-term, sub acute rehabilitative care. Nine out of every ten patients admitted to our facilities come directly from an acute care hospital, and virtually all of them have Medicare as their initial payment source. The adequacy and fairness of Medicare rates is a crucial issue for our members. While we will address a number of issues contained in your proposal, our most detailed comments will focus on what we believe to be the most serious issue in your proposal for many Massachusetts SNF providers, namely the redefinition of regional wage areas used to calculate PPS rates.

Redefinition of Wage Regions Used to Adjust the Labor Portion of PPS Rates

The totality of SNFs in New England will see an average rate reduction of 1.2% under the CMS proposal, the largest decrease of any region in the country. We estimate that the impact on Massachusetts will be of a similar magnitude. Close to one-half of the reduction will be due to the move from Metropolitan Statistical Areas (MSAs) to Core Based Statistical Areas (CBSAs) when adjusting the wage-related portion of PPS rates.

32-E

In Massachusetts, the scope of the wage region redefinition issue does not concern urban SNFs reclassified as rural SNFs. Rather, the issue in Massachusetts concerns SNFs in large urban areas reclassified into smaller urban areas, even though they essentially operate in the same labor markets. SNFs in five of twelve Massachusetts counties would experience lower PPS rates under the new CBSAs than under the old MSAs. SNFs located in one of those counties just to the north of Boston, Essex County, would see a significant decrease of close to 6%, or more than $15/day, in their PPS rates **solely due to the wage region redesignation.** This would overwhelm the anticipated small October 1, 2005 increase due to the 3% market basket inflation adjustment, causing October 1, 2005 rates for providers located in this region to be lower than current rates. Rates would be even lower on January 1, 2006 when the add-ons would be eliminated and the RUG reclassification would take effect.

Nationally, the impact of the wage region redesignation would be catastrophic in some counties. 363 counties would see a decrease of four percent or more in the wage adjustment portion of their Medicare rates. 15 states would experience substantial rate decreases due to regional wage adjustments in one or more of their counties.

Given the dramatic impact of the Office of Management and Budget (OMB) CBSA wage region designations on certain SNFs, **CMS should not proceed with the CBSA designations at this time**. Instead, it should continue to use the MSA determinations until it develops and implements a SNF-specific wage index that would allow the payment system to more accurately reflect differences in area wage levels. However, if CMS decides that it has the authority to apply the CBSA area wage designations effective with fiscal 2006 PPS rates, it should develop and implement a multi-year plan that would allow facilities to transition to the new system gradually so as not to radically disrupt facility operations.

It is ironic that CMS, which uses hospital nursing wages to determine SNF payment levels, was willing to transition certain hospitals to the new CBSA system last year when it was first introduced but does not recommend any transition in its current proposal for SNFs. In your proposal, you argued that it is not appropriate or necessary to propose a transition to the new CBSA-based labor market areas for the SNF wage index adjustment because it involved "an extremely small number of providers" and "the potential benefit of a hold harmless policy for an extremely small number of providers would be outweighed by the resulting decrease in payment rates for all providers." We could not disagree more with this statement. A $15/day rate cut for 55 SNF providers in Essex County Massachusetts is hardly inconsequential. PPS rate decreases for close to half of all Massachusetts' SNFs due to the CBSA redefinition is a major concern.

In your proposal, you discussed three options for transitioning to the new CMSA system, before dismissing the idea of a transition altogether. If CMS believes it has the right and obligation to use the new CBSAs in its PPS rate calculations, then it should not limit the discussion to the three transition plans offered and then rejected by CMS in the original proposal. If the changes have to be revenue neutral, then any plan would have to have the "winners" win less so the "losers" could lose less. We're sure that "winners" with

32-E

only marginal geographically determined rate increases wouldn't consider themselves "winners" since the increase would be below inflationary wage and benefits cost increases. Accordingly, we would recommend a transition plan that capped the "winners" at a certain percentage and capped the "losers" at a certain percentage for a period of time such as four years until SNFs in those areas could adjust to the new labor market redesignations. The cap on the percent of rate decrease due to new CBSA designations could be set at a percentage such that the CBSA rate "loss" would equate to the market-basket rate "gain," leaving these providers with October 1, 2005 PPS rates equivalent to their current rates. We estimate that the "loss" cap under this scenario would be in the range of minus 3 percent. While we believe that this option would be the fairest approach toward lessening the impact using the new CBSAs in calculating PPS rates, it should be emphasized that any transition option is preferable to no transition. Another option would be to phase in the wage index change **for all SNFs over a four-year period** to allow providers to transition to the new system without significant financial dislocation. Under this option, the wage index for each provider would consist of a blend of the MSA-based wage index and the CBSA-based wage index over a four-year period. Year 1 would be 25%CBSA-75%MSA; year 2 would be 50%CBSA-50%MSA; year 3 would be 75%CBSA-25%MSA; and year 4 would be 0%MSA-100%CBSA.

Lastly, it is our understanding that individual SNFs (as opposed to individual hospitals) are not allowed to petition CMS to have their wage area designation changed. Shouldn't SNFs be subject to the same rules as hospitals? As wage regions are made smaller, there will be situations where providers competing in the same wage market will be receiving vastly different wage adjustments to their Medicare PPS rates. SNFs should have the ability to make their case individually and, if they can demonstrate that they belong in a different wage region, be reclassified to the higher wage region. It is our further understanding that CMS has the authority to establish such a reclassification methodology, but only after it has collected the data necessary to establish a SNF-specific index. Thus, CMS's inaction is not only prolonging the use of an inappropriate hospital wage index, with its accompanying negative impact on the accuracy of the SNF wage adjustment, but is also depriving SNFs of the ability to be reclassified to more appropriate indices should the wage and employment market in which they operate justify such action. On both accounts, it is imperative that CMS develop a SNF-specific wage index as soon as possible.

Hospital Observation Stays and Medicare SNF Eligibility

We urge CMS to include hospital "observation days" toward the three-day prior hospitalization stay requirement for fee-for-service Medicare eligibility. We do not believe such as change would change hospital practice and cause a "woodwork effect" under which hospitals would increase their use of observation days. Instead, counting observation days would recognize current hospital practice and, as was noted in your proposal, address the inequity of denying SNF eligibility solely on a "recordkeeping convention on the part of the hospital rather than a substantive change in the actual care that the beneficiary receives there."

32-E

Consolidated Billing

In its proposal, CMS has also asked for comments on the services subject to the Medicare Part A consolidated billing requirement. CMS has consistently held they have the authority to exclude from the Medicare Part A SNF consolidated billing requirement only those services that fall within one of the four categories specified in the Balanced Budget Refinement Act (BBRA) (chemotherapy items, chemotherapy administrative services, radioisotope services, and customized prosthetic devices) and meet the standards of high cost and low probability in the SNF setting. We would like to bring up another item which should be excluded from the consolidated billing requirement, namely MRIs and CAT Scans delivered to SNF residents during a Part A stay **in freestanding clinics and not in hospital outpatient departments or in hospital outpatient departments but provided on a contractual basis by outside vendors and not by hospital radiology staff**. We have received many calls since Part A consolidated billing was first implemented from SNFs that sent their residents out for MRIs or CAT scans ordered by their physicians, only to learn weeks later after the $3,000 plus bill arrived that the services were provided in sites or by vendors that could not be excluded from the consolidated billing requirement. We believe that Congress intended the consolidated billing exclusions to be **service-specific, and not site-specific.** CMS should recognize this extreme inequity and work with AHCA and Congress to exclude MRIs and CAT scans from the consolidated billing requirement **regardless of where those services have been provided**. Such action would recognize current medical delivery practices and spare SNFs from paying for costly services that are not within their control.

This concludes our comments on CMS's PPS and Consolidated Billing Proposal. We thank you very much for considering our testimony. Should you have any questions regarding our comments, you may call me at 617-558-0202.

Sincerely,

W. Scott Plumb
Senior Vice President
Massachusetts Extended Care Federation

CMS-1282-P-33

Submitter : **Mr. Richard Miller** **Date: 07/08/2005**

Organization : **Kentucky Association of Health Care Facilites**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issue

Issue

See attachment

Proposed Revisions to the SNF PPS Labor Market Areas

See attachment

Implementation Issues

See attachment

Wage Index Data

See attachment

Case-Mix Adjustment and Other Clinical Issues

See attachment

CMS-1282-P-33-Attach-1.DOC

KAHCF

KENTUCKY ASSOCIATION OF HEALTH CARE FACILITIES . REPRESENTING LONG TERM CARE IN KENTUCKY

33-E

July 8, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1282-P
Post Office Box 8016
Baltimore, Maryland 21244-8016

Dear Sirs/Madame:

The Kentucky Association of Health Care Facilities (KAHCF) is responding with formal comments to the recent Notice of Proposed Rule Making regarding the proposed OMB geographic area designation changes (42 CFR Part 424, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006; Proposed Rule).

A preliminary analysis of the impact of the proposed geographic area designation changes on all facilities in Kentucky has been performed by the KAHCF staff and while some general assumptions were necessary due to the uncertainty of the proposed rates and RUGs distributions, the effect on many facilities within Kentucky appears to be significant; especially upon those facilities in Carter and Madison Counties. In Carter County, the proposed geographic changes would change the Carter County designation from an "urban" to "rural," and in Madison County, the revised designation from "urban" to "micropolitan" would have the same effect as being in a "rural" county, adversely impacting their reimbursement rates.

Our calculations show that 75.6% of facilities in the state experience rate reductions resulting from the new OMB designations. Five (5) facilities located in Carter and Madison counties are projected to lose over $500,000 in revenue annually due to the proposed changes in the wage index; the reductions in reimbursements range from $29 to $38 per Medicare day for these facilities. Reductions of this magnitude will have a negative affect on the care given to residents, leaving facilities no choice but to reduce staffing and other expenses to remain financially viable. A combination of rate reductions due to labor region changes, along with further major rate reductions scheduled for implementation on January 1, 2006 of $14-$20 (over 10/01/05) rates for all providers, makes a labor region change at this time extremely problematic with the significant potential for adverse implications on patient care.

9403 MILL BROOK ROAD . LOUISVILLE, KENTUCKY 40223 . PHONE: 502-425-5000 . FAX: 502-425-3431

33-E

In order to forestall this inevitable decline in critical resources, the KAHCF requests that CMS develop and implement a SNF-specific wage index that would help to more accurately reflect local market conditions and determine the appropriate impact on affected nursing facilities. It is the position of KAHCF that while the goal of establishing a wage index system to better reflect local market conditions is laudable, the currently proposed methodology is seriously flawed. In order to fulfill its statutory mandate, CMS must first devise, and subsequently implement a system that more accurately reflects local market conditions. Prior to any further action in this regard, CMS must develop and implement a SNF specific wage index before implementing the OMB CBSA based urban/rural area definitions.

Absent this preferred and recommended option of developing and implementing a SNF-specific wage index prior to implementation of the OMB definitions, KAHCF requests a four (4) year phase-in to those facilities negatively affected, and for facilities positively affected, to go immediately to the new urban/rural designation. The funding to support these changes should not be attained by a reduction in the proposed new rates, but instead be accomplished by a reduction of the proposed savings that this Refinement is intended to achieve.

Sincerely,

/s/

Richard G. Miller
President

9403 MILL BROOK ROAD . LOUISVILLE, KENTUCKY 40223 . PHONE: 502-425-5000 . FAX: 502-425-3431

CMS-1282-P-34

Submitter : **Ms. Heather Olson** **Date: 07/08/2005**

Organization : **Iowa Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-34-Attach-1.WPD

34-E

IOWA HOSPITAL ASSOCIATION

July 12, 2005

The Honorable Dr. Mark McClellan
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS -1282-P, P.O. Box 8016
Baltimore, MD 221244-801

Ref: CMS 1282-P Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006: Proposed Rule (69 *Federal Register* 29070).

Dear Dr. McClellan,

On behalf of Iowa's 34 hospitals reimbursed under the Skilled Nursing Facility (SNF) prospective payment system (PPS) the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the FY 2006 SNF PPS published in the May 19, 2005 *Federal Register*. In addition to a market basket update, the proposed rule includes structural changes to the current payment system and a related termination of payment add-ons, as required by law. The following are IHA's comments.

Case-Mix Adjustments and Other Clinical Issues

The SNF PPS has been widely criticized for under-reimbursing providers for costly non-therapy ancillary services, such as dialysis, intravenous feeding and medications, ventilator care and prescription drugs. These services are frequently used by medically complex Medicare patients who are most commonly treated in hospital-based SNFs and swing-beds. Since 1998, this pattern of under-reimbursement has caused one in three hospital-based SNFs nationwide to close, resulting in reduced access to care for many medically complex Medicare patients.

In recognition of this problem, Congress initiated several temporary payment adjustments. Two of these payment adjustments, authorized by the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000, are to remain in effect until CMS comprehensively refines the SNF PPS. Under the proposed rule, CMS calls for such a refinement which would terminate the remaining payment add-ons. These include a 20 percent add-on for medically complex Resource Utilization Groups (RUGs) and a 6.7 percent add-on for rehabilitation RUGs. Currently, **these add-on payments provide an additional $1.02 billion annually to SNFs.**

In FY 2001, CMS attempted to implement case-mix refinements. However, in validating its refinement, CMS concluded that the refinement failed to explain an extremely low percentage of cost variation. Accordingly, CMS decided not to adopt the proposed case-mix refinement. In this rule

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www.ihaonline.org

34-E

CMS again proposes to refine the case-mix reimbursement system by expanding the existing case-mix classification system from the current 44 RUG-III categories to 53 categories to better account for non-therapy ancillary services.

IHA supports refinement of the existing classification system. There are inherent flaws within the existing RUG-III classification system that create inequities between free-standing and hospital-based SNFs that must be eliminated, but **IHA's position is that the addition of the nine RUGs will not adequately accomplish that goal.** Since the enactment of the Balanced Budget Act (BBA) in 1997 and the adoption of the RUG-III classification system, Iowa hospital SNF PPS Medicare margins have been on a sharp decline and as of 2003 those margins reached a **negative 101 percent!** IHA disagrees with the premise that cost shifting is the primary contributing factor to negative margins. These negative margins verify that the current system does not adequately reimburse Iowa hospital-based SNFs for providing services to medically complex patients. In contrast, CMS states that Medicare margins of free-standing SNFs are **positive 13 percent**.

CMS is also proposing to add 8.4 percent to the nursing component of the case-mix weights as **CMS itself recognizes the proposed nine additional RUGs will still not adequately account for the non-therapy ancillary services.** By adding the 8.4 percent the result will be approximately an additional 3 percent in payments to SNFs. The increase will be distributed across all RUGs, as opposed to being dedicated to the under-reimbursed services. Until a broader, more comprehensive refinement is available, CMS should adopt measures to provide relief to hospital-based SNFs and swing-bed providers as they serve a disproportionate share of medically complex patients. The proposed refinements fail to meet the intent of Congress in ensuring adequate payment for medically complex SNF patients. **IHA urges CMS to withdraw its proposals to add an additional nine RUGs, and to work with the SNF provider community to develop a longer range, more comprehensive and equitable case-mix classification system. In the meantime CMS should provide additional funding to hospital-based SNF to recognize the higher acuity level of care they provide.**

Specifically, **IHA recommends that CMS implement a hospital-based SNF facility adjustment to support the medical infrastructure needed to care for beneficiaries with advanced skilled nursing needs.** The adjustment would recognize the costly personnel, equipment, and other operational features that must be maintained to provide proper care for medically complex patients. This would provide needed relief until a comprehensive fix for underpayment of non-therapy ancillary services is available and implemented.

CMS should consider weighting the per diem payment through variable per diem adjustments, as applied in the Inpatient Psychiatric Facility PPS, which would pay a larger daily rate for the early days of a stay than the later days. This approach would be a good fit for the SNF PPS since it would acknowledge the higher costs incurred in the early days of a SNF stay. This would provide an incentive to treat sicker, short-stay patients.

The Skilled Nursing Facility Market Basket Index

In the analysis of the market basket update and in response to its economic impact, this rule indicates CMS has over stepped one important variable. With the market basket update, the increase to the nursing component, in combination with the $1.02 billion loss in add-on payments, the net result is **an estimated $510 million cut to SNF providers**. The variable that has been over stepped is that **every year, SNFs receive an inflation factor regardless of whether or not the case-mix classification is refined. CMS should not factor in the market basket update when determining**

34-E

impact of the loss of the add-on payments.

IHA urges CMS to ensure the entire $1.02 billion <u>in addition to a full market basket update</u> for FY 2006 is maintained for SNF PPS payments. Congress did not direct CMS to implement cuts, it directed CMS to refine the existing case-mix classification system, and CMS has yet to do so adequately and fairly.

It would have been very helpful for providers and trade organizations such as IHA if the proposed rule would have been released along with the data and analyses used by CMS to develop the provisions in the proposal, especially for provisions that would restructure the RUGs. Also, a more detailed impact file with provider numbers, such as the file provided for Inpatient Rehabilitation Facilities, would assist organizations in determining the estimated impact of the proposed rule at the provider and state levels, which would in turn contribute to more robust feedback to CMS on how to strengthen the proposal. Without these data, stakeholders lack the key tools to assess the proposed rule and develop comprehensive, informed comments.

<u>SNF Wage Index</u>

Although IHA supports immediate transition to the Core Based Statistical Areas (CBSAs), it also supports the development of a SNF-specific wage index. In the past IHA has encouraged CMS to move forward in developing a SNF-specific wage index. In this rule, CMS states that adopting the CBSAs is one big change to the SNF wage index and that adding a SNF-specific wage index would institute a second big change and that would be inappropriate at this time. CMS' defense of its position contradicts the FY 2005 Inpatient PPS final rule when the agency instituted a number of significant changes to the wage index: adoption of the CBSAs, an occupational-mix adjustment, and numerous geographical reclassification criteria.

IHA urges CMS to begin developing instructions for the collection of SNF data <u>in conjunction with the provider community</u>. Implementing a SNF-specific wage index would allow CMS to establish geographic reclassification criteria for SNFs and would better recognize the employment mix among labor markets. A SNF wage index would also more appropriately distribute Medicare payments nation wide.

<u>14-Day Look Back and Five-Day Grace Period Provisions</u>

The minimum data set (MDS) items presented for discussion in the proposed rule should not be acted upon in a piecemeal fashion. CMS already has a process underway to update the current 2.0 version of the MDS, which has been the subject of ongoing discussions between CMS and national stakeholders in order to ensure that the pending revisions effectively captures the primary concerns for CMS, providers, and patients. All MDS changes should be conducted in a coordinated fashion with regard to the development of MDS 3.0 and a broader refinement of the SNF PPS. The potential MDS modifications identified in the proposed rule (the look-back period, grace days, and anticipated therapy) would be very detrimental since they would significantly limit the cases that would be eligible for the proposed new RUGs categories. Hospital-based SNFs cannot absorb further financial burden in combination with the under-payment for non-therapy ancillary services. Any proposed changes should be presented with full analysis of their implications for patients and providers through formal rulemaking that allows for review and comment.

Also, IHA continues to be concerned about the MDS' inability to capture short-stay patients, commonly treated in hospital-based SNFs, who are discharged before the standard five-day assessment. One possible solution to this issue is to implement an assessment at the beginning of the

SNF stay. This approach would be consistent with MedPAC's testimony provided to the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives on June 16, 2005. Another alternative would be to allow the SNF to complete the MDS upon the patient's discharge, regardless if it falls before the five-day assessment.

Qualifying Three-Day Inpatient Hospital Stay

This rule requests comment on whether or not an observation stay immediately preceding an inpatient stay should qualify for the three-day prerequisite for SNF level of care. Given changes in the delivery of health care since the creation of the SNF benefit in 1965, it is more common for physicians to admit patients to observation when it is questionable whether or not the patient will require or meet medical necessity criteria to qualify for an inpatient admission. **IHA supports changing the policy to include observation stays immediately preceding an inpatient stay to meet the admission criteria for SNF level of care.**

Designing Pay for Performance

In this rule CMS acknowledged that Medicare Part A pays for only a small portion of nursing home care (10 percent), which is not enough to affect broad-scale pay for performance criteria to enhance the quality of care Medicare beneficiaries receive. The agency also wishes to move toward a performance measurement model that coordinates an approach to payment for post-acute services that reaches across settings and focuses on quality of care for the overall post-acute episode, regardless of provider type. This model would require CMS to transition from provider-centric payment approaches to patient-centric approaches based on patient characteristics and outcomes.

Despite the inadequate reimbursement, Iowa hospital-based SNFs and swing-bed providers continue to demonstrate value through the provision of efficient and quality health care services, as evidenced by CMS rankings of Iowa's delivery of quality health care as the sixth highest in the nation. For the Medicare program to become a purchaser of value, it must focus on improving the health outcomes for program beneficiaries and more effectively manage the disperse resources that Congress provides.

IHA has been a long-time supporter of the Medicare program becoming a purchaser of value. Any design of paying for the post-acute care episode based on patient characteristics and outcomes must embrace the following principles:

Payment incentives should:

- Reward providers for improving quality and providing effective care.
- Evaluate the consumption of resources in achieving desired health outcomes as this is necessarily required in measuring effective care.
- Use a system of rewards that increases payments and reduces regulatory burdens for successful providers.
- Be aligned between institutional providers and physicians.

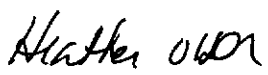
Performance measures should be:

- Based on measures of adherence to quality improving processes.
- Selected to insure that all SNFs have an opportunity to participate and succeed.
- Selected to minimize the data collection burden for providers.

34-E

Thank you for your review and consideration of these comments. If you have questions, please contact me or Tracy Warner at the Iowa Hospital Association at 515/288-1955.

Sincerely,



Heather Olson
Director, Finance Policy

cc: Iowa Congressional Delegation
IHA Board of Trustees
Iowa hospitals
CMS Kansas City Regional Office

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www.ihaonline.org

Submitter : **Mr. Mark Jaeckle** **Date: 07/08/2005**

Organization : **Catholic Health System**

Category : **Physical Therapist**

Issue Areas/Comments

Issue

Proposed Revisions to the SNF PPS Labor Market Areas

I had previously commented on the elimination of section T for projecting patients into Rehab RUG groups. I feel that removing this from the MDS is reasonable, though there will be need to utilize grace days on the 5-day MDS to allow accurate days and minutes to be reflected in section P to appropriately score the patient in the RUG group that reflects the level and intensity of therapy provided. After further thought, the use of section T is extremely valuable in the cases where patients are in the SNF for only a few days. For instance if a patient is discharged on day 3 or 4 back home or even back to the hospital, section T is needed to capture an appropriate RUG group. If section T is removed from projecting patients into Rehab High, Medium, or Low, there will need to be a system built in to provide a RUG score/payment for patients that have a length of stay under 8 days. With this in mind, if there is not a proposed system to score these types of patients, I recommend continuation of the current section T system.

Submitter : Mrs. Debbie Griffin **Date:** 07/08/2005

Organization : Northwoods Lodge

Category : Occupational Therapist

Issue Areas/Comments

Issue

Issue

Grace Periods:

Would like to address the issue of eliminating or decreasing the grace days for the 5 day PPS. Currently if a patient is transferred to our facility with significant medical issues the current estimation of minutes under section T allows the facility to capture at least an RH level during the first 14 days of treatment. Many patients may have decreased ability to participate at an RH level for the first day or two, however, by day 4 or 5 their therapy time is increasing and they are truly at an RH level, sometimes approaching RV or RU depending on number of disciplines involved. If the grace days are eliminated a patient that does not tolerate minimum therapy for day 1 or day 2 would have no way to classify into an RH by day 5. With the requirement that at least one discipline see the patient for 5 days with RH level and admits to our facility at 4:00, 5:00 and 6:00pm it is quite difficult to complete a same day evaluation.

The same holds true if projection of anticipated therapy services is eliminated. Currently under section T if an RV level is projected for the 5 day PPS the only way it is paid out is if the minutes actually support this, many times we utilize the grace days to achieve this level. The same could be done for RH minutes, if grace days are kept in place.

Concurrent Therapy

Concurrent Therapy:

An example of how we use concurrent therapy: Activities of Daily Living. Our rooms have a private bathroom as well as an additional sink in the room. If we have a patient who is approaching independence with dressing and bathing but still needs skilled oversight, cues, we may give them 1:1 attention for the first 20-30 minutes of their session, then start the roommate bedside or at the sink(who would also have to be at a minimum assist level or greater). In this way the therapist can move back and forth between the clients providing supervision and input as needed. As you can tell from this description we do not do a significant amount of clients in this manner due to the levels they need to be at. It would not be appropriate to complete this with 2 patients requiring maximal assist.

I believe CMS should look at this issue of concurrent vs. group therapy in general. Theoretically if you are working with more than 1 person at a time you are not providing individual treatment. Perhaps the definition of group therapy should be expanded to mean more than 1 person at a time, regardless of whether they are working on common skill development. With outpatient Medicare Part B it is very clear that if you are not providing 1:1 treatment you are completing a group. Why should the requirement be different for Medicare Part A? By using the ?no greater than 25% of total minutes in a 7 day period be in a group? you would be insuring that patients are not grouped solely for productivity reasons in a clinic. I would be interested to see comments from facilities that demonstrate when concurrent therapy is skilled outside of the above example provided.

Case-Mix Adjustment and Other Clinical Issues

Qualifying Three-Day Inpatient Hospital Stay:

This issue needs to be addressed. Many clients are not aware that they have not been admitted to the hospital, that they were under observation only, particularly when a large number of tests have been completed. By allowing the days of observation to count towards the qualifying 3 day hospital stay I do not believe facilities will use this as the floodgates to transfer pts to SNF?s for a less expensive convalescence. I have seen patients affected by the 3 day qualifying stay, 80 year old male with back strain, transferred to SNF for rehab to allow safe discharge back home. After 2 weeks of intensive therapy including daily use of modalities he had a successful outcome. This would have been difficult to complete on an outpatient or home health basis due to the intensity of services he needed. Because his ?3 days of observation? did not qualify as a hospital stay he paid privately for his stay at the SNF. He had an intensive workup in the hospital, at a level of complexity that would have been difficult to complete on an outpatient basis. In this case he should have been able to access his SNF benefits under Medicare.

If this issue is not changed I feel facilities should have the ability to present case by case issues as they occur for immediate review. We are a skilled nursing facility with no long term care, only sub-acute rehab so the frequency that we encounter a patient in this situation is infrequent. I do not have a good feel for how much this is utilized with long term care patients moving back and forth from hospital with a change in condition.

Thank you for the opportunity to comment on these issues.

Submitter : **Mrs. Jan White** **Date: 07/08/2005**

Organization : **Shoreline Healthcare Management**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1282-P-37-Attach-1.DOC

37-E

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006

CMS-1282-P

Comments on SNF PPS Proposed Rule

Proposed Refinements to the Case Mix Classification System

I strongly disagree with removing the look-back provision and limiting special care services to those provided only after admission to a SNF. A SNF resident should not be excluded from a medically complex designation because special care services were provided in a hospital rather than a SNF.

The grace day periods should not be decreased or eliminated for the 5-day MDS or any other assessments. SNFs should have the flexibility to set an assessment reference date that best reflects the resources used by a SNF resident.

Projecting therapy services during the 5-day assessment should continue. The Interim Final Rule stated that projecting rehabilitation services in Section T allowed a resident time for transition in a SNF and allowed for accurate classification when rehabilitation is planned. This has not changed.

Removing the look-back provision, reducing or eliminating grace days and eliminating the projection of therapy services would all have a negative economic impact on SNFs. Since SNF PPS is the only Medicare PPS system without an outlier policy, the development of an outlier policy for high ancillary costs would be a better option than further modifications to the case-mix classification system.

Consolidated Billing

While not related to the four service categories for which comments were requested, I believe that PET scans should be considered for exclusion to consolidated billing. Also, radiation therapy services, CT scans and MRIs should be excluded whether provided in a hospital or freestanding clinic. These services are not provided by hospitals in many instances.

CMS-1282-P-38

Submitter : Ms. Susan Klanecky

Date: 07/08/2005

Organization : Madonna Rehabilitation Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-38-Attach-1.DOC

38-E

July 7, 2005

File Code – CMS-1282-P

"Proposed Refinements to the Case Mix Classification System"

Elimination of pre-admission period "look back" timeframe.

Starting with the MDS manual 2002 and subsequent updates, those items coded under special treatment and procedures have already significantly decreased the number of residents having those items coded from the pre-admission period. Residents who do receive special treatments and procedures during the pre-admission process often require intense clinical monitoring after they are admitted to the SNF. Therefore, elimination of these items from the pre-admission process would not adequately reflect the clinical acuity of residents and resources used in the SNF after admission. In addition, as acute care hospital stays continue to shorten, SNF's are caring for higher acuity patients.

Elimination of grace days in the 5-day assessment period and elimination of grace days for other assessments.

It has been our experience that SNF residents are already medically fragile and exhausted due to acute care hospitalization and the transfer trauma. In the initial development of the SNF PPS payment system, CMS (then HCFA) recognized this and developed the system to not subject the resident to immediate intense therapy if the resident's clinical condition contraindicated it. In the present system, use of grace days allows the facility to be reimbursed for the level of service that is being provided to the resident even if those services started once the resident stabilized on admission. The elimination of grace days with the 5-day assessment would result in either a push to start intense therapy sooner which could jeopardize the clinical status of the resident, and/or unfairly penalize the facility by not reimbursing them for the level of service provided. Grace days during the 5-day assessment are especially important to allow the facility adequate observation time to implement a clinically appropriate plan of care.

In addition, many residents are not admitted to the SNF until mid-afternoon because physicians do not make rounds and discharge the resident from acute care in time for the resident to be transferred in the morning. This does not give the facility adequate time to admit the resident and attend to his/her clinical needs and do therapy evaluations (which can't be counted as therapy minutes) the first day. Without the use of grace days, this would also unfairly penalize the facility. Therefore, retaining grace days for the 5-day assessment are absolutely critical.

The majority of facilities do not use grace days for other assessments; therefore, the impact of eliminating those grace days would be minimal.

Elimination of projected for anticipated therapy during the 5-day PPS assessment.

Some of the same issues identified in elimination of grace days are applicable to elimination of projections for therapy services to be provided during the first 15 days of the residents

38-E

stay. For example resident's may not be clinically ready and able for intense therapy services immediately upon admission to the SNF as CMS also recognized when the SNF PPS system was first developed. Projected days and minutes of therapy services are based on a skilled evaluation of the service needs of the resident. The facility should be reimbursed for the level of service that is clinically appropriate and being provided to the resident.

Submitted by:

Susan Klanecky, RN, BSN, CCM, CRRN
Director of Case Management

Madonna Rehabilitation Hospital
5401 South Street
Lincoln, NE 68506

Submitter : **Ms. Carol Kroboth** **Date: 07/08/2005**

Organization : **Medical Facilities of America, Inc.**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

Issue

Issue

See Attachment

Wage Index Data

See Attachment

Proposed Revisions to the SNF PPS Labor Market Areas

See Attachment

Concurrent Therapy

See Attachment

CMS-1282-P-39-Attach-1.DOC

Medical Facilities of America, Inc.

39-E

July 8, 2005

Dr. Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1282-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington DC 20201

Submitted Via E-Mail www.cms.hhs.gov/regulations/ecomments

RE: Comments on Medicare Program; Proposed Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2006
May 19, 2005 Federal Register Proposed Rules - 42 CFR Part 424
CMS-1282-P

Dear Dr. McClellan:

Medial Facilities of America, Inc. operates thirty one facilities in the state of Virginia. We thank you for the opportunity being provided to comment on the proposed rules for the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2006.

The Skilled Nursing Facility Market Basket Index – Federal Register Pages 29074 & 29097

It is a concern that cost data from 1997 is being utilized in the calculation of the market basket index. Cost data for skilled nursing facilities is provided annually in the form of Medicare cost reports. Reports are to be filed within one hundred and fifty days of the cost report year end; therefore as filed cost data should be available for all providers with cost report year ends on or before January 31, 2005. Although it is understandable the "as filed" reports would not be acceptable to determine the factors utilized in the market basket adjustment, why couldn't the most current Notice of Program Reimbursement (NPR) be utilized? All of the reports with cost reports ending on or before December 2002 should have NPRs issued by now.

On page 29097 of the May 19, 2005 Federal Register it is noted the cost categories & price proxies can be found on Table 10.B in the July 31, 2001 Federal Register. The July 31, 2001

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Table 10.B shows Wages Salaries and Employee Benefits use the Employment Cost Indexes for Private Nursing Homes. Are all of the nursing homes reflected in the Private Nursing Home indexes providers of skilled nursing care? Since labor and related costs make up a majority of the cost in a skilled nursing facility, it is a concern that the increasing labor costs SNFs have experienced over recent years may not be appropriately recognized in the factors being utilized. Again, it seems utilization of cost data provided in the SNF Medicare cost reports could be utilized to provide more accurate information for skilled nursing facility market basket adjustments.

Proposed Refinements to the Case Mix Classification System – Federal Register Page 29080

Look Back Period

There are four clinical services that were highlighted on page 29080 as special services that utilize the that utilize the look back period: "... four items contained in the Special Services section of the MDS (P1a – IV medications, suctioning, tracheostomy care, and use of a ventilator / respirator) that serve to classify residents into Extensive Care, the category used for most medically complex SNF patients under the RUG-III classification system." Patients receiving these treatments are clinically unstable upon entering a skilled nursing facility setting.

Often patients are admitted to a skilled nursing facility directly from hospital ICU, rather than being placed in a hospital step down unit. Many patients enter a skilled nursing facility shortly after surgeries. Although patients entering a skilled nursing facility may not continue to utilize equipment available in a hospital setting and they may not continue with all of the procedures provided while in a hospital setting, these patients require extensive monitoring, observation, assessment of medical conditions, and follow up after the hospital discharge. It is important to include the look back period, to capture the extensive services that continue for these higher acuity patients.

Grace Day Period

Residents that require ultra high or very high rehabilitation can not always get the five days and 500 to 720+ minutes of rehabilitation in the initial five day assessment, without the use of grace days. An example would be of a patient that enters a SNF on a Wednesday. If the facility does not provide rehabilitation on Sunday's, the patient would not be able to receive the five days of therapy required to place them in a RU or RV RUGs level. When services are provided in this example the facility will not be reimbursed for the care they delivered without the grace period.

Concurrent Therapy – Federal Register Pages 29082 - 29083

In the discussion of concurrent therapy on page 29083 it is stated "we acknowledge that concurrent therapy can have a legitimate place in the spectrum of care options available to the therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations." There must always be a clinical consideration to provide therapy in a

skilled nursing facility, since a physician must order therapy before it can be provided to the patient. 39-6

Proposed Revisions to the SNF PPS Labor Market Areas – Federal Register Pages 29091 to 29096

Specifically dealing with a skilled nursing facility in Culpeper Virginia In the proposed regulations Culpeper Virginia is being moved into the Culpeper County, Virginia State County Code Area # 49230, which is in the Rural Virginia Core Based Statistical Area #99949. Culpeper Virginia is located just south of Washington DC, Arlington, Fairfax& Manassas Virginia, north west of Fredericksburg Virginia and north east of Charlottesville Virginia.

Location	Distance From Culpeper
Arlington, VA	69 Miles
Fairfax, VA	56 Miles
Fredericksburg, VA	36 Miles
Manassas, VA	39 Miles
Charlottesville, VA	45 Miles

Many individuals that live in Culpeper commute to the surrounding cities for work, and it is also necessary to employ individuals from outside of the county to meet the clinical needs of the patients in the nursing facility. During the first six months of 2005 just under 70% of the employees were from outside of the county. The high cost of wages has been reflected in the MSA & the CBSA wage indexes for these surrounding cities, as reflected in the chart below:

	Metropolitan Statistical Area (MSA)	2005 MSA Wage Index	2006 MSA Wage Index	Core Based Statistical Area (CBSA) State/ County Code Area (SSA)	
Culpeper VA	**Included in DC MSA 8840**	**1.0971**	**1.0983**	**Culpeper County, VA - SSA 49230**	**.8012**
Arlington, VA	Included In DC MSA 8840	1.0971	1.0983	Arlington County VA - SSA 49060	1.0932
Fairfax, VA	Included in DC MSA 8840	1.0971	1.0983	Fairfax City County, VA SSA 49288	1.0932
Fredericksburg, VA	Included In DC MSA 8840	1.0971	1.0983	Fredericksburg City County VA – SSA 49342	1.0932
Manassas, VA	Included in DC MSA 8840	1.0971	1.0983	Manassas City County VA – SSA 49565	1.0932
Charlottesville, VA	Charlottesville, VA - MSA 1540	1.0295	1.0234	Charlottesville City County VA - SSA 49191	1.0234

The Culpeper skilled nursing facility must compete with the wages in these nearby cities to obtain the clinical help that is necessary to care for their patients. The proposed wage indexes for the surrounding cities have remained fairly consistent for the period 2005 to 2006, where the Culpeper wage index is proposed to decrease by 27%. A twenty seven percent decrease in the wage index for Culpeper equates to a $70 per day decrease in the average daily Medicare Part A rate.

Based upon wage surveys prepared for the State of Virginia Department of Medical Assistance, for the year ended December 31, 2004, nursing salaries made up of RNs LPNs and CNAs for other facilities we operate that are grouped in the Rural Virginia Core Based Statistical Area had salaries far below those of the Culpeper facility:

	RNs	LPNs	CNAs
Culpeper Facility	**28.08**	**20.22**	**11.02**
Facility 1	24.23	15.54	10.15
Facility 2	23.10	16.70	9.34
Culpeper vs (Rural Facility 1 &2)	+28.08 / 23.67 =119%	+20.22 / 16.12 = 125%	+11.02 / 9.75 = 113%

Another issue that can cause huge reduction to the Medicare rates is when has a decrease in the wage index coupled with a change in the facility designation from a rural facility to an urban facility. We have a facility in Pulaski Virginia that is currently recognized as rural with a wage index of .8480 and it is being proposed that they will be moved into an urban designation with a wage index of .7962. The variance in the wage indexes of 6% coupled with the change to an urban designations will result in a reduction in the average daily Medicare rate of $28 a patient day for the wage adjustment portion of the rate.

Ceiling & Floor

We believe the CBSAs appropriately reflect wages in a majority of the wage areas, however, it will be devastating to facilities that have great fluctuations in rates due to this change in the wage indexes, and facilities that have a shift from rural to urban in addition to a decrease in the wage index. To avoid the devastating impact of the extreme changes in wage indexes in many of the areas around the country, we strongly recommend, that for facilities which experience a significant reduction to the wage index have a phase in be established, or a floor put in place.

Three Day Stay

CMS has invited comments on the possibility of counting the time spent in hospital observation status toward meeting the SNF benefit's qualifying 3-day hospital stay requirement, when the observation status is immediately prior to a hospital inpatient stay.

To qualify for a Medicare Part A stay in a skilled nursing facility, a beneficiary must first be an inpatient in a hospital for three or more consecutive days, before being admitted to a SNF to receive daily skilled services. The three day hospital stay requirement dates back to 1965 when Medicare legislation was first initiated, and before observation days became prevalent

39-E

in hospitals. The hospital stay preceding a SNF stay was intended to ensure the Part A beneficiary in a SNF was in need of skilled care not custodial care.

A distinction has been made between observation services and emergency room services in section VI on page 29099: "(Medicare Benefit Policy Manual), Chapter 6 (Hospital Services Covered Under Part B), section 70.4 (Outpatient Observation Services) in which a patient who needs more care than can be provided in an emergency room is moved from the emergency room, placed in a hospital bed in the appropriate hospital unit and monitored by the unit nursing and physician staff." Although a patient in an observation status is considered outpatient for hospital billing purposes, by the definition above the observation patients are in need of a greater level of care than patients remaining in the emergency room.

The hospital observation period, prior to an inpatient admission, should be combined with the hospital inpatient stay, to meet the 3-day hospital stay requirement necessary to qualify a beneficiary for Medicare Part A services in a skilled nursing facility. Hospitals are acute care settings. Patients are being observed while in an observation status, as well as after they are formally admitted as an inpatient. If it is determined a patient needs to be admitted after an observation period, the patient is in need of professional care, not being prepared for a custodial setting.

In addition to the three day qualifying hospital stay a Medicare beneficiary must have a physician certify the need for daily skilled care, for a beneficiary to receive Part A coverage in a skilled nursing facility. When the daily skilled services end, the Medicare Part A coverage also ends. Medicare Part A is not responsible for custodial care in a skilled nursing facility.

Thank you for your considerations of these comments. If you should have questions concerning these comments you can contact me at (540) 776-7535 or at the address below.

Sincerely,

Carol R. Kroboth
Vice President of Reimbursement
Medical Facilities of America, Inc
2917 Penn Forest Boulevard
Roanoke, VA 24018

CMS-1282-P-40

Submitter :

Date: 07/08/2005

Organization : **MedPAC**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

No attachment in system, see Comment 12-H

Submitter : **Jane Belt** **Date: 07/11/2005**

Organization : **Plante & Moran**

Category : **Long-term Care**

Issue Areas/Comments

Issue

Issue

5-Day Grace Day Period
Eliminating the grace day period for the 5-day PPS MDS assessment would have a clinically negative impact for long term care residents. Frequently newly admitted residents cannot tolerate therapy on the day of admission because many are admitted in the afternoon or evening and they are extremely tired. If residents are required to be evaluated on the day of admission their abilities and potential may be misinterpreted because of admission anxiety or fatigue. Requiring therapy evaluations on the day of admission would in most cases not be wise and done only for reimbursement purposes. It would be done because the MDS must reflect therapy actually given in the facility for a seven-day period. Residents who are experiencing anxiety or extreme fatigue on admission will be asked to participate in therapy in order to maintain their Medicare Part A status regardless of their physical and emotional ability.
In addition, I respectfully encourage CMS to consider the information found on page 2-28 of the Resident Assessment Instrument Version 2.0 manual which specifically states, ?Grace days can be added to the Assessment Reference Date (ARD) in situations such as absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting the ARDs, and should be used sparingly.? I would ask that CMS remember that there is a severe nursing shortage in this country which effects staffing in long term care facilities. Further, there is a shortage of physical therapist as well that impact the start dates of therapies, especially related to weekends, holidays and evenings.

Case-Mix Adjustment and Other Clinical Issues

Elimination of the Projected Therapy on the 5-day Assessment in Section T of the MDS
I encourage CMS to maintain the current policy for Section T of the MDS. Often within the ARD of the 5-day assessment it is not possible to attain the 5-days of therapy required to classify in the Rehab category. The projection of days and minutes allows for this consideration and permits facilities to capture payment that is provided on the remaining days of this payment period. Without the projected days, facilities will not be compensated. More importantly the Medicare beneficiary may not receive the services at a level they require or can benefit from when there is inadequate compensation for the services. The projected therapy should remain to capture a situation where the beneficiary does not start out strong in therapy, but is assessed to have a good potential for an aggressive program.

Proposed Refinements to the Case-Mix Classification System

Section: P1a, IV medications, suctioning, tracheostomy care and use of ventilator/respirator that classify residents into Extensive Services.
The proposal to eliminate the 14-day look back period for the items in P1a that cause a resident to group in Extensive Services will greatly affect the number of residents who attain that category and may affect the quality of care those residents receive if those items are not addressed on the Minimum Data Set (MDS). I respectfully ask that CMS remember the original reason for the MDS assessment, which is to provide a standardized assessment tool to improve quality of care in the long-term care setting. A comprehensive assessment requires that information be obtained from a variety of sources, thus eliminating the 14-day look back period for these items would compromise the resident?s assessment. Proposing to eliminate the look back period would not identify special needs of the resident and would negatively impact the care planning process and level of quality care. Residents who are transferred to a long term care facility and who have experienced IV medications, suctioning, tracheostomy care and/or use of a ventilator/ respirator during their hospital stay have special care requirements upon admission, requiring more acute monitoring for possible infections and complications following those treatments. Respiratory care residents are often known to have frequent relapses after receiving suctioning or if they have had a tracheostomy or have had ventilator/respiratory care.

CMS-1282-P-41-Attach-1.DOC

CMS-1282-P-41-Attach-2.DOC

Centers for Medicare and Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8016

Attention: CMS 1282-P

Date: July 10, 2005

41-E

(form letter 31-E)

My name is Jane Belt and I am writing on behalf of Plante & Moran to offer testimony for the proposed Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006.

My comments are specific to possible changes that CMS might consider in the future.

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I would like to thank you for the opportunity to submit comments and suggestions.

Sincerely,

Jane C. Belt, MS, RN, CS, CLNC
Director of Clinical Services

41-E

Centers for Medicare and Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8016

Attention: CMS 1282-P

Date: July 10, 2005

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I would like to thank you for the opportunity to submit comments and suggestions.

Sincerely,

Jane C. Belt, MS, RN, CS, CLNC
Director of Clinical Services

Submitter : **Date: 07/11/2005**

Organization : **American Health Information Management Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-42-Attach-1.DOC

Attachment #42

July 8, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P
PO Box 8016
Baltimore, Maryland 21244-8016

Dear Dr. McClellan:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNFs) for fiscal year 2006, as published in the May 19, 2005 *Federal Register*. The American Health Information Management Association (AHIMA) is a professional association representing 50,000 educated health information management (HIM) professionals who work throughout the healthcare industry. HIM professionals serve the healthcare industry and the public by managing, analyzing, and utilizing data and records vital for patient care and making it accessible to healthcare providers and appropriate researchers when it is needed most.

Managing the records for health care has been a role for HIM professionals for over seventy-five years, and AHIMA members are now working diligently to ensure that we soon have standard, interoperable electronic health records to improve the quality and safety of patient care. Currently we are working on a variety of projects with the Health Level Seven (HL7), the Office of the Coordinator for Health Information Technology (ONCHIT), and other groups to ensure that in the future electronic health records (EHRs) will provide the same complete and accurate record, only in an environment that will permit better health and safety than in the paper environment.

II-B: Case-Mix Adjustment and Other Clinical Issues

II-B-2b: **Constructing the New RUG-III Groups** (70FR29077)

AHIMA supports the creation of nine RUG-III groups to capture individuals who qualify for both the Extensive Services category and the Rehabilitation Therapy category. We recommend that additional detail be added in Table 3a (page 29077) to describe the composition of the new RUG-III groups, similar to the 44-RUGs group documentation found on page 26262 of the May 12, 1998 Interim Final Rule.

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phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

42-E

II-B-3: Proposed Refinements to the Case-Mix Classification System (70FR29078)

We are concerned that elimination of the 14-day "look-back" period will adversely affect clinical data accuracy and have a negative impact on the clinical proxy used for SNF Medicare presumption of coverage. It is important to note that the data analysis that led to a proposal to create the new RUG-III groups utilized claims data based on the "look-back" and grace day provisions being in effect. Currently, MDS Section P1a captures treatments and programs of significant clinical impact irrespective of site of service, such as chemotherapy, dialysis, transfusions, etc. The clinical relevance of the resident receiving these services within the prior 14 days is not diminished by the service occurring prior to admission, and should continue to be reported. In the July 30, 1999 SNF PPS Final Rule, it stated that the occurrence of one of the specified events during the "look-back" period, when taken in combination with the characteristic tendency for a SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances.

On page 29080 of the proposed rule, it states that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) that were furnished exclusively during the period before SNF admission. Presumably, a portion of this significant number of residents only received skilled benefits because of the "presumption of coverage" provisions. The July 30, 1999 SNF PPS Final Rule indicated that residents classified as skilled as a result of the look-back provision may need the types of services formerly listed in § 409.33(a) of the regulations. However, often facilities are reluctant to use subjective services, such as assessment and care planning, to classify residents as needing skilled care because of the increased risk of denial by the fiscal intermediary.

AHIMA opposes changes to the grace day periods, as we feel the rationale for their use, as described in the RAI Manual and in the July 30, 1999 SNF PPS Final Rule, is still valid. We also oppose the elimination of the projection of anticipated therapy services. A change in this policy could potentially result in inappropriate RUG-III classification of beneficiaries receiving therapy services. The quality of patient care could be adversely impacted, as therapists may decide to start therapy too soon or delay the start of therapy because of reimbursement implications. Elimination of provisions for projecting anticipated therapy removes the ability to accurately reflect the intensity of Rehabilitation service delivery for short stay residents. For example, a resident in a SNF for four days, who receives therapy on all days, would not group appropriately to the Rehabilitation category without the provision for projecting service delivery.

We fully support CMS' efforts to promote and improve the continuity and quality of healthcare through the use of interoperable electronic health record (EHR) systems and standardized data. Moving from paper-based records and systems to electronic health records and systems offers significant benefits to the healthcare consumer, provider and payer such as reduction in medical errors, improved use of resources, accelerated diffusion of knowledge, and increased consumer involvement in their care. Long term care providers, like the rest of the health care community, face significant challenges in moving towards an EHR. In addition to the daunting challenges posed by technical obstacles, fiscal resources and staff capacity to implement and maintain fully electronic health records are huge hurdles in an industry known for reimbursement and staffing issues. In addition to using electronic information exchange to improve

42-E

communication between hospitals and SNFs, we believe it is also important to include physician practices in this process. Federal incentives are needed to accelerate the adoption of interoperable electronic health records and achieve the goals of improved quality, safety, and coordination among healthcare providers.

II-B-4: Implementation Issues (70FR29081)

AHIMA is concerned that January 1, 2006 may be too soon to base payments entirely on the proposed new RUG-53 classification system. Software vendors may not be able to complete system modifications in this time frame. We also recommend that CMS issue guidance on claim submission processes during the transition period. Clarification is necessary regarding issues such as:

1. Is the Health Insurance Prospective Payment System (HIPPS) code reported on the Medicare claim to reflect the RUG classification based on date of service versus MDS assessment reference date (A3a) or MDS completion date (R2b) (i.e. claims for dates of service through December 2005 reflect the 44-group RUG classification and claims for dates of service on or after January 1, 2005 reflect the 53-group RUG classification)?

2. For MDS assessments that are used to cover skilled services days in both December 2005 and January 2006 (e.g. a Medicare 30-day assessment covering services dates of December 15, 2005 through January 13, 2006):

    a. Which date triggers the reporting of a 44-group or 53-group RUG classification at MDS item T3a - the service date, MDS assessment reference date (A3a), or MDS completion date (R2b)?
    b. What documentation trails are facilities to maintain regarding the 44-group RUG assignment and 53-group RUG assignment when an MDS is used to cover services in both December and January?

3. Will the federal MDS edits calculate and accept submission of 44-group RUG classification on MDS correction assessments submitted through April 2006 (covering the 120 day maximum for submitting corrected SNF claims)?

II-B-5: Assessment Timeframes (70FR29082)

The discussion of OMRA assessments on page 29082 is very confusing for readers who are not familiar with the CMS history of equating a Medicare assessment "due date" with the MDS assessment reference date found at item A3a. Language found in the May 12, 1998 Interim Final Rule (page 26266) and the July 30, 1999 Final Rule (page 41656) clearly discuss OMRA assessments in terms of the "assessment reference date". We recommend that the language in the current proposed rule be reconciled with the language in these prior rule issuances and the current RAI Manual.

II-B-6 SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists (70FR29082)

We appreciate CMS' efforts to define "direct" and "indirect" employment relationships. However, the definition of an "indirect" employment relationship is still somewhat confusing and needs further clarification.

42-E

VI: Qualifying Three-Day Inpatient Hospital Stay Requirement (70FR29098)

AHIMA fully supports the inclusion of the time spent in observation status toward meeting the SNF benefit's qualifying three-day hospital stay requirement. Analysis of 1997 – 2001 SNF and hospital claims data by the Office of the Inspector General identified 60,047 SNF claims that were potentially reimbursed erroneously due to lack of a qualifying three-day hospital *inpatient* stay. While this number is significant, it would obviously increase substantially if it included the number of beneficiaries who did not receive SNF Part A benefits due to appropriate recognition of technical ineligibility by SNF providers.

Observation vs. inpatient status is a business decision related to payment policy. A beneficiary's eligibility for SNF benefits should not be jeopardized because his status was classified as observation rather than as inpatient. Patients classified as observation occupy an inpatient bed, and the level and type of services provided are identical to that which would have been provided if he had been admitted as an inpatient.

The three-day inpatient hospital stay requirement was established long before observation status existed, and it seems reasonable to assume that this requirement was intended to include patients who remained hospitalized overnight for a total of three days. At the time Congress enacted this provision, only inpatients stayed in the hospital overnight.

On occasion, a hospital may keep a patient in observation status for three days rather than admitting the patient as an inpatient. This means the patient would have had a three-day hospital stay, but it would not be considered an inpatient stay. We recommend that any three-day hospital stay, regardless of whether it is comprised of inpatient services only, a combination of observation and inpatient services, or observation services only, should be considered as meeting the qualifying hospital stay requirement.

Conclusion

We appreciate the opportunity to comment on the proposed modifications to the Medicare SNF PPS program for fiscal year 2006. If AHIMA can provide any further information, or if there are any questions or concerns with regard to this letter and its recommendations, please contact either Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS

Submitter : **Ms. Helen Savitzky** **Date: 07/11/2005**

Organization : **Memorial Hermann Hospital System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The Provider would be in favor of counting the time spent in Observation towards the three day qualifying stay requirement. In most cases, the patient who has been placed in Observation status is being treated as he/she would be treated as an inpatient. Currently, an Observation patient must stay an extra day in an acute care setting in order to qualify for SNF care, since the first day of their acute care stay (the Observation time) does not count towards the three day qualifying stay. This delays the patient's placement into the most appropriate setting for treatment by one day, in addition to tying up an acute care bed that could be used by another patient. If the Observation time was counted towards the three day qualifying stay, the patient could be moved through his/her treatment protocol on a more timely basis, ultimately reducing the amount of time that the patient remains hospitalized (in all inpatient settings).

Issue

Issue

This comment concerns the grace day period for the 5 day PPS MDS assessment. The grace days allow for additional time to appropriately evaluate the patient and administer necessary therapies. Many patients are admitted in the afternoon or on weekends, such that the start date of the therapy is delayed. The grace days allow the assessment personnel to spend the requisite amount of time with the patient to ensure that the MDS correctly reflects the patient's therapy needs. The discontinuation of the grace days will cause the initial MDS assessment to be less accurate.

Case-Mix Adjustment and Other Clinical Issues

This comment concerns the elimination of the projection of anticipated therapy services during the 5 day PPS assessment. Since the first RUG III code reimburses the provider for days 1 through 14 of the patient's stay, an estimation of the number of therapy minutes allows the facility to be reimbursed for the patient's expected condition during that time period. The initial RUG III code cannot be revised during this period, therefore, an estimation of the therapy time is necessary in order to properly reflect the care that the patient is expected to receive during days 1 through 14.

Submitter : **Mr. William Walters** **Date: 07/11/2005**

Organization : **Acute Long Term Hospital Assn**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-44-Attach-1.PDF

CMS-1282-P-44-Attach-2.PDF

44-E

July 11, 2005

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Room 443-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: 42 CFR Part 424
File Code # CMS-1282-P
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006

Dear Dr. McClellan:

This letter presents the Acute Long Term Hospital Association's (ALTHA's) comments and recommendations on the proposed policy changes contained in the FY 2006 skilled nursing facility (SNF) PPS update. In particular, we are commenting on CMS' interest in developing a unified post-acute reimbursement system.

INTRODUCTION

ALTHA represents over three hundred Long Term Care Hospitals (LTCHs) across the United States, constituting over two-thirds of this provider community nationwide. ALTHA's member hospitals provide care to severely ill, medically complex patients with multiple co-morbidities. Patients require hospitalization averaging at least 25 days LTCH facilities.

Many LTCH patients—including Medicare beneficiaries—are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent conditions and/or other complex medical conditions. At LTCHs, these patients receive a specialized treatment program with aggressive clinical and therapeutic intervention. LTCHs are a critical provider in the continuum of post-acute care. They provide a specialized level of care to medically complex patients that could not be provided elsewhere.

44-E

Comments of the Acute Long Term Hospital Association (ALTHA)
July 11, 2005

THE POST-ACUTE CONTINUUM OF CARE

In the past 20 years, health care provided after the general acute hospitalization has become known as "post-acute care." Included in this term is the care provided in long-term care hospitals (LTCH) even though these hospitals meet the requirements of acute care hospitals. Also included are inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), home health agencies and hospices. Each post-acute setting is paid by CMS at a different rate for Medicare patients if the service is medically necessary and admission and continued stay criteria are met.

The purpose of our comments is to offer to CMS our perspective on the similarities and differences between the settings so that policy decisions can be made to achieve the goals of fiscal responsibility, patient access to care, and quality care.

Post-acute healthcare providers play an important role in meeting the needs of an important patient population. The continuum of post-acute care that can be quite confusing for policymakers, payers and patients in determining which healthcare setting is the most appropriate for patients with certain medical conditions.

ALTHA believes that CMS' policy should be guided by four overriding principles.

First, each provider in the post-acute sector plays a critical and distinct role in meeting the needs of the Medicare patient population.

Post-acute facilities have few similarities and many differences. Although post-acute facilities tend to be categorized together, each setting is unique and CMS should maintain distinctive definitions that support the clinical care each type of facility is organized to deliver. CMS policy should seek clear definitions of these distinct roles but should recognize that a certain amount of overlap is inevitable and necessary to ensure continuity of patient care across settings.

Second, ALTHA supports CMS' efforts to explore and evaluate development of a comprehensive post-acute assessment tool.

Development of such an instrument is an important prerequisite to integrating care, and possibly payment, across the post-acute setting. We caution CMS, however, that development of a common instrument is a complicated and important task. ALTHA would like to include as part of its comments the recent testimony of Pat Rice, RN, Chief Operating Officer for Select Medical Corporation. Ms. Rice testified at the House Ways & Means health subcommittee on June 16, 2005.

As described more fully in Ms. Rice's testimony, the range, depth, and content of clinical information necessary to evaluate and treat LTCH patients is more comprehensive than is captured in the assessment instruments used by other post-acute providers. Accordingly, policy makers should proceed carefully in developing a common instrument and ensure active participation by clinicians involved in treating patients across the post-acute continuum.

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Third, ALTHA supports the principle that patients should be cared and paid for in the most appropriate setting.

While determination of appropriate setting is a complicated decision requiring extensive input from treating physicians in consultation with patients, ALTHA agrees with the premise of MedPAC's recommendation that the decision should be made based primarily on patients' clinical characteristics and needs.

Patients who can be safely and effectively cared for in SNFs should not be treated and paid for in LTCHs or IRFs. Conversely, severely ill, medically complex patients with multiple co-morbidities should have access to the intensive interventions only available in LTCHs.

Again, from a clinical perspective, these determinations are not always clear. Policy should allow for some flexibility so that clinical judgment can be effectively exercised in the best interests of patients. MedPAC's recommendations and CMS's current research on revised certification criteria for LTCHs should help achieve this goal.

Fourth, as noted by MedPAC, CMS policy should also require not only that patients be placed in the appropriate setting, but that providers in the post-acute sector have the capacity to meet the needs of the patients.

As noted in Pat Rice's Ways & Means testimony, staffing levels, staff skill mix, availability of diagnostic tests, sophistication of technology and intensity of service vary significantly across post-acute settings.

While tempting for CMS policy-makers to encourage patients to be placed in the least intensive and least costly setting, this decision must be made in light of patient needs and quality of care, as measured by the providers' capacity to effectively treat patients with certain clinical conditions.

Thank you for taking the time to consider our comments. As always, we look forward to working with CMS to develop a responsible health policy for Medicare patients.

Sincerely yours,

William Walters
Chief Executive Officer

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44-E

U.S. House of Representatives
Committee on Ways and Means

HEALTH SUBCOMMITTEE HEARING ON POST-ACUTE CARE
June 16, 2005

TESTIMONY

Pat Rice, BSN, MSN
President/Chief Operating Officer
Select Medical Corporation
4716 Old Gettysburg Road
Mechanicsburg, PA 17055
717-972-1100

Representing
The Acute Long Term Hospital Association (ALTHA)
625 Slaters Lane · Suite 302
Alexandria, VA 22314

Madam Chair, Members of the Committee:

Thank you for convening this hearing on post-acute care and for involving providers in these discussions. By way of background, I have served as a registered nurse and healthcare administrator for the past 37 years in a variety of settings including seven years at a university medical center, twenty years in inpatient rehabilitation, two years in hospital based skilled nursing and nine years in long term care hospitals. Currently, I am the President/Chief Operating Officer of Select Medical Corporation, operator of 99 long term care hospitals (LTCH), in 26 states and Kessler Rehabilitation Institute in New Jersey that is recognized as a premier rehabilitation hospital. U.S. News and World Report ranks Kessler the leading rehabilitation hospital in the East – and 4th best nationwide – marking the 13th consecutive year that Kessler has been named to this prestigious list.

I am also a Board member of the Acute Long Term Hospital Association (ALTHA). ALTHA represents over 300 LTC hospitals across the United States, constituting over two-thirds of LTC hospitals nationwide. ALTHA's member hospitals provide care to severely ill, medically complex patients with multiple comorbidities who require hospitalization for extended

periods of time. Both Select Medical and Kindred Healthcare, another leading LTCH provider who also is the third largest operator of skilled nursing centers, are ALTHA members. ALTHA represents the vast majority of the LTCH industry.

Introduction

I commend the Committee for convening a hearing to discuss the critical role that post-acute providers play in meeting the needs of an important patient population. To be sure, there is a continuum of post-acute care that can create confusion among policymakers, payers and patients about which setting is most appropriate for patients with certain medical conditions. The purpose of my testimony today—as a nurse and operator of LTCHs and rehabilitation hospitals—is to assist the Committee in understanding the similarities and differences between the settings so that policy decisions can be made to achieve the goals of fiscal responsibility, patient access to care, and quality care.

In general, I believe the Committees deliberations should be guided by four overriding principles.

First, each provider in the post-acute sector plays a critical and distinct role in meeting the needs of the post-acute patient population. Policy should seek clearer definitions of those distinct roles but should recognize that a certain amount of overlap is inevitable and necessary to ensure continuity of patient care across settings.

Second, both ALTHA and Select support the Committee's efforts to explore and evaluate development of a comprehensive post-acute assessment tool. Development of such an instrument is an important prerequisite to integrating care, and possibly payment, across the post-acute setting. I caution the Committee, however, that development of an common instrument is a very complicated and important task. As described more fully in my testimony, the range, depth, and content of clinical information necessary to evaluate and treat LTCH patients is more comprehensive than is captured in the assessment instruments used by other post-acute providers. Accordingly, policy makers should proceed carefully in developing a common instrument and ensure active participation by clinicians involved in treating patients across the post-acute continuum.

Third, we support the principle that patients should be cared and paid for in the appropriate setting. MedPAC's recommendations and CMS's current research on revised certification criteria for LTCHs are designed to achieve this goal. While determination of

appropriate setting is a complicated decision requiring extensive input from treating physicians in consultation with patients, we agree with the premise of MedPAC's recommendation that the decision should be made based primarily on patients' clinical characteristics and needs. Patients who can be safely and effectively cared for in SNFs should not be treated and paid for in LTCHs or IRFs. Conversely, severely ill, medically complex patients with multiple co-morbidities should have access to the intensive interventions only available in LTCHs. Again, from a clinical perspective, these determinations are not always clear. Policy should allow for some flexibility so that clinical judgment can be effectively exercised in the best interests of patients.

Fourth, as noted by MedPAC, policy should also require not only that patients be placed in the appropriate setting, but that providers in the post-acute sector have the capacity to meet the needs of the patients. As summarized below, staffing levels, staff skill mix, availability of diagnostic tests, sophistication of technology and intensity of service vary significantly across post-acute settings. While tempting for policy to encourage patients to be placed in the least intensive and least costly setting, this decision must be made in light of patient needs and quality of care, as measured by the providers' capacity to effectively treat patients with certain clinical conditions.

Differences in Post Acute Levels of Care

In the past 20 years, health care provided after the general acute hospitalization has become known as post acute services or the post acute care continuum. Included as post acute are long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF)–whether rehab unit or freestanding rehabilitation hospitals, skilled nursing facilities (SNF), hospices and home health. Although they tend to be categorized together, each setting is unique and there should be unique definitions of each that support the clinical care they are organized to deliver. They have few similarities and many differences. Similarities between post acute settings include providing for the health care needs of patients and doing so through medical personnel such as physicians, nurses and therapists. Each is regulated by state and federal authorities, and each is paid by CMS at a different rate for Medicare patients if the service is medically necessary and admission and continued stay criteria are met.

Differences between each of these levels of care include:

1) Reason for patient admission
2) Severity and acuity of illness

44-E

3) Risk of mortality

4) Intensity of monitoring services

5) Type and availability of services

6) Knowledge, specialization, amount of staff

Reason for Admission

The reason for admission for each level of care is:

LTCH: Medical observation and intervention for complex multiple medical conditions.

IRF: Comprehensive rehabilitation requiring rehabilitation physicians, nurses, therapists.

SNF: Restorative, requiring skilled nursing and/or skilled therapy.

HH: Skilled or unskilled care managed safely in home environment when patient/primary care giver demonstrates ability to manage care at home.

Each of these locations has the potential to care for the patient with a specific diagnosis(es). The placement decision should be based upon: patient needs, patient acuity, complexity of multiple conditions, stability, intensity of monitoring/observation required, knowledge and intensity of services required, staff expertise and knowledge, staff time required, and availability of technology and equipment.

For example, the patient who has experienced a stroke has the potential of being admitted to an LTCH, IRF, SNF or returning home with home health. The potentially unstable medically complex stroke patient who has multiple co-morbidities such as unstable diabetes, renal failure with dialysis, and/or respiratory insufficiency requiring respiratory therapy, will require multiple physicians' specialists, frequent laboratory tests, dialysis, nutritional support and acute frequent nursing observation and interventions would most appropriately be admitted to an LTCH.

The stroke patient with functional impairments in eating, dressing, bathing who is aphasic and has progressed to sitting, is medically stable, and can participate in a minimum of three hours of therapy a day, would most appropriately be admitted to an IRF where the patient would receive a comprehensive rehabilitation program that is medically directed. The patient would have a goal directed rehab treatment plan that is aggressive, rapidly responsive to change in the patient status, and delivered by the highly trained, experienced and licensed rehab team.

The stroke patient with functional impairments who is medically stable, but whose endurance is insufficient to participate in an active three hour a day program, or who has

cognitive impairment that prevents learning would most appropriately be admitted to a SNF if she/he cannot be cared for safely at home with home health care.

LTCH Characteristics

Severity and Acuity of Illness; Complexity of Care

Patients with medically complex conditions that are severely ill tend to utilize more staff time and clinical resources/interventions and be more medically unstable. In the post acute continuum, these patients are typically treated in LTCHs. These patients have multiple co-morbidities and many of these are being actively treated along with the primary diagnosis. LTCH care requires frequent, often daily physician assessment and intervention due to the high risk nature of the patients and multiple medical conditions that exist and have potential for rapid or unpredictable deterioration. Overall, severity of illness is significantly higher in LTCH than in other post acute settings.

Risk of Mortality

The risk of mortality is increased when the severity of illness is greater. The LTCH patient typically has multiple medically complex conditions, and the acuity of illness is high. When risk of mortality is higher, the need for intensity of monitoring services is greater.

Intensity of Monitoring Services

Intensity is established by a list of treatments, medications, interventions and therapy required by the patient based on the patient's needs and condition. When the patient's condition requires more frequent monitoring, intervention procedures, invasive treatment, intravenous medication and/or nutrition, the level of care required is of greater intensity and LTCH care is indicated.

Types and Availability of Services

The need for the availability of on-site services increases with the acuity and complexity of the patient's condition. Continuous cardiac monitoring, on-site pharmacy, diagnostic services, dialysis, intensive care or high observation units, emergency rescue services, i.e., code team are common services in LTCHs. Patients in IRF's and SNF's tend to be more stable, so available services on-site vary based on patient programs.

Knowledge, Specialization, Amount of Staff

The knowledge, specialization and amount of staff vary greatly in the different post acute levels of care. The medical staff in the LTCH is comprised of multiple specialists including pulmonologists; cardiologists; gastroenterologists; general, plastic and vascular surgeons; infectious disease and internists. These physicians see patients daily and consult routinely at the LTCH. The medical staff at the inpatient rehabilitation facility is also an organized staff model. The attending physician is typically the physiatrist. Consultants may see the patient at the hospital or in his or her office. The SNF typically does not have an organized medical staff. The attending physician may be the patient's family physician or a physician contracted with the nursing home to see patients. Consultants, when required, see the patients in his or her office.

The amount of nursing hours required by the patients, the ratio of RNs to other nursing staff, and the clinical expertise required is different in each setting. LTCHs require acute care nurses with emphasis on monitoring and managing potential and actual acute events with a higher number of nursing hours per patient day and a higher ratio of RNs. Advanced cardiac life support is paramount. Inpatient rehabilitation requires nurses with rehabilitation training with emphasis on mobility, cognitive and elimination, etc.

Rehabilitation therapists at inpatient rehabilitation facilities specialize in neurological treatment, spinal cord injury and traumatic brain injury. The level of specialization they need in rehab is not required in the LTCH or SNF.

Respiratory therapists in LTCHs utilize ventilator weaning protocols jointly developed with the pulmonologist to facilitate weaning. This level of expertise may not be required in a SNF with chronic ventilator management or in inpatient rehabilitation.

Assessment Tool

Developing a common assessment tool for post acute providers is an important but difficult task. Inpatient rehabilitation utilizes Inpatient Rehabilitation Facility- Patient Assessment Instrument (IRF-PAI) as their assessment tool. SNFs utilize Minimum Data Set – Resident Assessment Instrument (MDS-RAI), home health utilizes OASIS. These tools are specific to that level of care and not usable for the other or LTCHs. The current tools, (MDS-RAI,OASIS, IRF-PAI), are not sufficiently comprehensive to capture the severity of illness/acuity, the intensity of the services and the complexity of the needs of the medically complex patient with multiple co-morbidities requiring multiple interventions The focus of these

tools is the level of disability and the amount of help a person needs from others to perform basic activities of daily living. If one tool is to be created, clinicians from each of the post acute levels of care must be involved. Adequate trials of the tool must be completed before implementation. At the individual hospital level, when IRF-PAI was implemented, a new position of PPS coordinator was created and with MDS-RAI a MDS coordinator was created to ensure compliance and timely completion. Both positions are typically filled by registered nurses in a time of nursing shortages taking more nurses from the bedside and increasing cost to comply.

Key elements of a patient assessment tool that would adequately assess LTCH patients would include:

Indicators of severity of illness and intensity of services, such as

- Emergency management
- Medical complexity of care
- Infectious disease monitoring and management
- Intravenous interventions including medication and/or nutritional support through TPN
- Blood and blood products
- Medication titration
- Respiratory interventions, respiratory therapist time
  - frequent suctioning
  - brochoscopy
  - tracheostomy care
- Potential for instability
- Lab monitoring
- Intensity of observations required in rapidly changing medical condition
- Hemodynamic monitoring
- Cardiac monitoring
- Frequent physician specialty consults
- Radiology diagnostic procedures
- Special procedures – CT scans, MRI, EKG

44-E

Summary

Again, on behalf of Select Medical and ALTHA, I commend the Committee for convening hearings on this important topic and soliciting the input of providers across the post-acute continuum. We urge the Committee to use as a guide the four principles summarized at the beginning of my testimony. ALTHA and Select Medical stand ready to assist the Committee in any way we can. Specifically, we urge Committee members and staff to visit LTCHs, IRFs and other post-acute providers to learn more about the fundamental differences in patients served in these settings and the capacity of different provider types to meet patient needs.

POST ACUTE LEVELS OF CARE

	LTCH	Rehabilitation	SNF
Reason for Admission	Medical and Respiratory Needs	Comprehensive rehabilitation requiring therapy for functional impairments	Restorative requiring skilled nursing and/or skilled therapy
Licensure/Registration (State)	Acute	Acute or Rehabilitation	SNF
Provider Number	LTCH	Rehabilitation	SNF
Medicare Classification	Excluded Hospitals CMS 412.23	Excluded Hospitals CMS 412.23	SNF
CMS Exclusion Criteria	25-day Length of Stay	• 75% of admissions within 13 diagnoses • Pre-admission screening • Team Conference • Medical Director – Full-time – Experienced/trained in rehab	---
Medicare Payment Basis	LTCH-PPS	Rehab IRF-PAI Case Mix Groups • Rehab Impairment Category (RIC) – FIM – Age • Comorbidities – 4 Tiers	MDS-RAI RUGS
Admission/Continued Stay Criteria	Interqual or Mass Pro (Designated by QIO)	• Functional deficit due to acute condition • Intensive, multi-disciplinary rehab • 24-hour availability – MD – Rehab Nurse • Able to tolerate 3 hours of therapy a day, 5 days a week • 2 disciplines required (PT, OT, Speech)	• Requires either skilled nursing or skilled therapy daily

44-2

	LTCH	Rehabilitation	SNF
Severity of Illness	Actual/Potential Instability	Stable	Stable
Intensity of Interventions/Services	High	Medium	Low
Physician Assessment/Intervention	• Daily or more frequent • Multiple Physician Specialists • Pulmonologist available 24 hours	• 3x week to daily • Physiatrist	• Monthly by regulation • MD/PA/NP
Nursing	Acute Care Nurse 8.5h-12h PPD High RN ratio	Rehab Nursing 6.2h-6.5h PPD	Skilled Nursing at least daily 3-4h Low RN ratio
Respiratory	Active weaning management 24h/7d	As needed	---
Pharmacy Services	On-site	On-site	Delivered from off-site
Diagnostic Services	On-site	Varies	Off-site
Rehabilitation Therapies (PT, OT, Speech)	Varies based on patient needs Averages – 1h/day	3 hours/day	1 hour/day
Interventions	• Continuous cardiac monitoring • Acute intubation • Ventilator weaning • Mechanical ventilation • Comprehensive Medical Assessment/Consultations • IV Medications/TPN • Renal Dialysis • Wound Assessment / Management including Enterstomal Therapist	• Rehab Therapies • Psychology • Cognitive Therapy • Urological Management	• Skilled Nursing • Skilled Therapy
Assessment Tools	No standardized assessment required by regulation	IRF-PAI	MDS-RAI
LOS	27	13	Approximately 40

44-E

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Long-Term Acute Care Hospitals:
MedPAC Report Supports Improved LTACH Certification Criteria

The Medicare Payment Advisory Commission (MedPAC) and other policymakers have expressed concern with the rapid growth in the number of LTACHs and whether the appropriate patients are admitted and treated in these facilities. Unchecked growth in this area is problematic for Medicare because it may unnecessarily increase costs for the program.

MedPAC recently completed an evaluation of the types of patients seen in LTACHs and the growth of this provider category. Its June 2004 report summarizes the findings from their evaluation and makes recommendations to better define LTACHs as a Medicare provider category. Specifically, the Commission recommends that Congress and CMS should establish patient and facility level certification criteria for LTACHs and encourage Quality Improvement Organizations (QIOs) to monitor medical necessity in this setting. In addition, the June report provides examples of criteria Medicare could use to better distinguish the LTACH provider category.

MedPAC Report Findings

Overall, MedPAC's research supports its recommendation to tighten LTACH certification criteria. In addition, the Commission's examples of certification criteria and recommendations are consistent with what Health Strategies has suggested previously on the basis of its own research.[1] Health Strategies believes new certification criteria will address rapid LTACH industry growth while preserving the clinical value of LTACH care and ensuring access to this care for Medicare beneficiaries with medically complex conditions.

The following MedPAC findings are consistent with Health Strategies' analysis and clearly support the conclusion that a better definition of this provider category is good policy.

- *LTACH Patients.* MedPAC concludes that LTACHs provide post-acute care to a small number of medically complex patients with unresolved complex medical conditions. Diagnoses such as tracheotomy, respiratory diagnoses with ventilator support, acute and subacute endocarditis, amputation, skin graft and wound debridement, and osteomyelitis predict LTACH use. In addition, those with the

[1] See *"Long-Term Acute Care Hospitals: Revised Certification Criteria Could Improve Medicare Provider Category,"* http://www.healthstrategies.net/about/archive/March_2004_Fact_Sheet.pdf, March 2004.

highest severity of illness, regardless of diagnosis, are nearly 4 times more likely to use an LTACH. The authors found that "fewer than 1 percent of Medicare beneficiaries discharged from acute hospitals are transferred to LTCHs." Health Strategies' analysis of patient characteristics is consistent with MedPAC's findings—LTACHs provide care to a small segment of acute care patients with high severity of illness and complex medical conditions.

- *Care Capacity.* MedPAC finds few SNFs are equipped to provide care to medically complex patients. The report states, "In qualitative studies, physicians told us that some patients without access to LTCHs stay longer in the acute hospital and others go to the relatively few SNFs equipped to handle patients with multiple complex illnesses or needing ventilator support. Our empirical results support that assertion [emphasis added]." Our analysis of LTACH and SNF data shows that there is little overlap in the most common primary diagnostic categories for patients seen in SNFs and LTACHs. Where overlap occurs, patient severity of illness in each setting is higher overall in the LTACH setting.

- *Cost/Outcomes.* MedPAC finds LTACH care to be cost-effective for targeted patients and to reduce the probability of readmission to acute care hospitals. According to MedPAC's analysis, patients with the highest probability of using an LTACH have comparable Medicare costs to similar patients who use alternative settings. In contrast, patients who do not have this high probability and receive care in LTACHs have higher Medicare costs per episode than similar patients receiving care in alternative settings. In addition, patients treated in LTACHs have fewer acute care hospital readmissions. These findings indicate that LTACHs do provide effective and cost-efficient care to certain targeted Medicare beneficiaries and that in many cases LTACH care can prevent re-hospitalizations for patients compared to other post-acute care settings. Consistent with our experience and research, LTACHs are identified as the most cost-effective and appropriate settings for the sickest patients.

- *Quality.* MedPAC encourages, as it does for all settings, that payments should be tied to improvements in quality of care. The Commission recommends that CMS take a closer look at quality in LTACHs and develop quality indicators that could be publicly reported. This finding supports current independent efforts by leading LTACHs to measure improvement in health status, ventilator weaning rates, infection rates, and other areas. It is a critical and important finding that reflects the future of health care. A broader, national approach from CMS would only improve LTACH performance in these areas.

These findings support the need for improved certification criteria which would ensure only the most medically complex patients receive care in LTACHs. However, some points in MedPAC's June report are not consistent with our analysis.

- *Geographic Distribution.* MedPAC asserts that the geographic distribution of LTACHs is uneven. However, a recent analysis of the geographic distribution of LTACHs shows that over the last decade there are an increasing number of LTACHs

in a larger number of states. According to the CMS Provider Service File, in 1993 there were 58 LTACHs in 20 states and in 2003 there were 280 LTACHs in 40 states. This change shows that while there has been growth in the number of LTACHs, this growth has been evening out the distribution of specialized LTACH care provided to the Medicare patient population.

- *SNF Substitution.* MedPAC's analysis finds patient substitution between SNFs and LTACHs. This MedPAC finding directly contradicts their previous finding in the report that relatively few SNFs can handle LTACH patients, LTACHs have similar capabilities to acute care hospitals, and LTACHs can do things "in house" that decreases readmission to hospitals. Our analysis shows there is not a significant amount of patient substitution between SNFs and LTACHs. The Health Strategies analysis was completed with data from a major LTACH provider who also operates a separate division of 268 nursing facilities in 38 states. We evaluated provider's skilled nursing facility data and industry-wide LTACH data and found the following:

  - There is little overlap in the most common primary diagnostic categories for patients seen in SNFs and LTACHs;
  - Where primary diagnostic overlap occurs, major differences in severity of illness exist between patient populations;
  - Overall severity of illness is significantly higher in LTACHs than in SNFs[2]; and
  - Results for this analysis were statistically significant.

- *Medicare Costs.* As part of this report, MedPAC presents a table comparing payment across post-acute care settings (Table 5-1). The tables shows average payment for an LTACH episode of care compared to average payments for patients in SNFs and rehabilitation hospitals with the same DRG upon leaving the acute care hospital. Although these patients have the same DRG upon leaving the acute care hospital, this DRG does not reflect the severity of illness these patients have when they leave the acute care hospital or their variable care needs. We caution readers of the MedPAC report to assess Table 5-1 carefully. The table shows the average cost per diagnosis across each setting, it does not reflect the variable severity of illness patients with the same diagnosis may have in each setting. For example a patient in DRG 475—respiratory diagnoses with ventilator support—may still be on a ventilator when they are discharged from an acute care hospital. In this case, they would receive the most appropriate post-acute care in an LTACH, while a patient in this DRG who is off the ventilator could receive appropriate post-acute care in a SNF.

MedPAC Report Recommendations

Based on its analysis and findings, MedPAC formally voted on and recommends the following changes to the LTACH provider category:

[2] LTACH 2001 MedPAR data and SNF claims data were evaluated using the 3M APR-DRG GROUPER to assign each discharge with a diagnosis and a Severity of Illness (SOI) score. SOI scores can range from 1 (moderate) to 4 (extreme).

(44-E)

- Congress and CMS should define LTACHs by facility and patient criteria that ensure patients admitted to LTACHs are medically complex and have a good chance of improvement. Any facility-level criteria should characterize the LTACH level of care by the operational features of LTACHs, medical review processes, and the case-mix of patients. Any patient-level criteria should identify specific clinical characteristics and treatment modalities; and

- CMS should encourage Quality Improvement Organizations (QIOs) to monitor medical necessity in LTACHs.

More specific examples of facility and patient criteria include a patient review process upon admission, adequate physician availability, multidisciplinary team treatment, national admission and discharge criteria, and patient severity of illness thresholds.

These findings are consistent with Health Strategies' previous recommendations regarding certification criteria. We recommended in our March 2004 report that LTACH certification criteria should be improved to limit unnecessary growth while ensuring the most medically complex patients receive the care they need. Improved criteria should be based on patient characteristics such as length of stay and severity of illness, structural capacities—such as adequate staff and multidisciplinary team care planning—and national, uniform admissions and continued stay criteria.

MedPAC's final recommendations reflect the need to curb unnecessary LTACH growth without arbitrarily limiting access to needed services. Improving certification criteria and ensuring medical necessity targets all types of LTACH providers and distinguishes the provider category from others based on the needs of beneficiaries with medically complex illnesses.

Submitter : **Mrs. Michelle Bell** **Date: 07/11/2005**

Organization : **Maine Veterans Home**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Case-Mix Adjustment and Other Clinical Issues

These comments are in response to the Interim Final Rule for SNF PPS published in the Federal Register on May 19, 2005. On page 29080, this document specifically asks for comments to enhance the accuracy of the payment system and improve the quality of care provided to Medicare beneficiaries during their SNF stay, without limiting access to post-acute care. Recommendations they have received include:

1. To decrease or eliminate the grace day period specifically for the 5-day MDS assessment.
2. To decrease or eliminate the grace periods associated with all PPS MDS assessments.
3. To eliminate the projection of anticipated therapy services during the 5-day PPS assessment.

In response to #1 and #2, grace days were originated to allow for an unusual occurrences including: 1.) a late pm admission, 2.) a weekend admission, 3.) illness or medical problem, 4.) holiday recognized by Medicare (New Years Day, Presidents Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, and Christmas) and 5.) bereavement or family tragedy. All of these ?unusual occurrences? continue to be valid in the SNF PPS setting. Eliminating the use of grace days in the first (or subsequent) MDS could potentially cause:

A. SNF refusal to take a late day or weekend admission thereby, increasing the length of stay in the hospital/acute care setting.
B. The smaller SNF to go out of business or loose their viability in the health care setting as they may not be able to provide the rehab intensity late day or on the weekends.
C. An increased length of stay in the SNF as the therapists only provide sufficient therapy time to make the medium or high category during the initial assessment period but the resident would have benefited from therapy time in a very high or ultra high category to enhance their function.

I feel that all of the reasons sited above are still sound in a SNF PPS setting, particularly in Maine. Not all SNFs have the therapy staff that can accommodate the resident 24 hours a day, seven days a week like nursing can. Typically, the full-time therapy staff cover 5 days/week and up to 40 hours/week of therapy. To require the full-time therapy staff to work beyond those hours would be difficult and finding part-time or as needed staff to cover the full-time staff on their days off is even more difficult. Subsequently, 1. the resident would suffer with reduced therapy minutes, 2. The facility would suffer with reduced payment (and potentially could go out of business) and 3. Medicare would suffer with increased costs at a more acute level of care and increased length stay in the SNF.

In response to #3, Section T was developed to recognize ordered and scheduled therapy services (physical, occupational, and speech therapy) during the early days of the resident?s stay. Often therapy is not initiated until the 3rd, 4th, or 5th day in the SNF secondary to a weekend admission, a medical complication, a holiday, etc. Section T provides the overall picture of the amount of therapy the resident will receive in the first 15 days of their stay. This section makes it possible for the resident to classify into an appropriate RUG-III rehabilitation group based on the anticipated receipt of therapy when the assessment is done in the first few days of the SNF stay and there has not been enough time to provide more than the beginning of a course of therapy. Eliminating the use of Section T to project a Rehab category, could potentially cause the same issues as stated above in A and B.

Please do not change the current system for grace days and Section T.

Sincerely,

Michelle Bell, MS, CCC-SLP
Rehabilitation Manager

Submitter : **Mr. Richard Bane** **Date: 07/11/2005**

Organization : **Bane Care Management LLC**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1282-P-46-Attach-1.DOC

July 11, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attn: CMS-1282-P

Dear Mr. McClennan:

Thank you for the opportunity to offer comments on CMS-1282-P, Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006.

My name is Richard Bane, and I am an independent skilled nursing provider and owner in Essex County, MA. I operate four skilled nursing facilities, comprising 375 skilled nursing beds and in that capacity, I employ over 400 committed staff members. I am a second-generation owner and operator, and have been in this profession since 1985. I am not a corporate chain, and run a hands-on, closely managed operation. My facilities score consistently well in all quality measures and I am proud that our facilities are reputed to be the quality skilled nursing facilities of our region.

The proposed revisions CMS-1282-P will have a highly significant and highly negative impact to our quality operation. Specifically, I refer to the Proposed Revisions to the SNF PPS Labor Market Areas. By using the revised definitions for MSA's using the Core Based Statistical Areas, our local geography, therein defined as Essex County, will be segregated from what was previously Greater Boston. If you are not familiar with the geography of our area, my four facilities are all within a 14-mile radius of Logan Airport in downtown Boston. Essex County is located north of Greater Boston, and my facilities are located in southern Essex County, immediately abutting greater Boston urban area. In fact many of my employees live in the Greater Boston area, as opposed to Essex County. The actual impact of the new definition is not at all reflective of the actual wages for my facilities. If the new definition

is implemented, my facilities would experience a 5.55% DECREASE in reimbursement, which calculates to nearly $18 per day. This decrease is DRAMATIC and not sustainable or feasible economically.

I have spoken and met with my colleagues in the immediate area, all of who share my fear and dissatisfaction. While only informal, the providers in our area (Essex County) report that if the revision is implemented as proposed, in our area alone, the loss of reimbursement could translate to over 70 jobs.

Given this dramatic, negative impact, I would respectfully suggest that CMS should not proceed with the OMBA CBSA designations at this time. Instead it should first develop and implement a SNF specific wage index that would allow the payment system to more accurately reflect differences in area wage levels and would allow SNFs to request reclassification to alternate, more appropriate local market designations. CMS should also implement provisions that would establish a "rural" floor similar to the inpatient hospital PPS to deal with budget neutrality created anomalies in the SNF PPS. It is my understanding that the definitions being contemplated are based on hospital based wage designations. SNF's are very different than hospitals. Many of our staff are drawn from broader geographies, in particular to our facilities, we draw directly from Greater Boston urban areas. Using Essex County hospital based wage designations is not at all reflective of the reality of staffing our nursing homes.

If CMS does not see fit to amend the definitions, at a minimum, CMS should develop and implement an appropriate multi-year phase-in plan that would allow SNF's to make appropriate adjustments in their operations, particularly for those SNF's such as ours, that are most dramatically affected by the proposed changes. In addition to a phase-in of the OMB CBSA wage area designations, the phase-in should include the development and implementation of a SNF-specific area wage index, and the establishment of a methodology in the SNF PPS for SNFs to request reclassification to alternate more appropriate local market areas. The use of such a "transition period" is absolutely essential for quality operations like ours to be able to provide the level of services and customer satisfaction that we are so proud of.

In summary, I would like to comment that there be specific revisions to the Proposed Rule as follows:

- CMS should proceed to develop and apply a SNF-specific area wage index, effective no later than FY 2007, and should immediately request the resources necessary to accomplish this;

- CMS should cease depriving SNFs of the ability, enjoyed by the hospitals, to have reclassifications to more appropriate indices, by developing the SNF-specific area wage index required by Congress as the basis of geographic reclassification for SNFs;

- Concurrent with the development of a SNF specific wage index, CMS should set in place the procedures for SNF geographic reclassification;

- CMS should not apply the OMBA CBSA designations to SNF since it does not have the authority to do so under the SNF PPS enabling legislation, the Balanced Budget Act of 1997 (BBA); and

- If CMS takes the position that it has the authority to apply the OMB CBSA area wage designations, CMS should develop and implement the four-year phase-in as outlined by AHCA in order to allow SNF's to make appropriate adjustments in their operations, particularly those SNF's that are most dramatically affected by the proposed changes.

Once again, thank you for the opportunity to present comment on CMS-1282-P. If promulgated without revision, the Rule will have a major detrimental impact on the wonderful quality facilities which we are so proud to operate. If you would like additional information, or would like to speak to me directly, please feel free to contact me directly.

Thank you.

Respectfully Yours,

Richard C. Bane
Bane Care Management LLC
978-745-8505 (w)
978-836-0078 (cell)
rbane@banecare.com

Submitter : Mr. Gary Eye **Date:** 07/11/2005

Organization : Tara Cares

Category : Long-term Care

Issue Areas/Comments

Issue

Wage Index Data

Wage Index Adjustment to Federal Rates
On page 87 it is stated that Section 1888 (e) (4) (G) (ii) of the Act requires the Federal rates to be adjusted to account for differences in area wage levels. It is proposed that the practice of using the hospital wage data continue in the absence of SNF specific wage data. We do not agree that SNF specific wage data is absent as SNFs are required to provide wage data on their annual cost reports. Specific wage data is reported and edited on required electronic cost reports, specifically Worksheet S-3 Part II of form CMS-2540-96. The data is collected pursuant to the Social Security Act Amendment of 1994 (P.L. 103-432) which directed CMS to collect data on employee compensation and paid hours of employment in SNFs for the purpose of constructing a SNF wage index. The data is being collected with every cost report and needs to be use as intended. Use of a SNF wage index would promote equality in payments among SNFs as they employ a significantly different group of health care professionals from hospitals.

Implementation Issues

Establishment of Rural and Urban Federal rates:

On page 24 there is a discussion regarding the development of the PPS system using allowable costs from cost reports beginning in FY 1995. It is indicated that separate Federal payment rates were developed for urban and rural areas. Moving ahead to the curently proposed revisions of SNF PPS geographic classifications as discussed on page 94 and the definition of Rural on page 98 it would seem that the new classifications would need to be applied retroactively to the FY 1995 data in order to properly establish revised Federal Urban and Rural rates. It appears that this step was not applied in developing the currently proposed PPS rates.

Submitter : **Mrs. Gail Polanski** **Date: 07/11/2005**

Organization : **Tara Cares**

Category : **Long-term Care**

Issue Areas/Comments

Issue

Issue

Case-Mix Adjustment and Other Clinical Issues:

Pg 57 Eliminating the 14 Day Look Back period would be detrimental to the delivery of services to the Medicare beneficiary. The services received during that 14 Day Look Back period, although not provided in the skilled nursing facility setting, reflect the true acuity and complexity of the patient. The Look Back period gives the clinical managers in the SNF an opportunity to develop a realistic and appropriate plan of care that is representative of the resident. Eliminating the 14 Day Look Back period will also hinder the SNF from capturing these treatments and services on the MDS, which could result in a poor reflection of the co-morbidities of the resident resulting in a compromised plan of care.

Pg 59 Eliminating the use of Grace Days, specifically for the Medicare 5 Day assessment will have a significant negative impact, resulting in inaccurate and inappropriate case mix scores. Ultimately, this will result in providing a lesser level of service to the resident who actually requires a greater intensity of resources. The final outcome will be to add costs that may not match the resident?s level of function. Grace Days are essential in order to capture an adequate and clear picture of the service delivery plan. Assessing the resident?s condition upon admission and the need for all service providers to evaluate and communicate regarding resident need, in addition to obtaining approval from the physician, are all essential in developing an appropriately designed program of care, the Grace Days are essential to capture an adequate and clear picture of the plan. In addition, in rural areas and communities where therapists are difficult to recruit, the service may be compromised or delayed due to lack of therapist availability.

Pg 59 Removing the ability to estimate services in Section T of the MDS will result in a delay of services for the resident who may be medically compromised upon admission. Due to the time frames affiliated with each MDS, a patient who does not need therapy until later in that first payment window may potentially wait until the second payment window to receive therapy services.

Implementation Issues

Section VI Qualifying Three-Day Inpatient Hospital Stay Requirement Page 142.
Under ?Coverage? you requested comments with regard to the Three Day Qualifying Hospital Stay. Skilled Nursing Facilities continue to admit sicker residents. They are more qualified than ever before to handle the medically complex resident. It is common for SNFs to provide IV?s, PICC lines, stat labs, x-rays and numerous other treatments or tests at the bedside. The cost of these services in the acute care setting including ambulance transportation services is extremely costly to Medicare and the resident. Thus, it is increasingly clear that the Three Day Hospital Stay requirement is no longer a cost effective alternative for care delivery. Strong consideration should be made to eliminate this requirement.

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

Pg 73 Nurse Practitioners who perform delegated physician tasks, as permitted by law, and are not employed by the facility would not function in a role requiring supervision of nursing staff. The only exception to this process could be in the setting where the physician is a staff member of the facility. Whether employed by the facility Medical Director or any other physician the NP would not supervise nursing staff. It remains apparent that if the MD, NP or CNS is not employed by the facility as a staff member (not as in the role of the Medical Director) there is clearly not a conflict of interest.

Concurrent Therapy

Concurrent Therapy

Pg 75 Please continue to recognize concurrent therapy as a skilled service with achievable and favorable outcomes. We agree that valid clinical appropriateness must be considered. However, there are clinical instances when such a delivery system would be valid as outlined in the RAI manual definition. In addition, in some rural areas or communities where it is difficult to recruit skilled professionals, concurrent therapy may be the only way to ensure that therapy services are provided to the resident. Also, it is clinically appropriate in many instances where other residents with similar deficit levels are motivated to participate in the program. Concurrent treatment often promotes a shared learning environment that would not be accomplished by individualized treatment delivery

Submitter : **Ms. Cleo Boulter** **Date: 07/11/2005**

Organization : **Home Quality Management**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-49-Attach-1.DOC

July 11, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed Rule, Part V 42 CFR Part 424
Medicare Program; Prospective Payment System
And Consolidated Billing for Skilled Nursing Facilities for FY 2006
Federal Register Thursday, May 19, 2005

In response to CMS request, the following comments are submitted on behalf of Home Quality Management, Inc (HQM). HQM, a privately held company, owns and manages 53 skilled nursing facilities (6,309 beds) in Tennessee, Kentucky, Florida, Maryland, West Virginia, and Pennsylvania. HQM supports changes in the current Prospective Payment System (PPS) that will more adequately address reimbursement based upon patient acuity and account for non-therapy ancillary costs.

General Comments

HQM wholeheartedly embraced the 1998 change from a Cost-Based to Prospective Payment System. The Acuity Based Staffing model used by HQM skilled facilities is based on the staff time measurement study used in the design of RUG 44. Because the staff time studies were conducted in 1995 and 1997, HQM is concerned that making any changes in the RUG 44 CMI without new staff time studies will not adequately reflect the resource utilization of post-acute patients. Additionally, there has been minimal change in patient distribution since the inception of PPS as shown in OIG 2001 and 2003 reports. Equally important prior to any change is adequately studying the non-therapy ancillary costs associated with medically complex patients, particularly in the upper 26 RUG 44 groups. Therefore, HQM recommends that any changes to the RUG 44 model be delayed until the CMS 2006 staff time studies are completed and analyzed.

Should the proposed RUG Refinement rules be implemented, HQM strongly opposes the changes proposed to the MDS. The look-back period, use of grace days, and anticipated therapy are significant elements that make up the RUG 44 CMI's and resulting classification. Tampering with these core areas places the entire integrity of the RUG 44 model in jeopardy. Any changes should occur only if validated by further research and staff time studies.

HQM supports changing the technical requirement of the three day inpatient stay to include observation days in order for the beneficiary to qualify for extended care. This change will better reflect current acute care practice regarding observation periods.

Should the proposed RUG 44 refinements be implemented, HQM urges CMS to provide ample time and detailed instructions for transition from RUG 44 to RUG 53.

HQM's specific comments to the proposed SNF regulations follow.

Case-Mix Adjustment and Other Clinical Issues

The temporary rate increases as a result of BBRA were to be in place until revision of the RUG 44 model "would better account for medically complex patients". While the summary provided by Urban Institute shows higher non-therapy ancillary costs for Medicare beneficiaries in Extensive Services categories the non-therapy ancillary costs for patients in Special Care and Clinically Complex are not addressed. Again, HQM recommends making no changes in the current PPS model until further research and studies are complete.

MDS Changes

HQM is concerned that although there has been no appreciable change in patient distribution throughout the RUG 44 model since 1998, CMS proposes to make substantial MDS changes that wreak havoc with model integrity. Further, there is no rationale provided for making the proposed changes. **Therefore, HQM strongly opposes all MDS changes proposed in this regulation**.

- **Grace Days:**

Grace days are a vital clinical tool, especially for the 5 day assessment. HQM recommends retaining this guideline in order to gather adequate assessment data and better formulate patient care during the time when the post-acute patient is most vulnerable. The rationale for grace days is best summed by the CMS explanation to the Final Rule for SNF PPS, Federal Register, July 30, 1999 p. 41657.

> "Unlike the routine use of grace days described above, we do expect that many beneficiaries who classify into the rehabilitation category will have 5-day assessment reference dates that fall on grace days. There are many cases in which the beneficiary is not physically able to begin therapy services until he or she has been in the facility for a few days. Thus, for a beneficiary who does not begin receiving rehabilitation therapy until the fifth, sixth or seventh day of his or her SNF stay, the assessment reference date may be set for one of the grace days in order to capture an adequate number of days and minutes in Section P of the current version of the MDS to qualify the resident for classification into one of the rehabilitation therapy RUG-III groups.
>
> Another reason for the provision of three grace days for the 5-day assessment was to make it possible for beneficiaries to classify into the two highest RUG-III rehabilitation sub categories. Classification into the Ultra High and Very High Rehabilitation sub

categories is not possible unless the beneficiary receives the sub-category's minimum level of services during the first seven days of the stay.

We also intended to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it, to stabilize from the acute care setting and be prepared for the beginning of rehabilitation in the SNF. We expect facilities will not compromise any beneficiary's health by beginning rehabilitation therapy prematurely or at a level that is too rigorous for the individual's status."

- **Look Back Days:**

The "look-back" days for the RUG 44 items correlate with the Case Mix Index (CMI) and resource utilization. According to RUGIII research, the clinical status of the patient regardless of location is the critical indicator(s) for determining resource use. Therefore, removing the look back period reduces the integrity and the predictability of the RUGIII model. It is important to understand that the items, such as transfusions (Special Care), IV medications (Extensive Services), suctioning (Extensive Services), etc. are *indicators* of resource use and are used to classify the patient, not to receive payment for the service itself. Therefore, **regardless of where the services are provided, the patient who received any of those services or interventions within the past 14 days needed substantially more care than someone who did not.** The entire nursing component of the model is based upon this premise. Altering the basic underpinnings of the model negates prior research and distorts the staff time allocation for beneficiaries with these resource needs.

The following excerpt is from PPS Regulation, May 12, 1998, p. 26263, regarding Extensive Services and the indicators used for the Extensive Services group.

"The Extensive Services category does not use ADL limitations except as a threshold for assignment into the category. Rather, *services that require more technical clinical knowledge and skill are the variables used for assignment of patients into this category.* Examples of these services are intravenous feeding or medications and tracheostomy care."

Further rationale for retaining the use of look back days is stated in the Final Rule for SNF PPS, Federal Register, July 30, 1999, p. 41668.

"We note that the use of the "look-back" period in making RUG-III assignments is essentially a clinical proxy that is designed to serve as an indicator of situations that involve a high probability of the need for skilled care. Thus, our expectation is that the occurrence of one of the specified events during the "look-back" period, when taken in combination with the characteristic tendency for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances...If it should become evident in fact this is not the case, it may become appropriate at that point

to reassess the validity of the RUG-III system's use of the "look back" period in making assignments."

Neither the Proposed RUG Refinement rule nor OIG reports include evidence that the approach to Extensive Services has changed significantly or that the indicators have become less reliable over time. Therefore, HQM supports and recommends leaving in place, the use of look back days.

- **Anticipated Therapy**

The use of anticipated therapy on the 5-day MDS assessment is critical for appropriate classification of the beneficiary during the first 14 days of the SNF stay. The Final Rule for SNF PPS, Federal Register, July 30, 1999, p. 41662 states the following regarding Section T where anticipated therapy is captured.

> "Section T of the current version of the MDS must be included with each Medicare PPS assessment, but in the case of a Medicare five day assessment, the clinician captures minutes of therapy that are anticipated for the beneficiary during the first two weeks of the nursing home stay. This makes it possible for the beneficiary to classify into the appropriate RUG-III rehabilitation group based on the anticipated receipt of rehabilitation therapy, even though the assessment is done during the first few days of the SNF stay.
>
> We realize that reporting therapy time that has not yet been provided is a significant change for providers, but it is in compliance with the grouper logic and allows the facility to provide the most accurate representation of the services to be provided to the beneficiary during the first assessment period"

Removing the anticipated therapy component of the RUG model further impedes proper classification of the beneficiary during the first 14 days of the SNF stay. HQM favors leaving the Section T portion for anticipated therapy in place for appropriate RUG 44 classification on the 5-day MDS.

- **Consolidated Billing**

HQM recommends the following items be added to the exclusion list for beneficiaries in a Medicare Part A stay.

L4396 Multipodus ankle foot arthosis
L3807 Wrist Hand Finger Orthosis
L3810 Finger Separators
L1930 Ankle Foot Orthosis
A5500 Diabetic Shoes
K0628 Diabetic Shoe inserts
L1832 Static Knee Orthosis

L3760 Elbow Orthosis

- **Pay for Performance**

HQM supports development of additional quality measures that can be used as performance incentives and agree that this type of model must be "carefully constructed".

Finally, HQM appreciates the opportunity to respond to the proposed regulation as well as the contribution of Urban Institute to the refinement process. HQM supports further staff time studies and offers assistance, if needed, for that initiative. Should questions arise regarding HQM comments, please contact Cleo Boulter at (561)301-6174.

Respectfully Submitted,

E. Joseph Steier, President and COO
Home Quality Management
2979 PGA Blvd
Palm Beach Gardens, FL 33410

Submitter : **Ms. Mary Ellard** **Date: 07/11/2005**

Organization : **Five Star Quality Care**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-50-Attach-1.DOC

Submitter : **Mrs. Kathy Clark** **Date: 07/11/2005**

Organization : **Titusville Area Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Questions, Comments and Concerns related to the SNF Proposed PPS Changes for 2006.

Questions:

-Do these changes include Rural Hospital Based Swing Bed?

-What RUG's will be Elimited?

-If I am interpreting the proposal correctly - it states that the changes are to help prevent hospital based SNF's (Swing Beds) from closing, yet the report also states that rural hospital based SNF's will experience an average DECREASE of 0.7% payment. How are the rural hospital SNF's to remain open and functional when reimbursement will be decreased while costs continue to increase?

Saftey is a big issue with our large elderly population and a decrease in reimbursement will make it very difficult to continue our Swing Bed Program.

Request Input/Comments on issues addressed-

-Services that should be added to the SNF PPS consolidated billing exclusions: *Peritoneal Dialysis Supplies
*Hemodialysis at Dialysis Units and needed
Transportation

-Observation DAys:

I fail to see the relevence in excluding the observation day from the prior 3 day inpatient qualifying stay - it only extends the acute care stay and increases costs.

-Concurrent therapy guidelines: What do you Mean? Needs Clarification.

-MDS Revisions

-Excluding the special care treatments and programs prior to SNF admissions eliminates the total picture of the patients' pre SNF (SWing Bed) status which helps to reveal the patient need for SNF Admission.

-MDS assessment grace period elimination/decrease: NO comment

-MDS projection of anticipated therapy services during the 5 Day assessment: I see no purpoase - Yes Eliminate!

Concurrent Therapy

As a Physical Therapist and in discussions with my peers, I do believe that the concept of concurrent therapy is being abused. This is not always related to pressure from an employer. It is occasionally a professional who has become confused by the differences between coding regulations for Medicare A and Medicare B and forgets the basic Medicare premise of services at a level of complexity that can only be delivered by or under the supervision of a therapist!

Occasionally, because of cardio-respiratory limitations in our geriatric clients, our patients cannot tolerate continuous activity for 30-60 minutes and requires "rest" breaks. During this rest break, the therapist could potentially move to another patient to initiate or continue interventions. In my mind, this would fall under the definition of concurrent therapy – more than one patient in the gym for treatment at the same time. What has caused problems and confusion is that PPS (Medicare A) first defined therapy treatment minutes as the total time from start of the first treatment intervention until the last intervention is completed. Therefore, if a therapist is moving between two patients because of their reduced tolerance to treatment, as those patients are in the gym for 60 minutes each, some therapists are counting 60 minutes on the MDS for each patient.

I believe that the therapist's time of involvement should dictate the minutes counted on the MDS for concurrent therapy sessions. As in the example above, the 60 minutes of time that the therapist was present should be appropriately divided by the time with each patient, so that one patient may have received 25 minutes of direct therapist time, while the other may have received 35 minutes – or any combination that adds up to 60 minutes.

This differs from group therapy defined as a group treatment session where up to 4 patients are interacting and working together toward common goals. The entire number of minutes for a group therapy session can be counted for each participant, but is limited to 25% of the weekly total. Therefore it is assured that the equivalent of approximately one day per week might be spent in a group therapy session. With the concurrent therapy guidelines as presently defined, the patient may never receive an individualized treatment session without other patients present – appropriately raising concerns about the complexity level of treatment.

I believe that, in the best interest of the patients with low tolerance for treatment, concurrent therapy sessions should continue to be acceptable but may need further definition. For example, a concurrent therapy session may need to be limited to two patients per therapist at a time (possible a third patient may be present if an aide is working under the direct supervision of the therapist as allowed by state practice act). The proper way to count minutes for each patient present needs to be more clearly defined. I believe that in all fairness, the minutes a therapist is present should be divided among the patients present, so that the total minutes counted never exceeds the number of minutes a therapist is physically present in the treatment area.

I have communicated with therapists who feel that they can appropriately have three to four patients in the gym at one time and be moving between them! If they count 45 minutes for each patient, they have just provided 135 to 180 minutes of treatment in 45 to 60 minutes time! Yes, their productivity is making their employer happy! This scenario is WRONG and needs to be controlled with regulatory guidelines.

Submitter : **Mrs. Melissa Snuggs** **Date: 07/11/2005**

Organization : **Medical Facilities of North Carolina Inc.**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-53-Attach-1.DOC

Attachment #53

Medical Facilities of North Carolina, Inc.

July 8, 2005

Dr. Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1282-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington DC 20201

Submitted Via E-Mail www.cms.hhs.gov/regulations/ecomments

RE: Comments on Medicare Program; Proposed Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2006
May 19, 2005 Federal Register Proposed Rules - 42 CFR Part 424
CMS-1282-P

Dear Dr. McClellan:

Medical Facilities of North Carolina, Inc. operates nine facilities in the state of North Carolina. We thank you for the opportunity to comment on the proposed rules for the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2006.

The Skilled Nursing Facility Market Basket Index – Federal Register Pages 29074 & 29097

The basis for the proposed market basket update is cost report data from 1997. Since that time, there have been significant changes in the way that SNFs operate and an increase in the acuity levels of the patients treated. The data being utilized has not been adjusted for changes brought about by the implementation of the prospective payment system or changes in the costs of providing services such as the increase in liability insurance. Would it not be possible to utilize cost reports ending on or before December 2002 all of which should have Notice of Program Reimbursements (NPRs) issued?

Another concern with the SNF Market Basket proposed is the use of the Employment Cost Index (ECI) for Private Nursing Homes as the basis for calculating price level changes for nursing home employees. The price proxy includes wage price data for many entities that are not SNFS and who do not participate in the Medicare program. The staffing mixes in a SNF are much different than those in a community care home or an intermediate care facility. SNFs employ more skilled staff, i.e registered nurses and licensed professional nurses than other types of nursing facilities and as a result the average wage paid to medical staff is higher than the other nursing facilities.

1300 South Mint Street, Suite 201, Charlotte, North Carolina 28203 Phone 704-338-5855

Since labor and related costs make up a majority of the cost in a skilled nursing facility, it is a concern that the increasing labor costs SNFs have experienced over recent years may not be appropriately recognized in the factors being utilized. Again, it seems utilization of cost data provided in the SNF Medicare cost reports could be utilized to provide more accurate information for skilled nursing facility market basket adjustments.

Proposed Refinements to the Case Mix Classification System – Federal Register Page 29080

Look Back Period

There are four clinical services that were highlighted on page 29080 as special services that utilize the look back period, IV medications, suctioning, tracheostomy care, and use of a ventilator / respirator). CMS has noted that patients receiving these services in the hospital prior to admission usually are classified into Extensive Care, the category used for most medically complex SNF patients.

We believe that the look back period should be included to capture the services that are provided for these patients in the skilled setting. Many patients are admitted to a skilled nursing facility directly from hospital ICU or following a surgery. Although patients entering a skilled nursing facility may not continue to utilize equipment available in a hospital setting and they may not continue all of the procedures provided while in a hospital setting, these patients require extensive monitoring, observation, assessment of medical conditions, and follow up after the hospital discharge.

Grace Day Period

The grace day period is very necessary and should not be eliminated. In some cases, residents who require ultra high or very high rehabilitation services may not be able to get the 5 days of therapy and 500 to 720+ minutes required for the five day assessment. While we do provide therapy 7 days per week there are always exceptions and if the grace period is eliminated, a SNF might not be reimbursed for the care that was delivered during the initial days of the stay.

Proposed Revisions to the SNF PPS Labor Market Areas – Federal Register Pages 29091 to 29096

CMS has proposed "to adopt for the SNF PPS the new CBSA-based labor market area definitions beginning with the 2006 SNF PPS rate year without a transition period and without a hold harmless policy." (p. 29095). CMS has also said that "only a minimal number of SNFs would experience a decrease of more than 5 percent in the wage index." (p. 29095).

We believe the CBSAs appropriately reflect wages in a majority of the wage areas, however, some individual facilities will be devastated by the great fluctuations in rates due to this change in the wage indexes. In addition, facilities that have a shift from rural to urban and a decrease in the wage index will be impacted even further. To avoid the devastating impact of the extreme changes in wage indexes in many of the areas around the country, we recommend a floor be put in place.

Three Day Stay

CMS has invited comments on the possibility of counting the time spent in hospital observation status toward meeting the SNF benefit's qualifying 3-day hospital stay requirement, when the observation status is immediately prior to a hospital inpatient stay.

To qualify for a Medicare Part A stay in a skilled nursing facility, a beneficiary must first be an inpatient in a hospital for three or more consecutive days, before being admitted to a SNF to receive daily skilled services. The three day hospital stay requirement dates back to 1965 when Medicare legislation was first initiated, and before observation days became prevalent in hospitals.

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The hospital stay preceding a SNF stay was intended to ensure the Part A beneficiary in a SNF was in need of skilled care not custodial care. A distinction has been made between observation services and emergency room services in section VI on page 29099: "(Medicare Benefit Policy Manual), Chapter 6 (Hospital Services Covered Under Part B), section 70.4 (Outpatient Observation Services) in which a patient who needs more care than can be provided in an emergency room is moved from the emergency room, placed in a hospital bed in the appropriate hospital unit and monitored by the unit nursing and physician staff." Although a patient in an observation status is considered outpatient for hospital billing purposes, by the definition above the observation patients are in need of a greater level of care than patients remaining in the emergency room.

The hospital observation period, prior to an inpatient admission, should be combined with the hospital inpatient stay, to meet the 3-day hospital stay requirement necessary to qualify a beneficiary for Medicare Part A services in a skilled nursing facility. Hospitals are acute care settings. Patients are being observed while in an observation status, as well as after they are formally admitted as an inpatient. If it is determined a patient needs to be admitted after an observation period, the patient is in need of professional care, not being prepared for a custodial setting.

In addition to the three day qualifying hospital stay a Medicare beneficiary must have a physician certify the need for daily skilled care, for a beneficiary to receive Part A coverage in a skilled nursing facility. When the daily skilled services end, the Medicare Part A coverage also ends. Medicare Part A is not responsible for custodial care in a skilled nursing facility.

Thank you for your considerations of these comments. If you should have questions concerning these comments you can contact me at (704) 338-5855 or at the address below.

Sincerely,

Melissa K. Snuggs, CPA
Chief Financial Officer
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Attachment #53

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