September 14, 2010

Donald M. Berwick, M.D., Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW, Room 314-G  
Washington, DC 20201

Subject: CMS-1338-NC: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2011; Notice

Dear Administrator Berwick:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2011; Notice, 75 Federal Register 42886, (July 22, 2010). Our comments focus on four items within the notice, including: implementation of Hybrid Resource Utilization Group Version 3 (HR-III), the RUG-III to HR-III/RUG-IV budget neutrality adjustment methodology, the market basket forecast error correction policy, and the wage index budget neutrality adjustment methodology.

As the nation’s largest association representing long term and post-acute care providers, our nearly 11,000 members include non-profit and proprietary skilled nursing facilities, assisted living residences, sub-acute centers, and homes for people with developmental disabilities that range from small, independently-owned facilities to regional, multi-facility corporations.

AHCA’s detailed analysis and specific recommendations are below. We stand ready to respond to any questions that you might have with respect to our research and the findings provided to you in these comments. We would also be pleased to answer any questions you might have regarding any of our recommendations.

Sincerely,

Bruce Yarwood
President & CEO
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AHCA Recommendations in Brief

AHCA Recommendations on the Design and Implementation of HR-III:

• Although CMS did not involve stakeholders in the development of HR-III, CMS should involve stakeholders in reviewing the design of the HR-III system and obtain stakeholder input on the transition from RUG-III/interim RUG-IV to HR-III;

• In order for stakeholders to replicate and appropriately comment on the transition from RUG-III to HR-III, CMS should provide the additional data needed for stakeholders to reproduce CMS analysis and results, particularly those related to the calculation of HR-III weights, the RUG-III to HR-III transition matrix, budget neutrality adjustments, etc.; and

• CMS should review its data and methodology used to transition from RUG-III to HR-III, and make appropriate revisions as necessary, before implementation.

AHCA Recommendations On The Application Of Adjustment For Budget Neutrality Between RUG-III and HR-III and RUG-IV:

• Since CMS asserts that it can not apply adjustments for budget neutrality equally to the four rate components of the SNF PPS and since the Agency prefers to apply adjustments for budget neutrality by means of a modification to the nursing case-mix weight only, CMS should instead:
  o Apply a variable percentage adjustment rather than a fixed percentage adjustment to the nursing case-mix weight that would ensure that payments under RUG-III, RUG-IV, and HR-III are budget neutral that would result in a proportional increase in overall RUG rates, without skewing the overall distribution of payments and payments rates at the RUG level from what they would otherwise have been using the budget neutrality adjustment as outlined in the notice.

AHCA Recommendations on a Cumulative Market Basket Forecast Error Correction:

• CMS should adhere to the precedent followed in its 2003 actions, which underscored the critical importance of accuracy in payment decisions, by acting decisively when the cumulative impact of market basket forecasting errors erode SNF payment rates by:
  o Withdrawing the propose 0.6% reduction in the market basket for forecasting errors since the cumulative forecasting error since the last cumulative adjustment in 2003 is 0.36%; and
- Modifying the agency’s threshold policy to apply a cumulative correction for market basket forecasting errors when the 0.5% threshold is reached on a cumulative basis.

**AHCA Recommendations on a SNF Wage Index Adjustment:**

- CMS should review its SNF wage index adjustment methodology, adjust its methodology as necessary to ensure that it is applied correctly as per statute in a manner that does not result in aggregate payments that are greater than or less than would otherwise be made in the absence of the wage adjustment, and make any necessary adjustments to make up for past wage index related underpayments.
I. Design and Implementation of HR-III  
(Comments on Section II.B: Hybrid Resource Utilization Group Version 3)

AHCA Recommendations on the Design and Implementation of HR-III:

• Although CMS did not involve stakeholders in the development of HR-III, CMS should involve stakeholders in reviewing the design of the HR-III system and obtain stakeholder input on the transition from RUG-III/interim RUG-IV to HR-III;

• In order for stakeholders to replicate and appropriately comment on the transition from RUG-III to HR-III, CMS should provide the additional data needed for stakeholders to reproduce CMS analysis and results, particularly those related to the calculation of HR-III weights, the RUG-III to HR-III transition matrix, budget neutrality adjustments, etc.; and

• CMS should review its data and methodology used to transition from RUG-III to HR-III, and make appropriate revisions as necessary, before implementation.

In the fall of 2005, CMS initiated the Staff Time Resource Intensity Verification (STRIVE) project. For this project, CMS retained the Iowa Foundation for Medical Care to update the national staff time measurement studies data from the 1990s that would provide data and analysis to revise the current Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has used the STRIVE study data to develop the proposed Resource Utilization Group Version 4 (RUG-IV) resident classification system and the nursing and therapy weights that underlie the SNF PPS. Notwithstanding issues that AHCA has with the STRIVE project and the design and implementation of the RUG-IV based SNF PPS, AHCA would like to commend CMS on opening the STRIVE project up to greater scrutiny by experts and stakeholders, and making the process that has led to the RUG-IV system more transparent.

Unfortunately, the same can not be said for the development of the Hybrid Resource Utilization Group Version 3 (HR-III) system. Other than the notice with comment that CMS issued and was published in the Federal Register on July 22, 2010, CMS has not involved stakeholders in the design and implementation of the HR-III based SNF PPS. Unless the Congress acts to implement RUG-IV for FY 2011 and as CMS moves toward retroactive implementation of HR-III for FY 2011, we ask CMS to reach out to stakeholders to obtain the feedback needed to get the HR-III system “right”. The operational challenges of dealing with interim payments under RUG-IV, retroactive implementation of HR-III, and implementation of RUG-IV for FY 2012, while providing critical nursing and therapy services to Medicare beneficiaries and enhancing the quality of care in a time of declining Medicaid reimbursement are great. Errors in the design or implementation of HR-III could dramatically damage the financial stability of providers and put Medicare beneficiaries at risk for having inadequate access to SNF services. AHCA is willing and ready to work with CMS to help ensure a smooth transition.

The lack of transparency and the unavailability of critical information and data have constrained the ability of stakeholders to replicate CMS analysis and findings, and impeded AHCA’s ability
to meaningfully comment on the notice. For example, CMS failed to provide data to the public on the distribution of FY 2009 SNF Part A days of service by urban and rural categories under the three RUG systems. This data should have been used by CMS as part of the calculation of the 61.0% and 34.2% increase in the nursing weights that were used to ensure budget neutrality between the RUG-III/RUG-IV and RUG-III/HR-III SNF PPS, respectively. It has not been released to date. Without such data, the public is unable to replicate the CMS findings, and help ensure that the CMS methodology and SNF PPS weights and rates are correct. CMS also failed to provide an updated STRIVE dataset with the HR-III groupings. Without this data and detailed information on the factors and methodology used to develop HR-III, the public is unable to replicate the design and calibration of the HR-III SNF PPS.

The inability for the public and stakeholders to replicate findings is all the more critical when the limited information provided by CMS suggests that there may be issues with the CMS SNF PPS HR-III or its underlying methodology or data. For example, information provided on days of service by RUG categories overall using FY 2009 data showed that about 39% of days fell into Rehabilitation plus Extensive Services RUG-III groups, and about 4% fall into these groups under RUG-IV. Surprisingly, the CMS data shows that 18% of days fall into the Rehabilitation plus Extensive Services groups under HR-III. Notwithstanding that three additional types of extensive services are likely included under HR-III, the limitation on the provision of extensive services within the last 14 days in the SNF setting, suggests that the 18% estimate is too high. If it is too high, then fewer days are likely to fall in the Rehabilitation plus Extensive Services categories, and everything else being equal, more days should fall into the Rehabilitation categories. Such a significant shift in days has significant implications on the budget neutrality adjustment and aggregate SNF expenditures. With the data we noted above, AHCA would have been able to examine, and if there were an issue, comment on the CMS methodology. Without the data, we can only raise this as a possible issue with the design of HR-III.

Immediately after the release by CMS of the FY 2011 SNF PPS notice, AHCA requested this key data. Despite follow-up over the past two-months, CMS has yet to make available this critical data to stakeholders and the public. While we continue to ask and hope that CMS will release this data shortly, the unavailability of this data has affected AHCA’s and the public’s ability to meaningfully comment on key aspects of development of HR-III and the transition from RUG-III to HR-III. Once CMS releases the data and we have had a chance to examine the data and undertake analysis, we plan to prepare, and ask CMS to review and consider our comments before finalizing the design and implementation of HR-III.
II. Proposed Revision to the Parity Adjustment Methodology

(Comments on Section II.B.2: Parity Adjustment)

AHCA Recommendations On The Application Of Adjustment For Budget Neutrality Between RUG-III and HR-III and RUG-IV:

- Since CMS asserts that it can not apply adjustments for budget neutrality equally to the four rate components of the SNF PPS and since the Agency prefers to apply adjustments for budget neutrality by means of a modification to the nursing case-mix weight only, CMS should instead:
  - Apply a variable percentage adjustment rather than a fixed percentage adjustment to the nursing case-mix weight that would ensure that payments under RUG-III, RUG-IV, and HR-III are budget neutral that would result in a proportional increase in overall RUG rates, without skewing the overall distribution of payments and payments rates at the RUG level from what they would otherwise have been using the budget neutrality adjustment as outlined in the notice.

A. Application of the Budget Neutrality Adjustment to the Nursing Case-Mix Component Is Inappropriate

AHCA is pleased to see that CMS will implement HR-III and RUG-IV in a budget neutral manner. Such a budget neutral implementation is critical to maintaining the financial stability of the SNF sector that ensures Medicare beneficiaries continue to have access to quality skilled nursing and therapy services that they need.

In the CMS FY 2009 SNF PPS proposed rule, CMS discussed its implementation of RUG-53 and clarified its methodology for ensuring that estimated total payments under RUG-53 would be the same as what they would have been under RUG-44. In establishing budget neutrality and adding the adjustment for the variability of non-therapy ancillary services (NTAS) in FY 2006, CMS applied both adjustments to the nursing weights as part of the implementation of RUG-53. It is our understanding that CMS applied the NTAS adjustment to the nursing index because NTAS are part of the nursing case-mix base rate component. It is also our understanding that CMS applied the budget neutrality adjustment to the nursing index because the establishment of the upper nine Rehabilitation plus Extensive Services RUG categories had no effect on the therapy weights, with all of the adjustment for the upper nine RUGs affecting the nursing weights. As the implementation of RUG-53 did not impact the therapy component, CMS applied the budget neutrality adjustment to only the nursing component. In moving from RUG-44 to RUG-53, AHCA understands CMS’ decision to apply both adjustments to the nursing index.

CMS further noted last year that its “intent in implementing RUG-IV is to allocate payments more accurately based on current medical practice and updated staff resource data obtained
during the STRIVE study, and not to decrease or increase overall expenditures” (74 Federal Register 22237). AHCA agrees that accurate allocation of payments is important, not only for the implementation of RUG-IV but especially on its foundation, the underlying data and basis for the categorization of residents and the relativeness of the nursing and therapy indexes (both within each index, but also between the indexes).

Given CMS’ desire for more accurate and appropriate payment for SNF services, it is puzzling that CMS would use a flawed methodology for implementing the budget neutrality adjustment in the move from RUG-III to RUG-IV and from RUG-III to HR-III by applying a fixed percentage increase to the nursing case-mix index. Application of a fixed percentage increase to the nursing case-mix component has the effect of skewing overall RUG-IV payment rates. Rather, CMS should strive to implement a budget neutrality adjustment that would increase overall RUG-IV payment rates proportionally.

The use of the flawed nursing case-mix index driven budget neutrality adjustment is all the more puzzling given that CMS recently completed the STRIVE project, which should have improved payment accuracy by getting the nursing and therapy case-mix weights “right”. Overlooking AHCA concerns with the STRIVE project, the STRIVE project should have developed nursing and therapy weights that are “right” on a relative basis across RUG categories within the nursing case-mix and the therapy case-mix components, as well as right on a relative basis between the nursing and therapy case-mix components. If the relative nursing and therapy weights are correct and the overall and component rates are appropriate, then application of a large budget neutrality adjustment to only one weight (the nursing case-mix weight, for example) would throw off the relativeness within and between the indexes. Such an adjustment dramatically and inappropriately skews SNF payments and RUG-level payment rates from what they otherwise would have been in the absence of the flawed budget neutrality adjustment.

To maintain accuracy and proportionality in payment rates, CMS might apply a proportional budget neutrality adjustment to the each overall RUG-IV rate, or by the distributive property apply the same proportional budget neutrality adjustment to all four rate components of the SNF PPS. CMS however argues that it can not apply an adjustment to all four components, only the two components where it has control over the design of the corresponding weights. For example, the application of the adjustment to the nursing component only has the effect of shifting more funds into the Rehabilitation and Extensive Services RUG groups and shifting funds away from lower activities of daily living (ADL) non-rehab RUG categories to the higher ADL non-rehab RUG categories. CMS appears to simply overlook the possible unintended incentives and accept the skewing of the STRIVE project driven weights and RUG payment rates despite the negative impact on payment accuracy. Having the weights and associated rates and payments about right is important for payment accuracy and adequacy, to prevent the possible introduction of perverse incentives, and for operational purposes. Providers and business that rely on the accuracy and appropriateness of the therapy portion of the payment rate, for example for therapy contracting purposes, may be significantly disadvantage. The application of the proposed adjustment for budget neutrality to only the nursing index is inappropriate. CMS could and should do better.
B. An Alternative Budget Neutrality Adjustment That Does Not Skew Payment Rates

AHCA would like to propose an alternative budget neutrality adjustment methodology for the change from RUG-III to the new HR-III and RUG-IV SNF PPS. The AHCA proposal has the effect of applying a fixed proportional budget neutrality adjustment to the overall rate, but implements the budget neutrality adjustment through the nursing case-mix index. The AHCA proposal offers the opportunity for CMS to apply a budget neutrality adjustment by means of a modification to the nursing case-mix weight, and allows CMS to implement the budget neutrality adjustment in a manner that does not skew the overall distribution of payments and RUG level payments rates from what they would otherwise have been in the absence of the adjustment.

Rather than implement the budget neutrality adjustment by means of a fixed percentage increase to the nursing case-mix weight, AHCA proposes that CMS apply a variable percentage methodology. By means of simple algebra, CMS could compute a RUG-level specific adjustment to each nursing case-mix weight. Through the application of the variable percentage, CMS could ensure that the overall rate rather than the nursing component rate would increase by a fixed or constant percentage. Such an approach has the advantage of ensuring that the accuracy, adequacy, and relativeness of payment rates within and between the nursing case-mix and therapy case-mix weights as well as payment rates overall would be maintained, and not inadvertently introduce unintended incentives. AHCA would like to meet with CMS to review and discuss our findings and proposal.
III. A Cumulative Market Basket Forecast Error Correction

(Comments on Section I.G.2: Market Basket Forecast Error Adjustment)

AHCA Recommendations on a Cumulative Market Basket Forecast Error Correction:

- CMS should adhere to the precedent followed in its 2003 actions, which underscored the critical importance of accuracy in payment decisions, by acting decisively when the cumulative impact of market basket forecasting errors erode SNF payment rates by:
  - Withdrawing the proposed 0.6% reduction in the market basket for forecasting errors since the cumulative forecasting error since the last cumulative adjustment in 2003 is 0.36%; and
  - Modifying the agency’s threshold policy to apply a cumulative correction for market basket forecasting errors when the 0.5% threshold is reached on a cumulative basis.

In 2003, CMS instituted two adjustments to the market basket to account for market basket forecasting errors. First, CMS made an adjustment to the market basket rate to account for the cumulative effect of forecasting errors covering the period FY 2000 through FY 2002. The adjustment resulted in a one-time 3.26 percentage point increase which was reflected in FY 2004 SNF PPS rates. At the same time, CMS also instituted a process for annual adjustments for market basket forecasting errors when the difference between the forecasted and actual change in the market basket exceeds a certain threshold in any given year. For FY 2003 through FY 2005, the threshold was set at 0.25%, and for FY 2006 onwards the threshold was raised to 0.5%. Since the last cumulative adjustment in 2003, AHCA estimates the cumulative market basket forecasting error has been 0.36%.

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In 2003, CMS chose a threshold of 0.25%, and raised it to 0.5% in 2006, contrary to AHCA’s position in public comments. The threshold, however, has functioned as CMS intended, and forecast errors less than the threshold have been permitted to remain standing. While not in favor of the 0.25% threshold then and especially not in favor or the 0.5% threshold now, the industry has accepted the process and the threshold.

At the same time, we believe CMS in the 2003 rule making set a precedent that the agency understood the cumulative erosive impact of forecast errors over time, and by its actions of adjusting for the cumulative impact of multi-year forecasting errors acknowledged the agency’s obligation to make corrections. We further believe that the policy adopted in 2003 recognized the cumulative impact of forecast errors in prior years, and set the precedent for corrective action when errors compound over a multi-year period.

As such we ask that CMS adhere to the precedent followed in its 2003 actions that underscored the critical importance of accuracy in payment decisions and act decisively when the cumulative impact of errors erode rates by apply a cumulative adjustment for market basket forecasting errors when the cumulative forecasting errors reach the 0.5% threshold. AHCA believes that such a policy and threshold is tolerable only if a correction is made when the forecast error cumulatively reaches the specified threshold. We urge CMS to follow the precedent it set, withdraw the proposed 0.6% market basket forecast error correction, and modify its market basket forecasting error policy and methodology to adjust rates for cumulative market basket forecasting errors rather than for discrete annual errors.
IV. CMS Wage Index Budget Neutrality Adjustment Methodology Appears To Be Inconsistent With The Statute

(Comments on Section II.C.: Wage Index Adjustment to Federal Rates)

AHCA Recommendations on a SNF Wage Index Adjustment:

- CMS should review its SNF wage index adjustment methodology, adjust its methodology as necessary to ensure that it is applied correctly as per statute in a manner that does not result in aggregate payments that are greater than or less than would otherwise be made in the absence of the wage adjustment, and make any necessary adjustments to make up for past wage index related underpayments.

As we noted in our comments last year, AHCA believes that CMS is misinterpreting Section 1888(e)(4)(G)(ii) of the Social Security Act (the Act) as it applies the wage index to SNFs.

Specifically, the provisions of the Act related to the wage index are as follows (emphasis added):

(ii) Adjustment for geographic variations in labor costs. – The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than would otherwise be made if such adjustment had not been made.

As part of our analysis last year, AHCA used its SNF reimbursement simulation model to estimate SNF PPS payments that included an adjustment for geographic variations in labor costs using the FY 2010 SNF wage index rule and in the absence of a wage adjustment. For our analysis, we utilized 2007 patient days from the CMS claims files, and information on the federal rates, and nursing and therapy weights for FY 2010 to determine total SNF Medicare payments. We ran the calculations using the FY 2010 wage index, the FY 2009 wage index, and without a wage index adjustment (setting the wage index to 1.0000). While we were able to more or less replicate the CMS methodology, AHCA found that aggregate SNF reimbursement were about $400 million lower with a wage index adjustment then without it. Since this methodology appears to have been in place since the implementation of the SNF PPS, we estimate that the incorrect application of the budget-neutral wage index adjustment has under-reimbursed SNFs by over $2 billion over the period from 2002 through 2009.

After reviewing the statute, and the CMS and AHCA methodologies, AHCA believes that CMS is utilizing a wage index budget neutrality adjustment methodology that is inconsistent with the statute. We ask CMS to review the statute and the Agency’s wage index adjustment methodology. We also ask CMS to correct the wage index calculation so that aggregate payments to SNFs are the same with and without the wage index adjustment, as required by statute. Further, we request CMS to review its wage index calculations since implementation of the SNF PPS. If we are correct, we request that CMS make a one time adjustment to reimburse
SNFs for the cumulative underpayment due to the observed non-budget neutral wage index adjustment methodology, or implement another reasonable and acceptable alternative.