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## MEMORANDUM

**TO:** AHCA Members

**FROM:** Peter Gruhn, Director of Research  
Sandra Fitzler, Senior Director of Clinical Services  
Elise D. Smith, Vice President, Finance Policy  
William W. Hartung, Vice President, Research  
Lyn Bentley, Director, Regulatory Services/Survey

**SUBJECT:** Overview of the Skilled Nursing Facility Prospective Payment System Proposed Rule for FY 2012

**DATE:** May 6, 2011

On April 28, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2012 update: *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information*. The proposed rule was published May 6, 2011 in the [Federal Register](#). A desk copy of the [proposed rule](#) and a spreadsheet with the proposed SNF PPS wage indexes can be viewed on the [Medicare page](#) of the Facility Operations section of the AHCA website. Comments are due to CMS no later than 5 p.m. on June 27, 2011. AHCA will be submitting comments. If members wish to provide comments to AHCA, we ask that they be provided by COB on June 1, 2011. Comments can be emailed to Peter Gruhn ([pgruhn@ahca.org](mailto:pgruhn@ahca.org)) or Elise Smith ([esmith@ahca.org](mailto:esmith@ahca.org)).

We have highlighted key components of the proposed rule, which range from financial and regulatory matters to clinical and quality issues. These highlights are followed by a more detailed overview.

### Highlights

- The proposed rule presents two options for updating the payment rates used under the SNF PPS for FY 2012. The first option, **Option One, would result in a net decrease of \$3.94 billion in SNF payments for FY 2012 (about \$55 – \$60 per patient day)**. This reflects a \$530 million net increase from the update to payment rates, and a \$4.47 billion reduction from the recalibration of the SNF PPS RUG-III to RUG-IV parity adjustment that sought to make the change in Resource Utilization Group (RUG) systems budget neutral for the Medicare program in FY 2011. The second option, **Option Two, would result in a \$530 million net increase in payments from the update (about \$7 – \$8 per patient day)**.

- The proposed rule projects **a market basket increase for SNFs of 1.5%** beginning October 1, 2011. The 1.5% market basket update **reflects a proposed market basket increase of 2.7%, less a 1.2% multifactor productivity adjustment** required by Section 3401(b) of the *Affordable Care Act (ACA)*. CMS estimates that the market basket update would increase SNF payments by approximately **\$530 million in FY 2012** compared to FY 2011.
- As part of Option One, CMS proposes to recalibrate the SNF PPS RUG-III to RUG-IV parity adjustment implemented in FY 2011. As part of the implementation of Minimum Data Set 3.0 (MDS 3.0) and RUG-IV, CMS increased the case-mix index (CMI) of the nursing component of the SNF PPS by 61% in order to achieve parity in Medicare payments between the RUG-III and RUG-IV SNF PPS systems. Based on FY 2011 first quarter data, CMS believes that the FY 2011 parity adjustment may have been too much and appears to have resulted in higher than projected payments to SNFs. CMS estimates that this recalibration of the parity adjustment **would reduce payments to SNFs by approximately \$4.47 billion or 12.6% (about \$65 – \$70 per patient day)**. **Taken together, CMS estimates that the productivity adjusted market basket update along with the parity adjustment recalibration would reduce projected aggregate payments by 11.3% or about \$3.94 billion.**
- There will not be a correction in the FY 2012 proposed rule for market basket forecasting errors, since the 0.2 percentage point overestimate in forecasting the market basket in FY 2010 (the most recently available fiscal year for which there is final data) is less than the 0.5 percentage point threshold for a forecast error correction.
- In accordance with the *Medicare Modernization Act (MMA)*, the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) had been increased by 128% as of October 1, 2004. Under the CMS proposed rule, this add-on would remain in effect for FY 2012.
- All rates and wage indexes outlined in the Notice of Proposed Rulemaking (NPRM) for the SNF PPS for FY 2012 apply to all swing-bed rural hospitals but not to critical access hospitals (CAHs) that would continue to be paid on a reasonable cost basis for SNF services furnished under a swing-bed agreement.
- The labor-related weight for FY 2012 is 68.805%, down from 69.311% for FY 2011.
- For FY 2012, CMS will continue to employ inpatient hospital wage data in the computation of the Core-Based Statistical Area (CBSA) SNF PPS wage index that is used to adjust the labor-related portion of the federal rate.
- In geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the SNF PPS wage index, CMS is proposing to continue to update the wage index using their alternative urban and rural methodologies in FY 2012.
- CMS proposes to modify its definition of a group therapy group to be four (4) participants for Medicare payments purposes. CMS also proposes to extend its SNF PPS policy on adjusting resident therapy minutes for concurrently provided rehabilitation to rehabilitation provided in group sessions. Under the CMS proposal, SNFs would continue to report the total unallocated group therapy minutes on the Minimum Data Set 3.0 (MDS 3.0) for each patient. In calculating minutes for RUG classification, an individual's reported group time would be divided by four to determine reimbursable group therapy minutes, which would be added together with individual therapy minutes and reimbursable (allocated) concurrent therapy minutes to determine total

reimbursable therapy minutes. CMS also asks for comments on the types of patients and the amount of group therapy that would be appropriate to assess appropriate use of group therapy and potentially revise standards of group therapy care.

- In order to address assessment timing issues that could result in an overlap of information from a previous assessment being used for a subsequent assessment, CMS proposes to modify the current Medicare-required assessment schedule. Their proposal would shorten the assessment reference date (ARD) window and grace days.
- In the proposed rule, CMS clarifies its ARD policy for End-of-Therapy (EOT) Other Medicare Resident Assessments (OMRAs). First, CMS proposes that an EOT OMRA must be completed once therapy services cease for three consecutive days, regardless of the reason, whether planned or temporarily due to illness, patient refusal, doctor office visits, etc., and regardless of whether therapy services are offered by the SNF 5-days per week or 7-days per week. Second, CMS proposes to establish a new End-of-Therapy Resumption (EOT-R) OMRA. The EOT-R OMRA could be used in place of a Start-of-Therapy (SOT) OMRA in cases where therapy stopped, an EOT OMRA was completed, and therapy subsequently resumes within 5 consecutive calendar days and at the same RUG-IV classification level that had been in effect prior to the EOT OMRA. CMS also proposes to establish a new Change-of-Therapy (COT) OMRA. The COT OMRA would be completed for patients classified into a RUG-IV therapy group whenever the intensity of therapy changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.

## **Conclusion**

AHCA has serious concerns about the data and methodology in the SNF PPS proposed rule for FY 2012. These highlights and following discussion of these key points reflect our initial review of myriad financing, regulatory, clinical and quality components included in CMS' proposed rule for FY 2012. We are conducting a thorough analysis, and will share that information with our membership when available. While we have tried to provide a report of the various proposals in this overview, we ask you to read the proposed rule carefully so that you will be fully apprised of the changes that will affect you.

As indicated above, AHCA will be submitting comments. It is important for us to hear from you, our members. Thus, if you wish to provide comments or feedback to AHCA, we ask again that they be sent to us by COB on June 1, 2011. Comments can be emailed to Peter Gruhn ([pgruhn@ahca.org](mailto:pgruhn@ahca.org)) or Elise Smith ([esmith@ahca.org](mailto:esmith@ahca.org)).

## Discussion

### I. CMS Projected Impact of the Proposed Rule

The CMS proposed rule presents two options for updating payment rates used under the SNF PPS for FY 2012. The first option, Option One, would result in a net decrease of \$3.94 billion in SNF payments for FY 2012 (about \$55 to \$60 per patient day). This reflects a \$530 million net increase from the update to payment rates, and a \$4.47 billion reduction from the recalibration of the SNF PPS RUG-III to RUG-IV parity adjustment that sought to make the change in Resource Utilization Group (RUG) systems budget neutral for the Medicare program in FY 2011. The second option, Option Two, would result in a \$530 million net increase in payments from the update (about \$7 to \$8 per patient day).

The proposed rule projects a market basket increase for SNFs of 1.5% beginning October 1, 2011. The 1.5% market basket update reflects a proposed market basket increase of 2.7%, less a 1.2% multifactor productivity adjustment required by Section 3401(b) of the *Affordable Care Act (ACA)*. CMS estimates that the market basket update would increase SNF payments by approximately \$530 million in FY 2012 compared to FY 2011.

As part of Option One, CMS proposes to recalibrate the SNF PPS RUG-III to RUG-IV parity adjustment implemented in FY 2011. As part of the implementation of MDS 3.0 and RUG-IV, CMS increased the case-mix index (CMI) of the nursing component of the SNF PPS by 61% in order to achieve parity in Medicare payments between the RUG-III and RUG-IV SNF PPS systems. Based on FY 2011 first quarter data, CMS believes that the FY 2011 parity adjustment may have been too much and appears to have resulted in higher than projected payments to SNFs. CMS estimates that this recalibration of the parity adjustment would reduce payments to SNFs by approximately \$4.47 billion or 12.6% (about \$65 to \$70 per patient day). Taken together, CMS estimates that the productivity adjusted market basket update along with the parity adjustment recalibration would reduce projected aggregate payments by 11.3% or about \$3.94 billion.

The distributional effect of Option One and Option Two, are detailed in the tables below:

#### **Option One (includes parity adjustment): Projected Impact to the SNF PPS for FY 2012**

	<b>Number of Facilities</b>	<b>Revised CMIs</b>	<b>Wage Index</b>	<b>Total Impact</b>
Total	14,266	-12.6%	0.0%	-11.3%
Urban	10,049	-12.8%	0.0%	-11.5%
Rural	4,217	-11.9%	0.1%	-10.5%
Hospital based urban	421	-12.4%	0.1%	-11.1%
Freestanding urban	9,628	-12.8%	0.0%	-11.5%
Hospital based rural	310	-11.4%	0.0%	-10.2%
Freestanding rural	3,907	-11.9%	0.1%	-10.5%
Government	710	-12.5%	-0.1%	-11.3%
Profit	9,959	-12.6%	0.0%	-11.3%
Non-profit	3,597	-12.7%	0.0%	-11.4%

**Option Two (no parity adjustment):  
Projected Impact to the SNF PPS for FY 2012**

	<b>Number of Facilities</b>	<b>Wage Index</b>	<b>Total Impact</b>
Total	14,266	0.0%	1.5%
Urban	10,049	0.0%	1.5%
Rural	4,217	0.1%	1.6%
Hospital based urban	421	0.1%	1.6%
Freestanding urban	9,628	0.0%	1.5%
Hospital based rural	310	0.0%	1.5%
Freestanding rural	3,907	0.1%	1.6%
Government	710	-0.1%	1.4%
For-Profit	9,959	0.0%	1.5%
Non-profit	3,597	0.0%	1.5%

**II. The SNF PPS Market Basket Update**

The proposed rule projects a market basket increase for SNFs of 1.5% beginning October 1, 2011. The 1.5% market basket update reflects a proposed market basket increase of 2.7%, less a 1.2% multifactor productivity adjustment required by Section 3401(b) of the *Affordable Care Act (ACA)*. CMS estimates that the market basket update would increase SNF payments by approximately \$530 million in FY 2012 compared to FY 2011.

Every year, CMS calculates a revised labor-related share based on the relative importance of labor-related cost categories in the price index. The labor-related weight for FY 2012 is 68.805%, down from 69.311% for FY 2011.

**III. The SNF PPS Market Basket Multifactor Productivity Adjustment**

Section 3401(b) of the *ACA* requires that the SNF market basket update be reduced by a productivity adjustment. The purpose of the adjustment is to help ensure that the increase in the cost of goods and services used to provide patient care in SNFs that is reflected in the market basket also reflect improvements in productivity that reduce the cost of providing SNF services. Section 1886(b)(3)(B) of the *ACA* amended *Social Security Act (SSA)* defines the productivity adjustment to be equal to the 10-year moving average of changes in the annual economy-wide private nonfarm business multi-factor productivity (MFP), as projected by the Secretary for the 10-year period ending with the applicable year/period.

CMS proposes to calculate the MFP-adjusted market basket update for the SNF PPS by subtracting the projected MFP percentage adjustment from the FY 2012 market basket percentage. CMS proposes to compute the MFP adjustment as the 10-year moving average of changes in the MFP for the period ending September 30, 2012, and round the final annual adjustment to the nearest tenth of a percentage point. As noted above, the MFP adjustment is calculated as 1.2 percentage points for FY 2012. The MFP adjustment is effective for FY 2012 and each subsequent fiscal year. It will be recalculated each year moving forward. Furthermore, the reduction of the market basket percentage change by the MFP adjustment may result in the market basket percentage change being less than zero for a fiscal year, and may result in unadjusted Federal payment rates being less than such payment rates for the preceding fiscal year.

#### **IV. The Forecast Error Correction to the SNF Market Basket**

There will not be a market basket forecast error correction in the SNF PPS market basket for FY 2012. Based on FY 2010 data (the most recently available fiscal year for which there is final data), the estimated increase in the market basket index was 2.2 percentage points, while the actual increase was 2.0 percentage points – a difference of 0.2 percentage points. Since the difference between the estimated and actual market basket forecast error is less than the 0.5 percentage point threshold, the payment rates for FY 2012 do not include a forecast error adjustment.

#### **Difference between Forecasted & Actual Market Basket Increases for FY 2012**

Index	Forecasted FY 2010 Increase	Actual FY 2010 Increase	FY 2010 Difference
SNF	2.2%	2.0%	0.2%

#### **V. Recalibration of Parity-Adjustment & Other Factors**

Section 1888(e)(4)(G)(i) of the *Social Security Act* requires the Secretary of the Department of Health & Human Services (HHS) to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. The Staff Time Resource Intensity Verification (STRIVE) project was established to (1) refine the current Resource Utilization Group (RUG) classification systems, and to (2) develop case mix indices (CMIs). Based in part on findings from the STRIVE project, CMS implemented changes to the RUG classification structure (RUG-IV) and relative weights for FY 2011.

In moving from the MDS 2.0 based RUG-III SNF PPS to the MDS 3.0 based RUG-IV SNF PPS, CMS sought to implement the change without increasing or decreasing overall Medicare expenditures (i.e., budget neutral). As part of the implementation of MDS 3.0 and RUG-IV, CMS increased the case-mix index of the nursing component of the SNF PPS by 61% in order to achieve parity in Medicare payments between the RUG-III and RUG-IV SNF PPS systems. Given overpayment issues that arose related to the parity adjustment CMS used in moving from the RUG-44 to the RUG-53 RUG systems in 2006, CMS indicated in last year's final rule that the agency intended to assess the effectiveness of the parity adjustment in maintaining budget neutrality, and if necessary, to recalibrate the adjustment in future years, and that it would monitor, and if necessary, act to respond to changes in overall SNF payments that result from changes in coding or classification of patients that do not reflect real changes in case-mix (i.e., so-called "code creep").

Using data from the first quarter of FY 2011 (October through December 2010), CMS noted in this year's proposed rule that they found that actual RUG-IV utilization patterns differed significantly from what had been projected, and that the FY 2011 parity adjustment may have inadvertently triggered a significant increase in overall payment levels. CMS notes that if this preliminary assessment is confirmed as additional FY 2011 RUG-IV claims data become available, a recalibration of the parity adjustment may become warranted in the FY 2012 final rule, in order to ensure that the adjustment continues to serve as intended to make the transition from RUG-53 to RUG-IV in a budget neutral manner.

As described above for Option One, CMS proposes to cut Medicare Part A payments to SNFs by approximately \$4.47 billion to prospectively correct for an unexpected overpayment to SNFs caused by the SNF PPS RUG-III to RUG-IV parity adjustment. CMS refers to this action as a recalibration of the

parity adjustment. Based on data for the first quarter of FY 2011, CMS estimates that the 61% parity adjustment that was applied to the CMI of the nursing component would need to be decreased to 22.55% to achieve budget neutrality.

CMS notes however that the most notable differences between expected and actual utilization patterns occurred within the therapy RUG categories, and that rather than apply the new parity adjustment percentage to all the nursing CMIs, it would be more appropriate to achieve budget neutrality between the RUG-III and RUG-IV system by maintaining the 61% parity adjustment to the nursing CMIs for the RUG-IV non-therapy groups, and reducing the parity adjustment applied to the nursing CMIs for the RUG-IV therapy groups to 19.81%. CMS further notes that any recalibration would be implemented on a prospective basis only. **There would be no retrospective recovery of FY 2011 “over” payments.**

## **VI. Area Wage Index Adjustment to the Federal Rates**

Section 1888(e)(4)(G)(ii) of the *Social Security Act* requires that CMS adjust the federal rates to account for differences in area wage levels, using an appropriate wage index. Given the “volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of the data,” CMS believes it is “appropriate and reasonable” to use hospital wage data for the SNF PPS wage index. Since the inception of a prospective payment system for SNFs, CMS has used hospital wage data in developing a wage index for the SNF PPS, a practice that CMS proposes to continue for FY 2012.

Section 1888(e)(4)(G)(ii) of the *Social Security Act* also requires that CMS apply the wage index in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. CMS currently adjusts the wage index to ensure that it is budget neutral in terms of aggregate payments. CMS proposes to continue this practice as well.

CMS will continue to use its urban/rural alternative wage index methodology in geographic areas where there are no hospitals, and thus, no hospital wage data upon which to base calculations for the FY 2012 SNF PPS wage index. For rural geographic areas without hospital wage data, CMS will use the average wage index for all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For urban geographic areas without hospital wage data, CMS will use the average wage index of all of the urban areas within the state as a reasonable proxy. The alternative FY 2012 SNF PPS urban wage index methodology will be used to construct the wage index for Hinesville-Fort Stewart, Georgia (CBSA 25890) and for Yuba City, California (CBSA 49700). Given that there is at least one hospital with wage data in all rural areas, the alternative rural wage index methodology will not be required in FY 2012.

## **VII. Group Therapy & Therapy Documentation**

CMS believes that one-on-one therapy is generally the most appropriate mode of delivering therapy for Medicare and Medicaid patients who are among the frailest and most vulnerable. CMS also believes that group therapy offers additional benefits to patients from the interaction with other patients during the group therapy session as they have the opportunity to observe and learn from other patients. However, the agency also believes that the current method of reporting group therapy, along with the allocation of concurrent therapy minutes, creates an inappropriate payment incentive to deliver group therapy since it does not require allocation of therapist time among all the involved patients.

To better align incentives, CMS proposes to modify its definition of a group therapy group to be four (4) participants for Medicare payments purposes. CMS also proposes to extend its SNF PPS policy on adjusting resident therapy minutes for concurrently provided rehabilitation to rehabilitation provided in group sessions. Under the CMS proposal, SNFs would continue to report the total unallocated group therapy minutes on the MDS 3.0 for each patient. In calculating minutes for Resource Utilization Group (RUG) classification, an individual's reported group time would be divided by four to determine reimbursable group therapy minutes, which would be added together with individual therapy minutes and reimbursable (allocated) concurrent therapy minutes to determine total reimbursable therapy minutes. CMS also asks for comments on the types of patients and the amount of group therapy that would be appropriate to assess appropriate use of group therapy and potentially revise standards of group therapy care.

CMS also discusses therapy documentation in the medical record and what is needed to support care plan development and changes, particularly related to supporting the need for group therapy. CMS states that medical record documentation should clearly show how the prescribed skilled therapy services contribute toward the patient's care goals and should include explicit justification for the use of group, rather than individual or concurrent therapy and how the type and amount of group therapy will meet the patient's needs and assist in reaching documented goals. Furthermore, CMS believes that changes to the mode or intensity of therapy must be justified by change in health condition and that the provider should describe in the plan of care reasons for deviating from the original plan of care. The proposed rule also requires the use of unscheduled assessments when the patient's condition changes call for therapy changes to determine if a change in payment is necessary.

**VIII. MDS 3.0 Assessment Schedules**

CMS believes that the combination of the current grace period allowances and observation period could cause MDS assessments to be performed in such a way that some of the information coded on a subsequent assessment is duplicative of the previous assessment. As a result, CMS plans to modify the current Medicare-required assessment schedule to incorporate new assessment windows and grace days and these changes will result in less duplication of information.

**Current MDS 3.0 Assessment Schedule**

<b>Medicare MDS Assessment type</b>	<b>Reason for Assessment (A0310B code)</b>	<b>Assessment Reference Date Window</b>	<b>Assessment Reference Date Grace Days</b>	<b>Applicable Medicare Payment Days</b>
5 day	01	Days 1 – 5	6 - 8	1 through 14
14 day	02	Days 11 - 14	15 – 19	15 through 30
30 day	03	Days 21 – 29	30 - 34	31 through 60
60 day	04	Days 50 - 59	60 – 64	61 through 90
90 day	05	Days 80 – 89	90 – 94	91 through 100

**Proposed MDS 3.0 Assessment Schedule**

<b>Medicare MDS Assessment type</b>	<b>Reason for Assessment (A0310B code)</b>	<b>Assessment Reference Date Window</b>	<b>Assessment Reference Date Grace Days</b>	<b>Applicable Medicare Payment Days</b>
5 day*	01	Days 1 – 5	6 - 8	1 through 14
14 day	02	Days 13 - 14	15 – 18	15 through 30
30 day	03	Days 27 – 29	30 - 33	31 through 60
60 day	04	Days 57 - 59	60 – 63	61 through 90
90 day	05	Days 87 – 89	90 – 93	91 through 100

\*Changes would also apply to Readmission/Return Assessment (A0310B code = 06)

## **IX. Other Medicare Required Assessments**

In the proposed rule, CMS clarifies the 2010 policy that the Assessment Reference Date (ARD) for an end-of-therapy (EOT) Other Medicare-Required Assessment (OMRA) must be set 1 to 3 days after discontinuation of all therapies. CMS cites concern and confusion over the meaning of the phrase “discontinuation of therapy services” in that they did not distinguish between planned and temporary unplanned discontinuation of therapy (as in illness, patient refusal, physician office visit). CMS is clarifying that providers must complete an EOT OMRA for a patient classified in a RUG-IV therapy group if the patient goes without therapy for 3 consecutive days; regardless of the reason for the discontinuation. By completing the EOT OMRA, the SNF will be paid the appropriate non-therapy RUG-IV rate. If therapy resumes, a Start-of-Therapy (SOT) OMRA can be completed to reclassify the patient into a therapy RUG-IV group at any time during the Part A stay. CMS is asking for comment on the proposed assessment window and grace day changes as well as the clarification of the ARD for EOT OMRA.

In the proposed rule, CMS clarifies its ARD policy for End-of-Therapy (EOT) Other Medicare Required Assessments (OMRAs). First, CMS proposes that an EOT OMRA must be completed once therapy services cease for three consecutive days, regardless of the reason, whether planned or temporarily due to illness, patient refusal, doctor office visits, etc., and regardless of whether the SNF offers therapy services 5-days per week or 7-days per week. By completing the EOT OMRA, the SNF will be paid the appropriate non-therapy RUG-IV rate.

CMS proposes to establish a new End-of-Therapy Resumption (EOT-R) OMRA. The EOT-R OMRA could be used in place of a Start-of-Therapy OMRA in cases where therapy stopped, an EOT OMRA was completed, and therapy subsequently resumes within 5 consecutive calendar days and at the same RUG-IV classification level that had been in effect prior to the EOT OMRA. For coding the resumption of therapy, 2 new items will be added to the Section O of the MDS. In cases where therapy resumes more than 5 consecutive days from the discontinuation of therapy, the SNF can either complete a SOT OMRA to classify the patient into a RUG-IV therapy group or wait until the next PPS assessment to classify the patient.

CMS also proposes to establish a new Change-of-Therapy (COT) OMRA. The COT OMRA would be completed for patients classified into a RUG-IV therapy group whenever the intensity of therapy changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.

## **X. Therapy Student Supervision**

The proposed rule will eliminate the standard that therapy students must perform activities in the line-of-sight of the supervisor. This standard is not a requirement in other settings of care where therapy is provided. CMS finds the SNF standard an inequitable requirement and is seeking public comment on the proposed revision to the supervision requirement.

## **XI. Medicare Cost Report & Direct Care Staffing Expenditures**

The proposed rule describes ACA-mandated changes to the [SNF Medicare cost report](#). SNFs will be required to submit data on direct care staff wages and benefits expenditures on Medicare cost reports with fiscal year beginning dates on or after December 1, 2010. CMS is currently seeking feedback on the redesign of the cost report from professionals familiar with Medicare and Medicaid nursing facility cost reports, and, in consultation with the Medicare Payment Advisory Commission (MedPAC), the Medicaid

and CHIP Payment and Access Commission (MACPAC), and the Department of Health & Human Services (HHS) Office of the Inspector General (OIG), CMS plans to categorize expenditures for each SNF into specific functional accounts.

## **XII. Disclosure of Ownership & Additional Disclosable Parties Information (Section 6101 of ACA)**

Section 6101 of the *Affordable Care Act* requires nursing facilities and skilled nursing facilities to make available on request to the Secretary of the Department of Health & Human Services (HHS), the Inspector General of HHS, the State in which the facility is located, and the State long-term care ombudsman expanded information about the ownership and managing employees of a facility. Further, facilities must collect and provide these authorities with similar information from other disclosable parties (as defined in law). Additionally, the law requires the Secretary to develop, by March 2012, a standardized format in which this information must be provided.

AHCA has previously provided members with a detailed summary and guidance on these provisions. Further, at the request of the Centers for Medicare & Medicaid Services (CMS), AHCA provided comments and recommendations on the provisions in the law. Specifically, AHCA requested that “managing employee” be limited to those individuals who are vested by ownership of the licensed legal entity with authority to make policy and decisions that govern the activities of the facility. As well, AHCA requested that CMS establish reasonable time periods for the reporting of changes for disclosable parties, perhaps on an annual or semi-annual basis.

AHCA is concerned that the definition of “managing employee” in the proposed rule is overly broad as it includes individuals who are under contract or through some other arrangement, exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operation of the provider.

Further, AHCA is concerned that the time period of 30 days is too short.

It is important to note that in the proposed rule there is no mention of the standardized format for submission of information that is required by law.

AHCA will carefully review and comment on the provisions of the Disclosure of Ownership and Additional Disclosable Parties information provisions contained in the proposed rule.

## **XIII. Value-Based Purchasing (Section 3006 of the ACA)**

Section 3006(a) of the *Affordable Care Act* directs the Secretary to develop a plan to implement a value-based purchasing program for SNFs, with a report to Congress due by October 1, 2011. According to CMS, value-based purchasing programs are intended to tie payment to performance in such a way as to reduce inappropriate or poorly provided care and identify and reward those who provide effective and efficient patient care. CMS indicates that it is in the process of developing the SNF value-based purchasing implementation plan and report.

It further indicates that in accordance with section 3006(a) of the *Affordable Care Act*, it will be consulting with stakeholders in developing the implementation plan, as well as considering the outcomes of any recent demonstration projects related to value-based purchasing, which it believes might be relevant to the SNF setting. It anticipates being able to provide further information on the progress of its efforts in future rulemaking.

AHCA is concerned with CMS reporting to Congress by October 1, 2011. While the deadline is in statute, we had recommended to CMS that it ask Congress for a delay in submission. The due date for the report is utterly out of sync with the current SNF VPB Demonstration.

The ACA directs the Secretary to consider experience with current demonstrations. However, there has been limited learning from the Nursing Home Value-Based Purchasing Demonstration. To date CMS has only tabulated pre-demonstration baseline data; actual first year demonstration performance data has yet to be released. A realistic evaluation of the initiative is, at best, a year or two away.

Secondly, the implementation of MDS 3.0 requires revisions in quality measures. Section 3006 of ACA requires the Secretary to consider the on-going development, selection, and modification process for measures and the reporting collection and validation of quality data. The nursing home sector has just transitioned from MDS 2.0 to MDS 3.0 and even CMS acknowledges the need to recalibrate its perceived quality measures to reflect the revisions in source data. Measure testing is needed to ensure that the selected items are validated before released for public reporting. The correlation between MDS 2.0 and MDS 3.0 is poor and in some cases non-existent. To move forward with a specific value-based purchasing plan for skilled nursing centers without validated quality measures that reflect data collected under MDS 3.0 would be a mistake.

We have provided the above information and many other points and observations to CMS. AHCA members and staff were interviewed by RTI International, CMS' contractor for the VBP report. In addition to the interview, we provided RTI with a written set of comments dated February 7, 2011, which were conveyed to CMS. On March 18, 2011, we provided analysis and recommendations again in writing after the CMS Listening Session.

We will review all the relevant VBP issues, timelines and developments since our last communications with CMS and reach you to them again in the comments to SNF PPS proposed rule.

#### **XIV. Payment Adjustment for Hospital-Acquired Conditions (Section 3008 of the ACA)**

Section 3008(b) of the *Affordable Care Act* directs the Secretary to conduct a study on expanding the already-existing preventable hospital acquired conditions (HAC) policy to payments made in various post-acute settings, including SNFs. In developing this study, due to Congress no later than January 1, 2012, the Secretary is directed to include the impact of expanding the HAC policy on patient care, safety, and overall payments.

The HAC payment provision for inpatient DRG hospitals is one of CMS' value-based purchasing initiatives. The principle behind the HAC payment provision is that Medicare not pay more for healthcare-associated conditions. In the ACA, Congress directed HHS to establish a payment adjustment beginning in FY 2015 for hospitals that fall in the top quartile of national, risk adjusted HAC rates. For such hospitals, the payment amount for all discharges would be reduced by 1%.

CMS indicates in the proposed rule that it is in the process of developing the report on the expansion of HAC policy to other providers. We will be filing a thorough analysis of the issue of expansion of the HACs to SNFs. AHCA has already addressed this issue in part in our comments to the proposed Medicaid rule on *Payment Adjustment for Provider-Preventable Conditions Including Health Care Acquired Conditions*, 76 *Federal Register* 9283, February 17, 2011.

While we acknowledge CMS' desire to avoid spending Medicare dollars to correct preventable health care acquired conditions, there are many complex and critical clinical issues that must be addressed in any

CMS attempt to expand even the concept of acquired conditions and related negative payment adjustment to SNFs, much less the actual existing HACs which have little relevance for SNF patients. For one thing, the complex and comprehensive regulatory system under which nursing facilities presently operate is unparalleled in its nature, reach, and intensity. Resident care, regulatory compliance, and quality expectations are all rigidly scrutinized and strictly enforced under a duplicative state/federal survey system, which is highly punitive. Caution must be exercised in layering yet more punitive regulation upon the present construct.

Further, much more work is needed on quality measures before advancing to application of adjustments for acquired conditions. The point is that the majority of patients cared for in our nation's nursing care centers are individuals with multiple chronic condition (MCCs). According to HHS' *Multiple Chronic Conditions: A Strategic Framework*,<sup>1</sup> more than one in four Americans have MCCs, which is a state of having two or more conditions that commonly include arthritis, asthma, diabetes, health disease, chronic respiratory conditions, hypertension and others. The prevalence of individuals with MCCs increases with age and is substantial among adults over the age of 65. In fact, the Institute of Medicine (IOM) noted in the *Crossing the Quality Chasm* report that twenty-three percent of Medicare beneficiaries have five or more chronic conditions.<sup>2</sup>

Since there is limited knowledge of MCCs, and individuals with multiple conditions are not addressed in evidence-based guidelines and quality measurement, concern arises about the application of the HAC concept to patients in such settings. More robust risk-adjustment is needed in measuring quality outcomes for the MCC patient. Individuals with MCCs are more likely at risk of an avoidable inpatient admission or a preventable complication.<sup>3</sup> Considering that the prevalence of individuals with MCCs is growing and that healthcare costs are higher for individuals having multiple conditions, the need for better and more comprehensive quality measurement is apparent.

Last but not least CMS must consider the implications of substandard and inconsistent care along the continuum. In the Medicaid proposed rule cited above, CMS states that “. . . one cannot prevent what one cannot detect.” This clear, simple statement has enormous applicability to the post-acute environment. Patients in SNFs are admitted having experienced care and treatment from a wide variety of care providers – hospitals, primary care physicians, and others. Uncoordinated and inconsistent care along the continuum can contribute to the development of preventable conditions in the receiving setting.

We will continue our dialogue with CMS and provide them with a detailed discussion of issues that must be addressed in any effort to develop a concept of avoidable conditions applicable to SNFs.

## **Conclusion**

Again, all comments on the SNF PPS proposed rule for FY 2012 are due to CMS no later than 5 p.m. on June 27, 2011. AHCA will be submitting comments, and we welcome comments from our members. If members wish to provide comments or feedback to AHCA, we ask that they be sent to us by COB on June 1, 2011. Comments can be emailed to Peter Gruhn ([pgruhn@ahca.org](mailto:pgruhn@ahca.org)) or Elise Smith ([esmith@ahca.org](mailto:esmith@ahca.org)).

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<sup>1</sup> Available at [http://www.hhs.gov/ash/initiatives/mcc/mcc\\_framework.pdf](http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf).

<sup>2</sup> Committee on Quality of Healthcare in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington D.C. National Academies Press; 2001.

<sup>3</sup> J. Wolff, B. Starfield, G. Anderson, *Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly*. 162 Archives of Internal Medicine, 2269-2276 (Nov. 2002).