July 1, 2013

Marilyn Tavenner, 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-1446-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014, Proposed Rule

Dear Administrator Tavenner:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, Proposed Rule, 78 Federal Register, 26438 (May 6, 2013).

AHCA’s mission is to improve lives by delivering solutions for quality care. As the nation’s largest association of long term and post-acute care providers, AHCA advocates for quality care and services for frail, elderly, and disabled Americans. Our members provide essential care to approximately one million individuals in 11,000 not-for-profit and proprietary member facilities.

AHCA stands ready to work with you on a variety of long-term and post-acute care (LTPAC) issues affecting providers and the beneficiaries that we serve. AHCA’s detailed analysis and specific recommendations on this year’s skilled nursing facility (SNF) prospective payment system (PPS) proposed rule are below. We would be pleased to answer any questions you may have regarding any of our comments and recommendations. We look forward to continuing to work with CMS on these and other critical issues affecting LTPAC.

Sincerely,

Mark Parkinson  
President & CEO

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 11,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.
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AHCA Recommendations in Brief

AHCA Recommendations on Revising and Rebasing the SNF Market Basket Index:

- AHCA recommends that CMS provide more detailed methodology descriptions in future proposed rules, and make available de-identified public use analytic databases on the CMS website to allow stakeholders to replicate, analyze, and provide more informed comments to CMS on proposed rule issues;
- AHCA recommends that CMS, in both this year’s final rule and future proposed rules, provide more specificity in the precise methodology that is used in calculating the weights for the various market basket cost categories; and
- AHCA recommends that CMS continue to utilize a blended index comprised of 50% of the hospital index (NAICS 622) and 50% of the new nursing care facilities index (NAICS 6231) as a more appropriate price proxy for measuring the change in the price of labor for the higher level of skilled labor needed to provide services to Medicare beneficiaries in SNFs.

AHCA Recommendations on the Market Basket Forecast Error Adjustment:

- In order to achieve the goal of the current 0.5 percentage point market basket forecast error adjustment threshold while maintaining the current methodology, AHCA recommends that CMS adopt a 0.45 percentage point adjustment for forecast error adjustment; and
- 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 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 Ensuring Accuracy in Grouping Rehabilitation Categories:

- CMS should not implement the proposal and instead rethink its goal in proposing the MDS change;
- CMS defer the proposed changes to MDS accounting for therapy to report the number of distinct calendar days of therapy and carefully review the impact of the change as discussed in these comments;
- At a minimum, CMS should establish a “special case” exceptions process to hold facilities harmless when they are unable to comply with the five-day rehab delivery during the initial assessment period because of a disruption of ordered services due to changes in the beneficiary’s medical condition;
- CMS should expand the timeframe for the implementation and integration of the new MDS reporting requirement into nursing facility software systems;
- CMS should establish, announce and adhere to a specific schedule for periodic revisions in the MDS-RAI manual and support materials;
- Proposed revisions should be vetted prior to issuance with technical experts from the sector providing opportunity for review and input; and
- CMS should make streamlining its MDS instructions a priority.

**AHCA Recommendations on Wage Index Reform:**

- AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings;
- AHCA encourages CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum;
- Any reform to the design, development, and implementation of the hospital wage index must be eventually applied to SNFs and other LTPAC settings;
- AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets;
- AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM;
- AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis;
- AHCA supports the collection of information on commuting patterns for all LTPAC settings, and not just for hospital employees, in order to make adjustments to the wage index methodology to resolve the boundary effect issue;
- CMS should phase-in any new wage index methodology, particularly one that resolves the boundary effect issue, to allow providers the opportunity to adjust their labor costs over time; and
- AHCA request CMS to provide an update in the final rule on its efforts and plans for wage index reform for the SNF PPS.

**AHCA Recommendations on the SNF Therapy Research Project:**

- In addition to research on potential payment alternatives for therapy services, CMS should undertake research to better pay for non-therapy ancillary services;
- CMS should collect additional supplemental data as part of the project to provide the information necessary to develop and evaluate payment alternatives for therapy services and improve payment for non-therapy ancillary services; and
- AHCA recommends that CMS seek input and feedback from stakeholders for its research on refining the SNF PPS.
I. Revising and Rebasing the SNF Market Basket Index
(Comments on Section V.A)

AHCA Recommendations on Revising and Rebasing the SNF Market Basket Index:

- AHCA recommends that CMS provide more detailed methodology descriptions in future proposed rules, and make available de-identified public use analytic databases on the CMS website to allow stakeholders to replicate, analyze, and provide more informed comments to CMS on proposed rule issues;
- AHCA recommends that CMS, in both this year’s final rule and future proposed rules, provide more specificity in the precise methodology that is used in calculating the weights for the various market basket cost categories; and
- AHCA recommends that CMS continue to utilize a blended index comprised of 50% of the hospital index (NAICS 622) and 50% of the new nursing care facilities index (NAICS 6231) as a more appropriate price proxy for measuring the change in the price of labor for the higher level of skilled labor needed to provide services to Medicare beneficiaries in SNFs.

A. Market Basket Weight

1. Background

Section 1888(e)(5)(A) of the Social Security Act requires CMS to establish a market basket index for SNFs that reflects changes in the prices of an appropriate mix of goods and services included in the SNF PPS. The CMS SNF market basket covers common cost categories for routine services, ancillary services, and capital-related expenses. With the introduction of the SNF PPS, CMS rebased and revised the market basket using fiscal year (FY) 1992 Medicare cost report data. CMS subsequently rebased and revised the SNF PPS in the FY 2002 SNF PPS final rule using FY 1997 cost report data, and again in the FY 2008 SNF PPS final rule using FY 2004 cost report data. For FY 2014, CMS is proposing to rebase and revise the market basket using FY 2010 cost report data.

Conceptually, AHCA is supportive of periodic rebasing and revisions to the SNF market basket index. The market basket should reflect the mix of goods and services that are used to produce SNF care, and accurately track the change in cost of purchasing those goods and services over time. Over time, as the type and mix of goods and services change due to patient characteristic changes, improved care delivery practices, technological changes, efficiencies, and other factors, the market basket should be rebased and revised to reflect the new mix of goods and services that are used to produce SNF care.

Given the importance of the market basket weights and price proxies in computing the market basket update factor, AHCA began an effort to replicate the CMS data, methodology, and findings to ensure that the proposed rebasing and revision accurately reflects SNF costs and will accurately predict market basket increases. However, as our comments below indicate, we have a number of concerns about the proposed rebasing and revision of the market basket, and recommend that CMS hold off on updating the weights and price proxies this year pending refinements to the underlying Medicare cost reports to correct issues with the data that may bias the weights associated with the major cost categories.
2. Replicating the CMS Analytic Database

In the proposed rule, CMS provides an overview of the methodology and data used in revising the market basket index. Unfortunately CMS does not provide sufficiently detailed information in the proposed rule for stakeholders to recreate the analytic databases CMS used to compute the cost category weights using publicly available CMS data. We applaud CMS, however, for its responsiveness and timely feedback during the comment period to provide stakeholders with additional information on the various exclusions that they used to create the analytic database that is the basis for the revision. We request that CMS formally provide this information to stakeholders in this year’s final rule, and ask that CMS include this type of detail in future proposed rules, both specifically as it relates to rebasing and revising the market baskets but also more generally as it relates to the description of data and methodologies for other reforms and updates to payment system components where relevant. In addition, in this year’s final rule and in future proposed rules, we request that CMS prepare and make available through the internet on the CMS website the underlying analytic databases that CMS uses for rebasing and revising market baskets, as well as for other updates or reforms to the PPS, where relevant.

As part of our efforts to replicate the major cost categories, AHCA downloaded the SNF PPS Medicare cost reports from the CMS website as of mid-May, shortly after CMS made available the second quarter update to the Medicare cost report data. Per the proposed rule, we included cost reports for free-standing SNFs with fiscal year beginning dates that fell in FY 2010 (14,414 cost reports).

We then applied the following exclusions per the supplemental information CMS made available.

<table>
<thead>
<tr>
<th>EXCLUSIONS</th>
<th>FACILITIES FLAGGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total Facility Costs $&gt;$ 0</td>
<td>359</td>
</tr>
<tr>
<td>(Worksheet B, part 1, L75, C18)</td>
<td></td>
</tr>
<tr>
<td>b. Total Operating Costs (Total Costs less Capital Costs) $&gt;$ 0</td>
<td>379</td>
</tr>
<tr>
<td>(Worksheet B, part 1, L75, C18 - Worksheet B, part 2, L75, C18)</td>
<td></td>
</tr>
<tr>
<td>c. Medicare General Inpatient Routine Service Costs $&gt;$ 0</td>
<td>4,183</td>
</tr>
<tr>
<td>(Worksheet D1, part 1, L19, C1)</td>
<td></td>
</tr>
<tr>
<td>d. Medicare Payments $&gt;$ 0</td>
<td>391</td>
</tr>
<tr>
<td>(Sum of Worksheet E, part 3, L7 and L11, C1)</td>
<td></td>
</tr>
<tr>
<td>ALL FOUR EXCLUSIONS TOGETHER</td>
<td>4,225</td>
</tr>
</tbody>
</table>

The resultant AHCA Medicare cost report analytic database contained 10,189 cost reports, which we understand is approximately the same as the number of facilities in the CMS analytic database. Though the effect on major cost category weights is likely to be small, we ask CMS to consider removing facilities with no and low Medicare utilization from the analytic database, as well as those that do not have cost reports that cover a full year as the cost reports for these facilities (e.g. new facilities or closing facilities), as these cost reports may not be reflective of costs of the typical SNF and could skew the weights.

AHCA is concerned about the effect of exclusion c (the Medicare General Inpatient Routine Service Costs $>$ 0 exclusion). This exclusion alone is responsible for dropping over 4,000 Medicare cost reports from the analytic database and the subsequent weight calculations. This represents approximately 30% of all SNFs filing a Medicare cost report. Given that SNFs would
and should have inpatient routine service costs greater than zero, the exclusion makes sense on its face. Clearly facilities with zero or negative inpatient routine service costs should be excluded. In reviewing the cost reports, however, the issue here is not that inpatient routine service cost are zero or negative, but rather that the worksheet is an optional worksheet. It is not required to be filed. Of the 4,183 cost reports with no data for this line item (Worksheet D1, part 1, L19, C2), only 24 cost reports had at least one item completed on the worksheet. The other 4,225 cost reports had no data on that worksheet at all. CMS should find some other means for eliminating erroneous or outlier values that are captured by this exclusion.

Overall, given that about 30% or all SNFs are excluded from the analysis, AHCA is concerned about the validity and accuracy of the weight estimates for the major cost categories. It also gives us pause and cause for concern about the findings of other stakeholders that are utilizing this data and similar methodologies. Given the utilization of this information for rate setting purposes, it is critical that the underlying data and analytics are as accurate as possible. We encourage CMS to examine, develop and evaluate other exclusion criteria that target the same issue that CMS seeks to address with the Medicare inpatient services routine cost exclusion. We further ask that CMS provide detailed information in the final rule so that other stakeholders are aware of underlying data and methodological issues and what methodologies CMS utilizes and recommends for valid and accurate analytics and results.

3. Replicating the CMS Major Cost Category Weight Methodology

Using the information in the proposed rule, we sought to replicate the formulas CMS used to compute the various cost categories. (See Appendix A). Some of the cost category methodology descriptions in the proposed rule are quite clear. For example on page 26452, it states that “Medicare allowable total expenses are equal to total expenses from Worksheet B, lines 16, 21 through 30, 32, 33, 48, and 52 through 54,” C18, post-reclassifications presumably.

Other descriptions were less clear.

First, we calculated pharmaceutical costs using the non-salary costs from the Pharmacy cost center and the Drugs Charged to Patients’ cost center, both found on Worksheet B of the SNF MCRs. Since these drug costs were attributable to the entire SNF and not limited to Medicare allowable services, we adjusted the drug costs by the ratio of Medicare allowable pharmacy total costs to total pharmacy costs from Worksheet B, part I, column 11. Worksheet B, part I allocates the general service cost centers, which are often referred to as “overhead costs” (in which pharmacy costs are included) to the Medicare allowable and non-Medicare allowable cost centers.

In subsequent clarification from CMS we learned that the pharmacy cost is calculated using non-salary costs (column 0 less column 1) from the Pharmacy cost center (line 11) and the Drugs Charged to Patients’ (line 30) cost center, both found on Worksheet B of the SNF MCRs. If true, it is unclear why, capital costs related to building and fixtures would be excluded from total pharmacy salary costs. Also, if true, then the methodology appears to be incorrect. After further review at AHCA, we can only infer that rather than subtract out worksheet B, L11, C1 (capital) from pharmacy cost (worksheet B, L11, C0) that CMS meant to subtract out pharmacy related salaries from worksheet A, L11, C1 to obtain non-salary pharmacy costs. There is however no reference to salary costs from worksheet A in the methodology description in the proposed rule.
Given the information in the proposed rule, it is difficult for stakeholders to replicate and provide meaningful comments on the accuracy of the weights for the major cost categories. Because of this lack of clarity, we ask that CMS in both this year’s final rule and future proposed rules provide more specificity in the precise methodology they are using. See Appendix A as an example. We also ask that the CMS final rule be a final rule with comment period so that stakeholders have an opportunity to comment on issues based on the clarified cost category weight methodology with detailed worksheet references that we are requesting be included in the final rule.

4. Replication Overview

Per supplementation information CMS made available, we then applied additional trims to the data when estimating the weights for each of the major cost categories (salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance, and capital-related expenses).

- Major expenses (such as, salary costs) > 0 and total Medicare allowable costs > 0
- Top and bottom 5 percent of the major cost weight (ex: salary costs / total Medicare allowable costs) were excluded

Our estimates of the major cost category weights can be found in Appendix B below.

As can be seen in Appendix B there is highly significant discrepancy between the wages and salaries cost weight AHCA found based on our replication (49.498%), with that in the CMS proposed rule (46.057%). We ask that CMS review its data and methodology to ensure the accuracy of the estimate. AHCA is willing to share our analytics with CMS to assist in identifying the discrepancy. We would also be willing to provide assistance to review the CMS analytics to identify and resolve the discrepancy. Please let us know how we can best be of assistance.

In addition to the significant discrepancy in the wages and salaries cost weight, we believe that CMS may not be appropriately calculating the numerator for the wages and salaries cost weight (Medicare allowable wages and salaries). In the proposed rule, CMS describes the calculation on page 26452 as:

We determined the share using Medicare allowable wages and salaries from Worksheet S-3, part II and total expenses from Worksheet B, part I. Medicare allowable wages and salaries are equal to total wages and salaries minus: (1) excluded salaries from worksheet S-3, part II; and (2) nursing facility and nonreimbursable salaries from worksheet A, lines 18, 34 through 36, and 58 through 63. Medicare allowable total expenses are equal to total expenses from Worksheet B, lines 16, 21 through 30, 32, 33, 48, and 52 through 54.

From this we infer that CMS is calculating the numerator as total wages and salaries (Worksheet S-3, part2, L16, C3) minus nursing facility related wages and salaries (Worksheet A, L18, C1), minus Clinical, RHC, and Other Outpatient Expenses (Worksheet A, L34 to L36, C1), minus Non-Reimbursable (Worksheet A, L58 to 63, C1). Since total wages and salaries is already net of Clinical, RHC, Other Outpatient and non-reimbursable salaries already, the CMS methodology appears to be excluding excluded and non-reimbursable salaries twice, resulting in a cost weight that is lower than it otherwise should be. See Alternative 1 on Table X.
Similarly, the calculation for the numerator of the benefits weight is based on the Medicare allowable wages and salaries calculation described above. If our understanding is correct, then the numerator (Medicare allowable benefits) would also be lower than it otherwise should be.

As indicated in I.A.ii.2 above, there also appears to be either confusion on the methodology or errors in the methodology for calculating the Pharmacy component.

Contract labor in a nursing facility is primarily comprised of agency nursing (commonly called nursing pool) and contracted therapy. CMS calculates Allowable Contract Labor by multiplying total contract labor cost by the ratio of SNF salaries and wages to SNF and NF salaries and wages. It is reasonable to assume that agency nursing would provide services to patients in skilled units and in NF units, and therefore allocating agency nursing costs by their ratio of SNF and NF salaries is appropriate.

While this allocation approach is reasonable for agency nursing, it is not appropriate for contracted therapy. Contract therapy costs relate almost exclusively to skilled patients and are reported as ancillary costs (Worksheet B Part I, lines 25-27) which are Medicare allowable expenses. Allocating these costs on the ratio of SNF and NF salaries results in a percentage of these costs being considered as non-allowable, which is inaccurate. Therefore, a more appropriate allocation methodology is as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Worksheet</th>
<th>Line</th>
<th>Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Labor Patient Related and Mgmt</td>
<td>S-3, Part 2</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td><strong>SUBTRACT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Therapy cost - ALL MEDICARE ALLOWABLE EXPENSE</td>
<td>A</td>
<td>25, 26, 27 (including sub-lines, i.e. 25.01)</td>
<td>2</td>
</tr>
<tr>
<td>EQUALS NET Contract Labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiply Net Contract Labor Times Ratio of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF Wages and Salaries Divided by</td>
<td>A</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>SNF and NF Wages and Salaries</td>
<td>A</td>
<td>16 and 18</td>
<td>1</td>
</tr>
<tr>
<td>Equals Allocated non-therapy Contract Labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ADD BACK:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Therapy cost - ALL MEDICARE</td>
<td>A</td>
<td>25, 26, 27</td>
<td>2</td>
</tr>
<tr>
<td>EQUALS Allowable Contract Labor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It could be argued that Worksheet A, Lines 25-27 include therapy supply costs, but such costs would be miniscule, representing no more than 1% to 2% of the total amount on the line.

We ask that CMS review its methodology for calculating the various weight categories. Our understanding of the CMS methodology can be found in Appendix A. We request that CMS make available a detailed item-by-item description of the formulas used in the calculation of the major cost category weights in the final rule. AHCA would like to offer our assistance in reviewing and discussing the CMS methodologies. Please let us know if you have any questions about our replication, the proposed alternative wages and salaries methodology, or our findings.
B. Price Proxies

In addition to rebasing and revising the cost category weights, CMS is also proposing to revise the price proxies for the SNF PPS market basket. In particular, CMS is proposing to replace the current price proxy for wages and salaries comprised of a 50% weighting of the ECI for nursing and residential care facilities (NAICS 623) and a 50% weighting of the ECI for hospital workers (NAICS 622), with the ECI for nursing care facilities (NAICS 6231).

The ECI for wages and salaries for nursing and residential care facilities (NAICS 623) is a poor proxy for measuring change in the price of labor. NAICS 623 reflects changes in the price of labor for facilities that provide residential care combined with nursing, supervisory, or other types of care. The care provided is a mix of health and social services with the health services being largely some level of nursing services. By contrast, NAICS 6231 reflects nursing care facilities primarily engaged in providing inpatient nursing and rehabilitative services. Compared to NAICS 623, NAICS 6231 better reflects changes in wages and salaries for Medicare-certified SNFs. Since, CMS now has the data to forecast this price proxy, AHCA supports updating the SNF PPS market basket price proxy for wages and salaries to use the ECI for nursing care facilities (NAICS 6231) instead of the ECI for nursing and residential care facilities (NAICS 623).

While the NAICS 6231 is better than NAICS 623 for measuring changes in the price of labor for SNFs, the proposal to replace the current blended nursing facility / hospital price approach with the ECI for nursing care facilities only does not fully nor adequately capture changes in the price of labor for SNFs. Like NAICS 623 before it NAICS 6231 continues to be suboptimal for measuring changes in the price of labor provided to Medicare beneficiaries in SNFs. First, Medicare beneficiaries in SNFs tend to be sicker and have a higher level of acuity then non-Medicare beneficiaries in SNFs and patients in the other care settings included in the nursing care facilities index. Second, the level and skill mix of staff required to provide services to the higher acuity patients is thus also higher in SNFs than for patients in nursing facilities or the other care settings included in the nursing care facility index. Furthermore, the index also includes convalescent homes, homes for the aged with nursing care, homes for the elderly with nursing care, rest homes with nursing care, and retirement homes with nursing care in addition to the SNFs that provide care primarily to Medicare beneficiaries, which provide lower intensity and levels of care then SNFs. Given that the purpose of the price proxy is to measure the change in the price of labor for the services provided to Medicare beneficiaries, the CMS proposal to use only NAICS 6231 is inadequate.

Rather than use the ECI for wages and salaries for Nursing Care Facilities (Private Industry) (NAICS 6231), AHCA recommends that CMS utilize a blended index comprised of 50% of the nursing care facilities index (NAICS 6231) and 50% of the hospital index (NAICS 622) as a more appropriate price proxy for measuring the change in the price of labor for the higher level of skilled labor need to provide services to Medicare beneficiaries in SNFs. Since the nursing care facility index reflects an occupation mix that is less skilled then the occupation mix in SNFs, and since the hospital index reflects an occupational mix that is more skilled then in SNFs, using a blended index that reflects changes in the price of labor for the higher skilled healthcare workers that provide services to Medicare beneficiaries in SNFs would be the best alternative given data limitations.
II. Forecast Error Adjustment
(Comments on Section III.B.3)

AHCA Recommendations on the Market Basket Forecast Error Adjustment:

- In order to achieve the goal of the current 0.5 percentage point market basket forecast error adjustment threshold while maintaining the current methodology, AHCA recommends that CMS adopt a 0.45 percentage point adjustment for forecast error adjustment; and
- 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 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.

As discussed in the supplemental proposed rule and finalized in the final rule, CMS established an adjustment to account for market basket forecast error in the SNF PPS for FY 2004. For FY 2004, CMS increased the market basket by 3.26 percentage points to take into account the cumulative forecast error for the period from FY 2000 through FY 2002, and for subsequent years established a process for applying a forecast error correction when the difference between the forecasted and actual market basket exceeded a threshold, which CMS originally set at 0.25 percentage points. CMS increased the threshold to 0.5 percentage points in the FY 2008 SNF PPS final rule when the actual market basket increase in FY 2006 was 0.3 percentage points greater than the estimated market basket increase. As such, the market basket forecast error adjustment to the SNF PPS was applied only once in FY 2012, when the SNF PPS market basket was adjusted downward by 0.6 percentage points.

In examining the estimated and actual market basket increase for FY 2012, CMS found that the actual increase was 0.5 percentage points lower than the estimated increase. In instances when the difference is equal to the threshold at one-decimal place precision, CMS proposes to modify its approach to evaluate the difference by going to two-decimal place precision. Under this approach, if the difference is between 0.45 and 0.49 percentage points, CMS would not apply the forecast error adjustment, and in cases where the difference is between 0.51 and 0.54 percentage points, CMS would apply a 0.5 percentage point forecast error adjustment.

After careful review of CMS processes and precedents, AHCA believes that the CMS proposal is a reasonable approach to determining whether the forecast error adjustment to the market basket has been triggered when the difference between the estimate and actual market basket increase is 0.5 percentage points when rounded to one-decimal place precision. While this two-decimal place precision approach seems reasonable given the precision of the data and model that CMS is using, AHCA believes that further modifications to three, four, or five decimal places of precision would stretch the capabilities of the model and the precision of the data in determining the difference particularly given measurement error. AHCA believes that in the future, were there to be instances where the difference between the estimate and actual market basket increase was 0.50 percentage points when using two-decimal place precision, that this would not trigger a forecast error adjustment. AHCA requests confirmation from CMS to their proposed evaluation methodology.

CMS may also wish to consider changing the threshold from greater than 0.5 percentage points to greater than 0.45 percentage points. Using the 0.45 percentage point threshold, like the
previous 0.25 threshold for the SNF market basket and like the 0.25 threshold for capital in the inpatient hospital PPS, would allow CMS to continue to measure, evaluate, and implement updates based on one-decimal place precision rather than establish a new two decimal place precision based approach.

AHCA also urges CMS to examine and reconsider its independent annual evaluation of market basket forecast errors. The cumulative impact of market basket forecasting errors is not to be discounted. AHCA believes CMS set an appropriate and much needed precedent in the final rule of FY 2003 where 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. We further believe that the policy adopted in 2003 recognized the cumulative impact of forecast errors in prior years, and set the necessary and needed 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 percentage point (or AHCA’s proposed 0.45 percentage point) 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.

Table 2: Annual Market Basket Forecasting Error Since Correction in FY 2002

<table>
<thead>
<tr>
<th>Federal Register Providing Actual Market Basket Update</th>
<th>Fiscal Year</th>
<th>Predicted Market Basket Update</th>
<th>Actual Market Basket Update</th>
<th>Percentage Point Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 30, 2004 69 FR 45778</td>
<td>FY 2003</td>
<td>3.1%</td>
<td>3.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td>August 4, 2005 70 FR 45029</td>
<td>FY 2004</td>
<td>3.0%</td>
<td>3.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>July 31, 2006 71 FR 43162</td>
<td>FY 2005</td>
<td>2.8%</td>
<td>2.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>August 3, 2007 72 FR 43415</td>
<td>FY 2006</td>
<td>3.1%</td>
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III. Ensuring Accuracy in Grouping to Rehabilitation Categories
-- The Reporting of Distinct Therapy Days (Comments on Section V.C)

AHCA Recommendations on Ensuring Accuracy in Grouping to Rehabilitation Categories:

- CMS should not implement the proposal and instead rethink its goal in proposing the MDS change;
- CMS defer the proposed changes to MDS accounting for therapy to report the number of distinct calendar days of therapy and carefully review the impact of the change as discussed in these comments;
- At a minimum, CMS should establish a “special case” exceptions process to hold facilities harmless when they are unable to comply with the five-day rehab delivery during the initial assessment period because of a disruption of ordered services due to changes in the beneficiary’s medical condition;
- CMS expand the timeframe for the implementation and integration of the new MDS reporting requirement into nursing facility software systems;
- CMS should establish, announce and adhere to a specific schedule for periodic revisions in the MDS-RAI manual and support materials;
- Proposed revisions should be vetted prior to issuance with technical experts from the sector providing opportunity for review and input; and
- CMS should make streamlining its MDS instructions a priority.

A. The CMS Proposal

CMS is proposing to add an item to the Minimum Data Set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a Beneficiary over the seven-day look-back period. Furthermore, CMS is clarifying that the qualifying condition for the Medium Rehab (RM) Category requires 5 distinct calendar days of therapy. Similarly, CMS is clarifying that the qualifying condition for the Low Rehab (RL) Category would be clarified to require 3 distinct calendar days.

Currently, the number of days for each therapy disciplines reported on the MDS is summed without having to report the number of separate days per week on which the patient receives therapy services across all rehabilitation disciplines. It is CMS’ contention that this results in some patients receiving higher SNF payments for an RM or RL Resource Utilization Group (RUG) when the patient actually does not meet the qualifying conditions for that RUG.

CMS proposes to modify the MDS Item Set by adding O0420 which would require facilities to record the number of distinct calendar days on which a patient receives rehabilitation therapy. The change would be effective on October 13, 2013.

CMS did not proffer any clinical basis for an action that has the potential to obliterate the flexibility of therapists to consider the physical capacity of a patient to withstand therapy on a specific day for specific health reasons -- such as a dialysis treatment day, or a brief illness. CMS, in cutting off flexibility will prevent a facility from receiving adequate reimbursement for rehabilitation care provided to unstable patients who are missing treatment sessions due to illness or treatments such as dialysis.
As indicated above, CMS contends that some patients are receiving higher SNF payments for an RM or RL Resource Utilization Group (RUG) when the patient actually does not meet the qualifying conditions for that RUG. CMS does not elaborate on the dimension of "some" and does not discuss any alternatives to its proposed solution, a solution which will negatively impact the ability of a facility to provide appropriate and timely care.

AHCA recommends that the proposal not be implemented and that CMS rethink its goal in proposing the MDS change. CMS has proffered no compelling reason for the change. It has not clearly laid out the specifics of the problem, its dimensions, and its impact. In effect, it did not properly consider all the circumstances surrounding the revision.

B. Background

As we indicate in Section VIII of these comments, AHCA is well aware of the concerns expressed by CMS, MedPAC, and other entities regarding the weaknesses of many of the current Medicare payment methodologies. With respect to the SNF PPS, developed with an updated base year of 1995, CMS has come to conclude that the therapy component methodology is flawed in that volume drives RUG beneficiary placement. CMS currently is looking to Acumen and Brookings for input on an initial phase of therapy component reform. Simultaneously, MedPAC, with similar concerns, is currently supportive of an approach proffered by the Urban Institute using patient conditions and stay characteristics to drive, using regression analysis, the appropriate level of care.

However, AHCA is not a bystander in efforts at reform. Again, as detailed in Section VIII of these comments, we are engaged in research and dedicating substantial resources to the modification of the therapy component and, in addition, the development of uniform and universal therapy outcomes measures.¹

In the interim, CMS has continuously revisited its methodology, modifying and revising year after year. With regard to some of the changes, such as MDS 3.0, we have not only applauded such, but AHCA members and staff were active stakeholders in the process. In contrast, we have questioned the necessity and the validity of many others. Part of our concern is the lack of CMS acknowledgment of the steep cost of continual modifications, the upheaval that endless re-working can cause, and the lack of stability that it can induce.

Moreover, CMS, in changing the MDS as proposed, CMS will cut off flexibility and prevent a facility from receiving adequate reimbursement for rehabilitation care provided to unstable patients who are missing treatment sessions due to illness or treatments such as dialysis.

These concerns underlie our comments on CMS' proposal to add an item to the Minimum Data Set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a beneficiary over the seven-day look-back period.

C. The Meaning of Daily Skilled Care

The SNF PPS payment system is a complex payment methodology that tries to determine on a prospective basis the cost of caring for a post-acute Part SNF PPS patient. Section 1888(e)(4)

¹ AHCA is working on this major undertaking with the National Association for the Support of Long Term Care (NASL).
of the Social Security Act provides the basis for the establishment of the per diem federal payment rates applied under the PPS. The overall approach of the system is the product of myriad demonstrations that presaged the ultimate development of the CMS SNF PPS system. The methodology is anchored to the determination of the cost of care per day.

Thus, it follows that the CMS Manual requires the provision of skilled care for Rehabilitation Medium to be delivered 5-times per week to reflect daily skilled care as defined by Chapter 8 of the Medicare Benefits Policy Manual. Section 30.6 of Chapter 8 of the Medicare Benefit Policy Manual, Coverage of Extended Care (SNF) Services under Hospital Insurance, defines daily skilled services as follows:

**30.6 - Daily Skilled Services Defined**

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis,” i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)

The guidance is consistent with the thrust of the overall methodology. **And, providers follow this guidance.** However, CMS, in this same provision expresses the realization that there may be conditions and situations where the letter of the law cannot be followed due to the condition of the patient. CMS provides that:

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

**EXAMPLE:**

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In sum, the guidance provides an understanding that therapy may not be possible for the resident on a given day and the current grouper takes this into account. There are similar situations that preclude the provision of 5 days of therapy to the patient in a particular week but who receives in toto the required amount of therapy.

- The patient who must receive dialysis every other day. Typically, dialysis patients are not medically able to receive therapy on the same day as the dialysis treatment but are typically able to tolerate two sessions of therapy on non-dialysis days.

- The patient ordered to receive individual Physical Therapy 5 days per week for 50 minutes per day and Occupational Therapy 5 days per week for 50 minutes per day. The patient was participating in therapy and progressing well up to the 4th day when the patient acquired an illness and was ordered to be on bed rest for 2-3 days. At this point

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2 (Rev. 161, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)
the center has delivered 8 therapy days over 4 calendar days and 400 therapy minutes by 2 disciplines. Despite the amount of therapy given the center will be reimbursed at a non-rehab RUG level.

The proposed rule runs completely counter to CMS’ guidance set forth above. It is difficult to imagine that CMS is abandoning its guidance. However, if CMS proceeds with the MDS change, the result will be the elimination of a much needed exception to the rule of daily skilled care. In addition, elimination of the exception to the rule abrogates resource utilization as the foundation of the SNF PPS.

In short, implementation of the proposal should be deferred until CMS provides clarity on the relationship between the guidance in Section 30.6 and the proposed MDS change and assurance that first and foremost the patient’s needs must be met. At a minimum, CMS should establish a “special case” exceptions process to hold facilities harmless when they are unable to comply with the five-day rehab delivery during the initial assessment period because of a disruption of ordered services and that the beneficiary’s medical condition continue to be considered and accommodated. AHCA recommends that:

- **CMS defer the proposed changes to MDS accounting for therapy to report the number of distinct calendar days of therapy and carefully review the impact of the change as discussed in these comments;**

- **At a minimum, CMS should establish a “special case” exceptions process to hold facilities harmless when they are unable to comply with the five-day rehab delivery during the initial assessment period because of a disruption of ordered services due to changes in the beneficiary’s medical condition.**

**D. Implementation of New Data Collection in Software**

CMS has proposed an unrealistic and insufficient timeframe for the implementation and integration of the new MDS reporting requirement into nursing facility software systems. The proposed change would require technical programming revisions in the MDS instrument. The logistics of having sufficient time to perform the programming changes and to verify that revisions in the software will not affect other elements of electronic medical records is not addressed.

CMS has released the “specs” in draft form accompanied by this warning, “**This version is scheduled to become effective October 1, 2013. Version 1.13.1 should be considered provisional or draft and is subject to change until the final specifications are published.**” Thus, under the timeframe in this announcement, software developers, SNFs, therapists and other stakeholders would have less than three months to re-code to conform to this change, test the software, make appropriate changes to the implementation guide and educate therapists and other SNF staff about the new requirement. These necessary steps cannot be completed in three months.

Software changes in themselves are a challenge to implement quickly and efficiently. The roll-out of MDS 3.0 in 2010 that required significant changes to the software systems in order to implement the new MDS 3.0, the change in assessment windows as well as the Change of Therapy and other OMRAs that were implemented in 2011, remind us that software vendors require more than 90 days to implement these changes nationwide.
AHCA appreciates CMS’ release of draft specs, but fear that software companies will have to re-code final specs to accommodate the final rule changes. These changes increase the prospects for billing errors that will need correction, increasing the burden on the CMS, providers and vendors. AHCA recommends that:

- **CMS expand the timeframe for the implementation and integration of the new MDS reporting requirement into nursing facility software systems.**

### E. MDS RAI Revisions

In addition to the above specific concerns, AHCA has the following overarching concern: continued CMS modification to the MDS 3.0 instrument is generating a great deal of confusion among front line troops. Providers are struggling to interpret, train and implement the repetitive revisions in instruction. Providers report that their systems teams are reeling under the challenges of endless revisions that require costly technical software edits.

In less than three years, CMS has made four major revisions to the RAI manual, issued multiple errata corrections to instructions and guidance and has issued countless revisions to its technical support. Seldom has the agency reached out for pre-release consultation from professionals who are engaged in direct patient care. Often the agency has provided inadequate implementation time for computer programs to be revised, updated and verified. Most alarming is that in several instances, these revisions have been informally announced as presentations at conferences rather than through any formal, systematic administrative process.

**Recommendations:**

- **CMS should establish, announce and adhere to a specific schedule for periodic revisions in the MDS-RAI manual and support materials**
- **Proposed revisions should be vetted prior to issuance with technical experts from the sector providing opportunity for review and input; and**
- **CMS should make streamlining its MDS instructions a priority.**
IV. Wage Index Adjustment  
(Comments on Section III.D)

**AHCA Recommendations on Wage Index Reform:**

- AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings;
- AHCA encourages CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum;
- Any reform to the design, development, and implementation of the hospital wage index must be eventually applied to SNFs and other LTPAC settings;
- AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets;
- AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM;
- AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis;
- AHCA supports the collection of information on commuting patterns for all LTPAC settings, and not just for hospital employees, in order to make adjustments to the wage index methodology to resolve the boundary effect issue;
- CMS should phase-in any new wage index methodology, particularly one that resolves the boundary effect issue, to allow providers the opportunity to adjust their labor costs over time; and
- AHCA request CMS to provide an update in the final rule on its efforts and plans for wage index reform for the SNF PPS.

The current area wage index methodology for adjusting Medicare payments is broken. It does not appropriately, nor adequately adjust Medicare payments for differences in wage rates across geographic regions for hospitals nor for long-term and post-acute care providers. MedPAC identified several critical problems with the current area wage index methodology including:

1. Large differences in wage indexes between adjoining geographic areas that have led to the establishment of numerous exceptions, which allow hospitals to be reclassified to other geographic areas;
2. Implementation of an additional annual occupational mix survey for each hospital to adjust the wage index for the skill level of employees;
3. Circularity in the establishment of the wage index, whereby hospitals located in markets with few providers have the ability to set or influence the wage index for their geographic area through business practices; and
4. Year-to-year volatility of the wage index within a geographic area that does not appear to be related to underlying changes in local labor market conditions.

The Medicare Payment Advisory Commission (MedPAC), Acumen LLC, the Institute of Medicine (IOM) and others have researched and described the deficiencies with the current data and methodology, and made recommendations on reforming the system.\(^3\)

SNF providers are routinely affected by these deficiencies. For example, in rural Oregon there are 7 hospitals that participate in the inpatient hospital PPS. In CY 2012, one hospital made an error in their Medicare cost report which contributed to an increase in the SNF wage index for rural Oregon by 3.1% (from 1.0029 to 1.0337). The subsequent correction to their cost report contributed to an 8.1% reduction in the wage index for rural Oregon SNF providers (from 1.0337 to 0.95). Such large reductions in the SNF wage index, a result of a mistake in completing a cost report, not by a SNF but by another type of provider altogether, had a dramatic impact on the operations of SNFs and their employees in rural Oregon. Errors in completing costs reports, coupled with hospitals jumping in and out of the inpatient hospital PPS and large geographic groupings, contribute to huge swings in the wage index for not only rural SNFs in Oregon but for all LTPAC providers participating in CMS PPS'. A new more accurate wage index methodology is needed.

In reviewing the variation in the SNF wage index over the last three year, the SNF wage index dropped by more than 10% in FY 2013 from FY 2012 in El Centro, CA and Wichita Falls, TX, and FY 2012 from FY 2011 the SNF wage index fell by over 10% in Ithica, NY and by over 18% in Racine, WI. While we have not researched the reason why the SNF wage index declined so significantly in El Centro, Ithica, and Wichita Falls, the 18+% decline in Racine was once again related to an error by a single hospital in its completion of its Medicare cost report. For FY 2014, SNFs in six CBSA’s are on track for a 10% or more decline in their wage index, and two CBSAs (Palm Coast, FL and Prescott, AZ) are on track for a 15+% reduction in their SNF wage index. It would be one thing if the large year to year variation in the wage index was related to local labor market issues, but they are not. For SNFs, it is quite the challenge to manage labor costs and operations to such large changes in the wage index, particularly when they are unrelated to local labor market conditions. A 15% reduction in the wage index corresponds to about a $65 reduction in rates. Such large changes in reimbursement rates can have significant implications for operations and staffing of SNFs in affected markets. AHCA requests CMS’ assistance in developing and implementing a new area wage index methodology that works appropriately in both acute and LTPAC settings. AHCA would further welcome CMS’ assistance in developing an interim solution to provide stability and relief to SNFs in markets where the year to year variation in the wage index is above a reasonable threshold that would reflect inflationary pressures (e.g. 3% - 5%).

Given the extent of the problems with the current area wage index methodology and its lack of application in both hospital and especially in long-term and post-acute care settings, AHCA

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supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets for the full spectrum of health care providers. We are encouraged that MedPAC, Acumen, and the IOM recognize that a system based solely on hospital labor cost data is inappropriate. We ask that CMS consider recommendations from MedPAC, Acumen, and the IOM that call for wage and benefit data to be used to create an area wage index that better reflects the price of labor in a broader context that also includes SNFs and other post-acute care settings.

It is critical that we get wage index reform “right”. AHCA has commented quite extensively on the need for a new, more accurate wage index methodology (See Appendix C). We are encouraged that CMS is working to improve the wage index methodology. AHCA encourages CMS to break down silos and other barriers within CMS to reform the wage index in a way that will work for both acute and LTPAC settings, and not just for inpatient hospitals. We request CMS to provide an update in the final rule on its efforts and plans for wage index reform on the SNF side. AHCA encourages CMS to have AHCA and other LTPAC stakeholders in addition to acute setting stakeholders involved in the process for reforming the wage index.
V. SNF Therapy Research Project
(Comments on Section V.D)

AHCA Recommendations on the SNF Therapy Research Project:

- In addition to research on potential payment alternatives for therapy services, CMS should undertake research to better pay for non-therapy ancillary services;
- CMS should collect additional supplemental data as part of the project to provide the information necessary to develop and evaluate payment alternatives for therapy services and improve payment for non-therapy ancillary services; and
- AHCA recommends that CMS seek input and feedback from stakeholders for its research on refining the SNF PPS.

For all of its weaknesses, the SNF PPS does a reasonable job at reimbursing providers appropriately for the services provided in a SNF to increasingly elderly, frail, and disabled Medicare beneficiaries. Over the years, CMS has made incremental changes to the SNF PPS that have by and large improved access to services and better aligned payments to the actual cost of providing services. AHCA is pleased that CMS is undertaking research to further improve the system.

Refinements made to the SNF PPS in 2006 based on work by the Urban Institute began to improve the system. In the FY 2006 SNF PPS final rule, CMS increased the number of Resource Utilization Groups version 3.0 (RUG-III) categories from 44 to 53 by adding nine new RUG categories for patients receiving rehabilitation services and receiving extensive services. Based on the findings from the STRIVE study, CMS updated the national staff time measurements from the late 1990s that formed the basis for the CMIs that underlie the SNF PPS for FY 2011.

Through this project, CMS revised the nursing and therapy weights and updated the RUG classification system. Despite some weaknesses and failings of the STRIVE project, the new CMS RUG-IV classification and payment system that are built on the update Minimum Data Set (MDS) 3.0 resident assessment instrument, are an improvement over MDS 2.0 and RUG-III.

Notwithstanding the improvements, AHCA, MedPAC, and other stakeholders have commented extensively on the continuing deficiencies of the SNF PPS. Stakeholders have identified the need for improvement in how the SNF PPS pays for non-therapy ancillary services (NTAS) as well as for therapy services. Recommendations have also been made for the inclusion of an outlier policy to the SNF PPS. AHCA is pleased that CMS continues to examine ways of improving the SNF PPS to appropriately reimburse providers for the care provided to the Medicare beneficiaries that we serve.

In its recent Reports to the Congress, MedPAC identified a number of issues with the SNF PPS that should be addressed. These issues include incentives to provide unnecessary therapy services and poor targeting of payments for NTAS such as drugs. CMS has undertaken research to refine the SNF PPS to better pay for NTAS for which high cost drugs seem to be the major driver. Research conducted by the Lewin Group for AHCA in 2008 showed that the RUG-53 system explained only about 5.9% of the cost of NTAS. Based on the findings of the Lewin Group and internal research, AHCA has concluded that Medicare cost report data alone are not
adequate or sufficient for refining the SNF PPS for NTAS. Additional supplemental data are needed for the creation of a separate NTAS component. We encourage CMS to work with stakeholders to examine and evaluate the potential and issues with collecting additional supplemental data, or alternatively work with stakeholders to devise an alternative to address NTAS payment issues.

The proposed research by CMS seeks to identify payment alternatives for therapy services. AHCA applauds CMS for working to improve the SNF PPS through this new project which seeks to deal with the incentive issue and identify potential alternatives to the existing methodology used to pay for therapy service under the SNF PPS. The issue of incentives is important, and the alternatives should take these into account. Patients or their families have an incentive to encourage providers to continue to deliver therapy services if the patient either liked it or benefited from it (physically and/or psychologically). Unlike other medical services, the usual fears or negative consequences associated with providing “too much” do not generally apply to therapy services. There is no “bright line” that lays out the conditions under which there is clearly enough or too much therapy. Clear definitions of medical necessity would be helpful in limiting incentives. Additional research and data above what is available in clinical and administrative data would be needed to develop the definitions.

As a first step in exploring and examining alternatives, AHCA urges CMS to collect additional data. AHCA believes that the administrative and clinical data available to CMS currently are inadequate for reforming the SNF PPS; neither NTAS nor therapy. Whether through a pilot, a demonstration project, or additions to submitted MDS and claims data, additional and cleaner (more accurate) data are needed to provide the information needed to examine, evaluate, and develop payment alternatives for the SNF PPS. AHCA encourages CMS to seek the input and support of stakeholders in identifying the critical data elements needed to devise and implement payment alternatives while balancing the additional burdens on providers for collecting and submitting the data.

As CMS examines and explores payment alternatives, the payment alternatives should consider the following factors:

- Period (day, episode, episode + warranty)
- Risk adjustment (acuity, diagnosis, co-morbidities, etc)
- Outcomes
- Treatment goals
- Outlier policy
- System incentives and unintended consequences
- Transition planning

AHCA would be pleased to discuss in detail each of these and other considerations with CMS as it proceeds with its research effort.

AHCA believes that meaningful reform of the SNF PPS and the therapy component in particular should provide adequate payment to the provider, establish incentives that deliver high quality outcomes to the patient, while delivering value to the payor. In support of this goal, AHCA has launched a series of research projects to help move payment reform and quality measurement forward.
On the payment side, AHCA has launched a research project to explore payment alternatives for both the therapy component as well as the SNF PPS overall. A key component of the research is to collect detailed data beyond what is available in current administrative and clinical data. As part of the project, our contractor will examine and evaluate coding issues, patient conditions and episodes of cares, and model alternatives. The data collection phase is currently underway. As results become available, we would like to share our findings with CMS along the way to help inform the CMS effort and refine AHCA's research.

Currently, there are inadequate quality measures available to evaluate the quality of care delivered to individuals receiving SNF post-acute care. Quality measures should reflect the goals and objectives of post-acute care (PAC). CMS currently measure PAC services using Five Star rating system and a set of National Quality Forum (NQF) endorsed MDS based quality measures. However, these measures mainly focus on quality of long term services and do not reflect the main goals or purpose of post-acute care. AHCA has undertaken an effort to develop a set of PAC specific quality measures that better reflect the goals and purpose of SNF Part A services. These include the following:

- 30 day all cause risk adjusted rehospitalization from SNF using MDS 3.0 data
- Risk adjusted discharge to community using MDS 3.0 data
- Improvement in mobility based on CARE tool
- Improvement in self-care based on CARE tool
- Consumer satisfaction & willingness to recommend SNF to another person

Taken together, these PAC measures provide a comprehensive framework for effectively and efficiently evaluating and potentially rewarding outcomes for services provided to short-stay patients receiving services in SNFs.

We are testing these measures, validating them against SNF claims and plan to submit them to NQF for endorsement. All of the measure will be risk adjusted, a requirement when comparing quality between facilities. The improvement in mobility and self-care quality measures will be based on the CARE tool. We are currently collecting data from nearly 3,000 patients across 100 skilled nursing centers to develop and validate these measures. The consumer satisfaction measure is based on the nursing home CAHPS survey but shortened.

We are testing it through focus groups and administering it to a large population of post-acute patients and their families for psychometric testing. The 30-day risk-adjusted rehospitalization measure that was developed by PointRight is currently being validated by Brown University against claims data and is being used by AHCA members to track, compare, and measure performance on achieving the AHCA Quality Initiative target of reducing rehospitalizations by 15% nationally. All of these measures should be ready for use in early 2014. We also plan to share them with CMS for possible use in public reporting and as part of SNF PPS reform.

As noted above, AHCA’s mission is to improve lives by delivering solutions for quality care. Our efforts to develop PAC outcome measures and our initiative to develop payment alternatives for the therapy component and the SNF PPS overall, we trust, in part demonstrate our commitment to our mission. As our results from our research become available, we would like to share our findings with CMS and it’s contractors that are working to reform payment for SNF and PAC services as well as measure and improve quality through measurement. We would also like to request that CMS keep AHCA and other stakeholders updated on it research initiatives and
provide stakeholders to provide comments and feedback as CMS proceeds with developing and implementing reforms.