UPMC | University of Pittsburgh Medical Center

June 26, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Via: UPS Delivery and
http://www.cms.hhs.gov/eRulemaking

Edward T. Karlovich
Chief Financial Officer
Academic and Community Hospitals

UPMC Montefiore, Suite N-739
200 Lothrop Street
Pittsburgh, PA 15213-2582
412-647-8280
Fax: 412-647-5551
karlovichet@upmc.edu

ATTENTION: CMS-1545-P

RE: CMS-1545-P
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule
(Federal Register/Vol.72 No.86/May 4, 2007 pages 25526-25600)

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (Federal Register / Vol. 72, No. 86 / May 4, 2007 pages 25526 - 25600) "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008". We are also submitting these comments electronically to www.cms.hhs.gov/eRulemaking.

The following summarizes our comments and concerns regarding these proposed changes to the consolidated billing for Skilled Nursing Facilities (SNF's) for FY 2008 and beyond, and why we urge CMS to withdraw some of the proposed rules.

CMS Proposal to Increase the Forecast Error Thresholds for FY 2008 and FY 2009 (FR page 25530)

Proposed CMS Rules FY 2008 & Beyond: CMS has proposed significant increases in the current forecast error thresholds for FY 2008 and FY 2009 as follows:

- FY 2008 – CMS proposes raising the threshold for triggering a forecast error adjustment under the SNF PPS from the current 0.25 percentage point threshold to 0.50 percent.
- FY 2009 – CMS is also considering a higher threshold for the forecast error adjustment up to 1.0 percentage point for FY 2009.

The reason cited by Medicare (FR 5-4-2007 page 25530) for this proposed forecast error threshold policy change increase is as follows:

'...it is now appropriate to draw a distinction between the kind of exceptional, unanticipated major increases in wages and benefits that initially gave rise to this policy and the much smaller variances between forecasted and actual change that more typically occur from year to year, in recognition that a certain level of imprecision is inherently associated with measuring statistics. In general, the SNF market basket is expected to reasonably project inflationary price pressures. Further, according to MedPAC analysis, we note that freestanding SNF's (which represent more than 80 percent of all SNF's) have received Medicare payments that exceeded costs by 10.8 percent or more since 2001, and Medicare margins are projected to be 11 percent in 2007."

Response: UPMC respectfully disagrees with the higher forecast error thresholds proposed by CMS for FY 2008 (from current 0.25% to 0.50%) and the even higher threshold level being considered for FY 2009 (up to 1.0%). UPMC urges CMS to maintain its current market basket forecast error threshold of 0.25 percent, or adopt an annual forecast error to actual adjustment for the following reasons:

- *Current 0.25% Forecast Error Threshold Seems More Than Adequate While a 0.5% or 1.0% Forecast Error Threshold Seems Excessive and Unreasonable* – **The current forecast error threshold is 0.25% and the historic average SNF market basket is 3.2% as based on the last 5 years published in the May 4, 2007 Federal Register page 25555. This equates into a current error rate of 7.8% (0.25 / 3.2 = 7.8%). The error level proposed for FY 2008 of 0.50 equates to a 15.6% error rate (0.50 / 3.2 = 15.6%) and a 1.0% threshold under consideration for FY 2009 equates to a 31.2% error rate (1.0% / 3.2% = 31.2%).**

  It does not seem reasonable that Medicare would propose increasing the market basket error rate threshold beyond the 0.25 % level since as noted above this is an annual Medicare savings of 7.8 % of the annual inflator. Since the Medicare market basket index methodology has generally understated the actual SNF market basket index in recent years, a savings of 39% of the annual inflation factor would be generated over a five year period (5 * 7.8% = 39%). To double that level as proposed for FY 2008 to 0.50% is the equivalent of 78% inflation savings over a five year period. The even higher threshold of 1.0% being considered by CMS for FY 2009 would equates to 156% inflation savings over a 5 year period. We do not support any of these proposed rules to increase the market basket forecast error thresholds in either FY 2008 or FY 2009. Instead we urge CMS to either keep the forecast error threshold at its current 0.25% level or to require a forecast error adjustment to actual, every year. The mere existence of this annual forecast error threshold provides Medicare with a built-in minimum savings benefit that SNF providers cannot recover. The SNF's are then forced to face the full market basket price changes with inadequate payment levels. This is especially true for hospital-based SNF's which according to a recent MedPAC report (March 2007, page 178)

indicated that hospital-based SNF's have negative Medicare profit margins of approximately 85%. We urge CMS to withdraw this proposal or to be fair to all SNF providers adopt the policy of an annual correction adjustment which would take the overstatement or understatement of previous years forecast error projections to actual and factor them into the current annual update.

- Medicare also indicated that the forecast error threshold should be increased because approximately 80% of the freestanding SNF's are making a profit margin of approximately 10.8% from Medicare. The proposed rule however, does not indicate the large losses that hospital-based SNF's are having (- 85 percent) according to a recent 2007 MedPAC report. At this time we would urge CMS to modify the SNF RUG's to better recognize the higher non-therapy ancillary costs that hospital-based facilities incur; to develop an outlier policy for exceptionally costly stays and to consider an add-on payment for hospital-based SNF's which are being underpaid.

Conclusion

We appreciate the opportunity to submit these comments on your proposed changes to the "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule" and hope they are considered before any final rule is adopted.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Concordia, Elizabeth
Farner, David M.
Huber, George
Kennedy, Robert A.
Lewandowski, Christine
Stimmel, Paul
System CFO's

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Charles N. Kahn III
President

June 29, 2007

VIA HAND DELIVERY

The Honorable Leslie V. Norwalk, J.D.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: ***CMS–1545-P; 42 CFR Part 413, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule***

Dear Ms. Norwalk:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, long-term care, rehabilitation and psychiatric hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule on Skilled Nursing Facility (SNF) Prospective Payment System and Consolidated Billing for Fiscal Year 2008.

I. Market Basket Index

CMS is proposing to raise the 0.25 percentage point threshold for forecast error adjustments under the SNF PPS to 0.5 percentage point effective with FY 2008. CMS is also considering a higher threshold for the forecast error adjustment, up to

1.0 percentage point. The FAH recommends that CMS delay increasing the percentage point threshold until at least FY 2009. In the meantime, the FAH requests that CMS provide a detailed analysis including a report on the occurrences of triggering the forecast error adjustment since the inception of the program (i.e. overpayments, underpayments). Until more data is provided and effective comments can be drafted, the FAH recommends maintaining the 0.25 percentage point threshold.

II. Revising and Rebasing

For FY 2008 CMS is proposing to rebase and revise the SNF market basket to reflect 2004 Medicare allowable total cost data (routine, ancillary, and capital-related). The FAH supports CMS using the most recent cost reporting data available on which to base the SNF market basket. We agree with CMS that using only Medicare allowable costs better reflects the cost structure of SNFs serving Medicare beneficiaries.

For the FY 2008 proposed rule CMS is maintaining its policy of using only data from freestanding SNFs to calculate the market basket. The FAH encourages CMS to reconsider this policy and include the data from hospital-based SNFs that is representative of the actual number of hospital-based SNFs to the total SNF population. The FAH recommends that CMS apply a percentage, proportionate to hospital-based SNFs' percentage of total cost, of the actual costs experienced by hospital-based SNFs. Hospital-based SNFs are typical SNFs that operate in an environment that is not dissimilar from freestanding SNFs. However, hospital-based SNFs have some unique aspects as well that must be considered in order to have a true representation of the costs that SNFs incur.

CMS has developed an alternative drug cost weight methodology used to derive the SNF market basket drug cost weight. It has determined that because of large inconsistencies between freestanding and hospital-based SNFs, including the substantial difference in the drug cost-to-charge ratios, as well as the dissimilarity in the relationships of those ratios to the cost-to-charge ratios from all ancillary cost centers by SNF type, that this methodology was inappropriate to use. The FAH reiterates its belief that hospital-based SNFs should not be excluded from the calculation of any factors that affect payment.

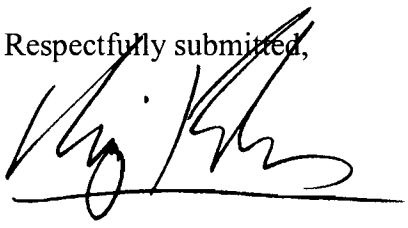
III. Impact Analysis

The FAH recommends that CMS provide an impact file for SNF PPS similar to the impact file CMS provides for the IPPS proposed rule. The file would need to include total payments and total days by provider number. The impact that certain provisions have on payments is difficult to model without adequate data.

* * * * * *

We appreciate the opportunity to comment on this proposed rule and hope that the agency carefully considers the comments in this letter. If appropriate, we would welcome the opportunity to meet, at your convenience, to discuss our views. If you have any questions, please feel free to contact me or Steve Speil, Sr. Vice President, Health Finance and Policy, of my staff at (202) 624-1529.

Respectfully submitted,



1001 Pennsylvania Avenue NW
Suite 600 South
Washington, DC 20004
(202) 742-6740 • (202) 742-6501 FAX
www.aqnhc.org

Friday, June 29, 2007

HAND DELIVERED

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1545-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments of the ALLIANCE FOR QUALITY NURSING HOME CARE on the proposed rule on the Medicare Prospective Payment System for Skilled Nursing Facilities for FY 2008
72 Federal Register 25526, May 4, 2007 (CMS-1545-P)

Dear Ms. Norwalk:

The Alliance for Quality Nursing Home Care welcomes this opportunity to comment on the proposed rule captioned above that would adopt changes to the Medicare prospective payment system for skilled nursing facilities for FY 2008. The Alliance is an organization representing large, nation-wide chains of nursing facilities, and several regional chains.[1] One purpose of the Alliance is to ensure that policies in Federal rulemaking do not hinder the ability of nursing facilities to provide the high quality and clinically proper care required by patients.

CMS is to be commended for its willingness to develop needed changes and to entertain proposals for further refinements. The Alliance wants to cooperate with CMS by participating in this effort as constructively as possible on a continuing basis. As with all the Medicare prospective payment systems, implementation of the SNF PPS is always a work in progress, subject to constant refinement and improvement in light of experience and changing conditions. The proposed methodology changes in the constituent parts of

[1] The membership of the Alliance includes: Advocat Inc., Alden Management Services, Inc., Britthaven, Complete Health Resources, Consulate Health Care, LLC, Cypress Healthcare, Direct Supply, Inc., Extendicare, Inc., FUNDAMENTAL, Genesis HealthCare Corporation, HCR Manor Care, Kindred Healthcare, Medical Facilities of America, NHS Management, LLC, SavaSenior Care, Sun Healthcare Group, Inc., and UHS-Pruitt Corporation.

the formulas that yield the SNF payment rate update for FY 2008 should not be regarded as the permanent answer to the need for rate making improvements, but rather as only an interim step toward more desirable refinements beginning in subsequent years. We hope CMS will continue to work with us and other affected interests to develop a more permanent solution to assuring fair and reasonable Medicare reimbursements to SNFs.

The most important matters presented by the proposed rule concern:

- the method for correcting forecasting errors in the annual update of SNF rates
- the structure of the wage index used to adjust the Federal rates, and especially the continuing need for a SNF-specific wage index
- the impact of the impending Federal minimum wage increase on the area wage index
- improving the inputs of the SNF market basket index, and especially the need to revise the input data for pharmacy costs
- the need for additional exclusions from consolidated billing
- the need to continue the refinement of the SNF update methodology
- Medicaid implications.

In view of the above, the Alliance respectfully submits these comments on the proposed rule.

BACKGROUND
§I.F.2., Rate Updates Using the Skilled Nursing Facility Market Basket Index
Page 25530

CMS has implemented a yearly adjustment to the SNF rates for errors in its forecast of the market basket (68 FR 46057, August 4, 2003).[2] Specifically, if the actual market basket change exceeds or is less than the estimated market basket change by .25 percent, the SNF rates are increased or decreased to reflect the amount of the forecasting error. The NPRM proposes to reset the trigger for forecasting error adjustment from its current .25 percent level to either .5 or 1.0 percent in either FY 2008 or FY 2009. The NPRM bases its proposed change on three arguments (page 25530): First, error is endemic to the forecasting process and corrections should be reserved only for "exceptional" errors. Second, the MedPAC analysis shows that Medicare SNF rates are projected to be 11 percent higher than costs in 2007 before taxes. And last, this change in policy would be "more consistent" with the Medicare inpatient hospital PPS policies in this area.

We disagree with the analysis and conclusions of all three arguments and urge you to consider the following points.

CMS: Error is endemic to the forecasting process and adjustments should be reserved only for "exceptional" errors

[2] See 42 C.F.R. §413.337(d)(2).

No one can argue that forecasting is an imprecise science. Forecasting usually overestimates or underestimates what it is predicting. However, as Table 1 shows, the CMS forecasting of the SNF market basket has consistently underestimated actual market basket growth.

TABLE 1
SNF PPS Forecast Error History

Federal Register Providing Actual Market Basket Updates	FY	Predicted Update Percents	Actual Market Basket	Percentage Difference
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2000	3.1	4.1	1
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2001	3.161	5.1	1.939
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2002	3.3	3.4	0 .1
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	Forecast Error Correction for FY 2000 through FY 2002			Rates adjusted by **3.26%** (cumulative forecast error correction)
July 30, 2004 69 FR 45778	FY 2003	3.1	3.3	0 .2
May 19, 2005 70 FR 29074	FY 2004	3.0	3.1	0.1
July 31, 2006 71 FR 43162	FY 2005	2.8	2.9	0.1
May 4, 2007 72 FY 25530	FY 2006	3.1	3.4	0.3

Given the historical data, it appears that there is a systematic bias in the forecasting methods CMS has historically used that penalizes the SNF community, and consequently its Medicare beneficiaries. The total cumulative forecasting error is .702 percent since the last forecasting error adjustment.[3] This translates at current total annual salary rates to "unfunding" approximately 2,500 nurses or 6,000 Certified Nurse Assistants who provide direct patient care in 2008 and even more in later years.

CMS states that the threshold amount for a forecasting error adjustment should represent "an amount that is sufficiently high to screen out the expected minor variances in a projected statistical methodology, while at the same time appropriately serving to trigger

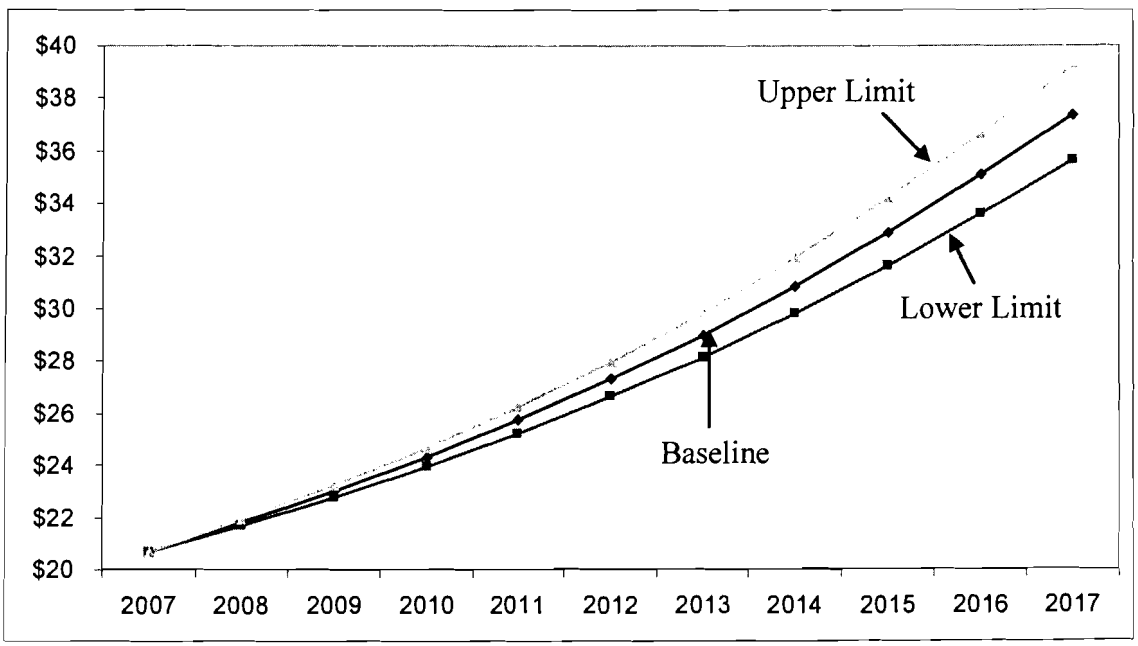
[3] 1.002 x 1.001 x 1.001 x 1.003 = 1.00702.

an adjustment in those instances where it is clear that the historical price changes are not being adequately reflected."[4] It may be administratively useful to screen out a "minor variance" in an annual estimate of changes in SNF costs. But once verified final cost data become available, there is no substantive difference between the sum of uncorrected projection errors for past years, and a forecast error from the most recently available single fiscal year for which there are final data. In either case, "it is clear that the historical price changes are not being adequately reflected."

A threshold amount of 1.0 percent would allow for a total possible unrecovered error of plus or minus $210 million dollars in FY 2008. This is equal to approximately one percent of total Medicare expenditures for nursing homes in that year. Please note that the Federal budget is at risk for excess payments of $210 million. Even a .25 percent unrecovered error represents a possible $53 million dollar reduction in FY 2008. Chart 1 details the impact of an error threshold of 0.5 percent over the ten year Congressional scoring window. As you can see, the scope of the error grows each year as the impact is compounded. **Over ten years, the potential loss increases to plus or minus $8.4 billion.**

CHART 1

Range of Dollar Impact if the Forecast Error Correction Formula is Set at 0.5 Percent and the Error is Plus or Minus .499 Per Year – In Billions of Dollars



The sum of past forecasting error percentages is a cumulative figure. Here is another illustration of this in dollars: in relation to a proposed 3.3 percent market basket increase and the related estimated increase in aggregate payments of $690 million, an

[4] 72 Federal Register 25530 (May 4, 2007)

underestimation error of .702 percent would translate into a loss of $147 million for just FY 2008. Based on the estimated increase in aggregate payments for FY 2008, the impact of the various forecast error thresholds is as follows:

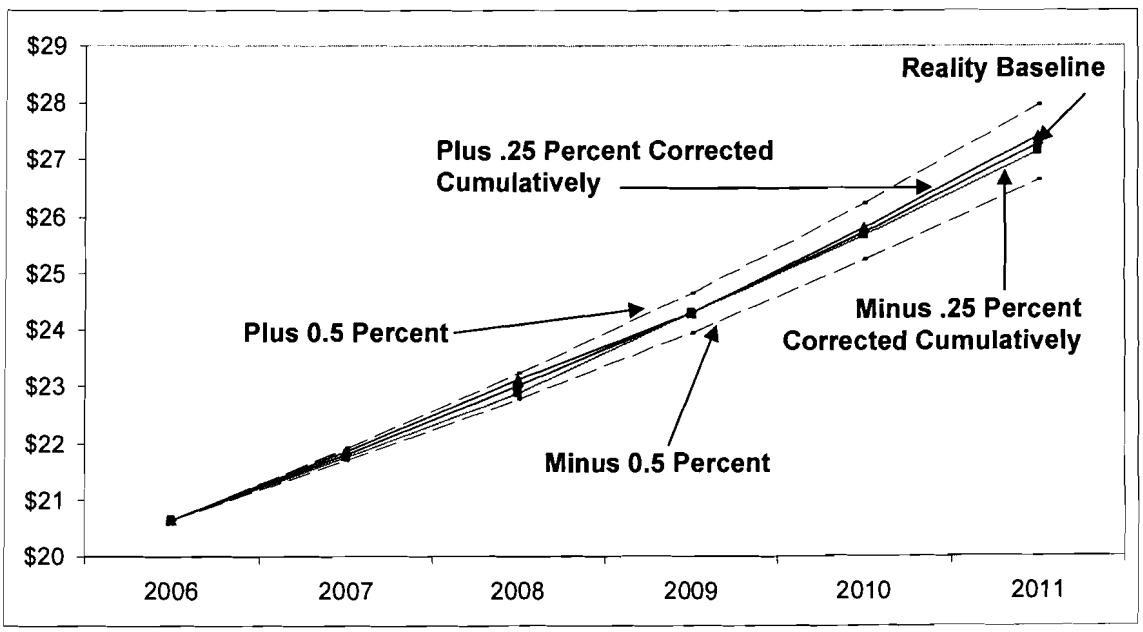
TABLE 2
Dollar Impact of Forecast Errors

Forecast Underestimation Error	Dollar Impact
.25 percent	$ 53M
.30 percent	$ 63M
.50 percent	$105M
.702 percent (cumulative since 2003)	$147M
1.00 percent	$210M

A swing of $105 million to $210 million on an overall increase of $690, just for one year, would virtually gut the overall increase. Finally, uncorrected errors of these proportions would be repeated year after year, and their cumulative effect would be confiscatory.

A threshold of .25 percent ($53 million) is the most appropriate of the alternatives presented. Further, if the forecast error threshold is set at .25% and is also corrected cumulatively, the margin of error is very small, less than $700 million over ten years.

CHART 2
If the Forecast Error Threshold is Set at 0.25 Percent and is Corrected Cumulatively, the Margin of Error is Very Small (0.249)



We urge to revise its SNF market basket procedures to provide routinely for a combined forecasting error adjustment when cumulative uncorrected forecasting errors amount to a

significant percentage. We believe that a combined .25% threshold is appropriate for this purpose.

CMS: MedPAC's analysis shows that Medicare SNF rates are projected to be 11 percent higher than costs in 2007 before taxes

Although the proposed amendments are restricted to the Medicare payment system for SNFs, their effect on the financial viability of the entire SNF community must not be ignored. The SNF community cares for Medicare, Medicaid and dually eligible beneficiaries, all of whom are dependent for their benefits on CMS. All of these facilities, and all of these beneficiaries, are indispensable stakeholders in CMS's programs. SNF residents, especially, are among the intended beneficiaries of the Social Security Act programs for whose implementation CMS is responsible. Nonetheless, MedPAC has consistently refused to look at operating margins for all beneficiaries who are dependent on CMS for benefits. The American Health Care Association (AHCA) has funded the Lewin Group to examine the operating margins for the total CMS-dependent population, who comprise more than 90 percent of all nursing home residents. These studies have found margins on the order of only 2 to 3 percent before taxes. But what is more relevant is that CMS must do everything it can to eradicate error and inaccuracy in its payment system methodology, especially when the ability to do so easily and efficiently is clearly within its current capabilities.

CMS: The proposed policy would make the Medicare SNF policy "more consistent" with the Medicare Inpatient Hospital PPS policies in this area

CMS states that it is considering a higher threshold for the SNF forecast error adjustment, up to 1.0 percentage point, and justifies such a figure as "consistent with the relative magnitude of forecast error that is addressed by the inpatient hospital capital forecast error adjustment."

We believe that this analysis is comparing apples to oranges. The patient populations, size, sources of capital, staffing patterns, among other things, are dramatically different for hospitals and nursing homes. More importantly, the analysis presented is very selective about the time periods and variables it utilizes.

The justification put forth in the NPRM focuses on inpatient *hospital capital* costs compared to *total SNF* costs. The analysis then compares "the relative magnitude" of the forecast error for these two forecasts. This is counter-intuitive. As a measure of the "relative magnitude" of growth, it would be one thing to compare, for example, the growth of total SNF costs to the growth of total hospital costs, or alternatively, to compare the growth SNF capital costs to the growth of inpatient hospital capital costs. For a statistics-based pricing system such as the SNF PPS, surely a more defensible justification would be appropriate, especially as the Government is committed, in the words of the Data Quality Act, to "ensuring and maximizing the quality, objectivity,

utility, and integrity of information (including statistical information) disseminated by the agency...."[5]

Determining total inpatient hospital capital costs has been problematic in the past. CMS is currently undertaking a very significant revision in this area. See its current proposed rule on the inpatient hospital PPS, in which it discusses the inadequacies of past measurements of inpatient hospital capital costs and proposes extensive changes. See "V. Proposed Changes to the PPS for Capital-Related Costs," 72 Federal Register 24818 - 24823 (May 3, 2007). It hardly seems appropriate to adopt as a standard of comparison a new system which is unproven and in such a state of flux.

Inpatient hospital capital is a small fraction of hospital costs. Medicare SNF payments are a much larger proportion of nursing home funding and therefore have a much greater effect. If the total CMS policy on market basket errors for hospitals is examined, rather than just its capital component, another picture would emerge.

Further, the NPRM selects data from FY 1996 through FY 2006 for PPS hospital capital costs and compares them to FY 2000 through FY 2006 total cost data for SNFs. This flawed comparison also makes the analysis appear more favorable to CMS's proposed change than a comparable time period comparison would.

Implementation Date

The NPRM invites commenters' views on whether the policy should be implemented in FY 2008 or FY 2009.

We believe that implementation in FY 2008 would amount in effect to retroactive implementation. SNFs have already anticipated FY 2008 revenues under the current regulation in their budget planning and their contracting for services. Commitments have been made in the context of the anticipated forecast of the growth of SNF costs, as computed under the current regulation, with the expectation that these costs would be reimbursed under the FY 2008 SNF rates, as computed under the current regulation. Implementation of the proposed amendments in FY 2008 would therefore effectively make a retroactive policy change, to the significant detriment of SNFs and ultimately to the beneficiaries whom they serve.

Recommendations

- **We recommend that the current basic forecasting policy be continued, including the .25% threshold for making a forecasting error adjustment.**

- **However, we recommend that the forecasting error adjustment be made cumulatively, for all uncorrected years, whenever the threshold is met. (This is similar to the procedure that was followed in 2003, when the adjustment corrected for the cumulative errors for FY 2000 through FY 2003.) For**

[5] 113 STAT. 2763A-154.

example, the current cumulative .702% forecasting error between FY 2003 through FY 2006 would represent a tripping not only of a .25% threshold, but also even of a 0.5% threshold.

- **CMS should not revise the .25 percent threshold for making a SNF forecasting error adjustment until it can demonstrate through statistically valid and persuasive analysis that the change is justified.**

- **If the threshold for making forecasting error adjustments is raised along the lines proposed in the NPRM, we recommend that it not be implemented until at least FY 2009 in a cumulative manner, in order to give SNFs adequate time to prepare for payment rates that are below the amounts they reasonably anticipated up to now for FY 2008, thus limiting its disruptive effect on SNFs.**

ANNUAL UPDATE
§II.C., Wage Index Adjustment to the Federal Rates
Page 25535

Impact of the new Federal minimum wage

The impending changes in the Federal minimum wage will have an impact on the Area Wage Index. Many of the States which currently have the lowest wages for low skilled labor correspondingly have the lowest Area Wage Indexes. It is thus safe to assume that an increase in the Federal minimum wage will impact these areas to a greater extent than areas that are already paying low wage earners more than the new Federal minimum wage. CMS should provide an adjustment for those States.

Use of the inpatient hospital wage index is inappropriate

In the proposed rule, CMS notes that §1888(e)(4)(G)(ii) of the Act requires that the Federal rates be adjusted to account for differences in area wage levels, using an appropriate wage index. Since the inception of a PPS for SNFs, in the absence of SNF-specific wage data, CMS has argued that it is appropriate and reasonable to use inpatient hospital wage data in developing a wage index to be applied to SNFs. For FY 2008, CMS again proposes to continue to use inpatient hospital wage data for the SNF wage index.

SNF-specific Area Wage Index

The use of hospital wage data to create an area wage index for SNFs is inappropriate. As we and others have commented in the past, a SNF specific area wage index is needed to improve the accuracy of SNF payments to providers to better reflect differences in local labor market conditions. The use of the hospital wage index in place of a SNF area wage index fails to fully capture differences in the features, operations and services in particular local markets, and the differences in skills and activities of staff providing

those services. While in many respects SNFs compete with other types of providers for staff, in other respects they may be significantly different. For example, nurse shortages may in fact be much harder for SNFs to overcome than for hospitals, which, given incentives in the system, may be fundamentally more attractive to nurses. Given these and other differences in the labor force and labor markets that hospitals and SNFs draw upon, a geographic area wage index reflecting hospital wage data is in our view not appropriate for the SNF setting.

Despite having been directed "to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under Section 1888(a)(4) of the Social Security Act" not later than 1 year after the date of the enactment of the Social Security Act Amendments of 1994, Pub. L. No. 103-432 (H.R. 5252), CMS never developed an appropriate area wage index for the SNF setting.

Geographic reclassification

Inpatient hospitals have long had the opportunity to request geographic reclassification for a growing list of exceptions to address numerous deficiencies in the hospital area wage index methodology. In FY 2007, nearly 40% of inpatient hospitals benefited from the exceptions process. The underlying issues that reclassifications seek to address for inpatient hospitals in most cases also exist for SNFs in affected local markets. While for hospitals reclassification may have remedied the underlying problems, SNFs do not have the option to request reclassification to address the same underlying issues.

Under Section 315(a) of the Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, CMS has the authority to establish and use a geographic reclassification methodology to allow SNFs to request reclassification to a more appropriate alternate area that would better reflect local labor market conditions. "Such procedure may be based upon the method for geographic reclassifications for inpatient hospitals established under section 1886(d)(10) of the Social Security Act. . . ."[6] Under §315(b), however, a SNF geographic reclassification system cannot be implemented until CMS has collected the data necessary to establish a SNF-specific area wage index. Thus, in addition to using an inappropriate index based on hospital wage data, CMS's inaction continues to prevent the establishment of a reclassification system for SNFs.

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[6] The Medicare Geographic Classification Review Board (MGCRB) was established by Congress in 1989. Section 6003(h) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Pub. L. No. 101-239) created the panel, and set forth criteria for the MGCRB to use in issuing its decisions concerning the geographic reclassification, or redesignation, of hospitals as rural or urban for prospective payment purposes, Soc. Sec. Act §1886(d)(10). Hospitals may be reclassified from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purpose of using the other area's standardized amount for inpatient operating costs, wage index value, or both, 42 CFR §412.230(a). Groups of hospitals may request reclassification of all PPS hospitals located in a county, as long as all of the PPS hospitals in the county or NECMA agree to the request. 42 CFR §412.252(b). Furthermore, 304(b) of BIPA (Pub. L. No 106-554), provided that a statewide entity, consisting of all PPS hospitals within a state, could apply for reclassification for a statewide wage index. 42 CFR § 412.235.

Consequently, SNFs must continue to struggle with local market issues that inpatient hospitals have been able to resolve through their reclassification system.

In addition to built in disadvantages in the payment system that impede the ability of SNFs to offer comparative wages compared to inpatient hospitals, the inability to request geographic reclassification in turn puts SNFs at an additional disadvantage in offering competitive wages and competing vis-à-vis inpatient hospitals for labor - particularly skilled labor - in local markets where the hospitals have been reclassified.

CMS must address the underlying problem with the current area wage index system affecting the various Medicare PPS systems and the additional inequities and comparative and competitive disadvantage that the hospital reclassification system has imposed on SNFs and other affected PAC settings. High quality direct care staff are critical for delivering high quality care to SNF beneficiaries. SNFs continue to struggle to compete for skilled labor with inpatient hospitals. Geographic reclassification that benefits acute care providers at the expense of post-acute care providers has exacerbated the problem. Given the competitive disadvantage that inpatient hospital-only geographic reclassification has created, it should come as no surprise to CMS that vacancy and turnover rates for direct care staff that are critical to providing high quality care are higher in SNFs, and that it in turn could have an impact on quality of care.

A new area wage index methodology – MEDPAC report

With the Tax Relief and Health Care Act of 2006 (TRHCA), the Congress mandated the Secretary to revise the wage index for the inpatient hospital PPS in FY 2009. The TRHCA also requires that CMS consider specific issues of concern to the Congress such as eliminating exceptions, minimizing variation in the wage index across county borders, and using the hospital wage index in other settings. The Medicare Payment Advisory Commission (MedPAC) in its June 2007 report made recommendations on alternatives to the current wage index. Specifically MedPAC recommended that:

- The Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems;
- The Secretary should establish a hospital compensation index that:
    - uses wage data from all employers and industry specific occupational weights,
    - is adjusted for geographic differences in the ratio of benefits to wages,
    - is adjusted at the county level and smoothes large differences between counties, and
    - is implemented so that large changes in wage index values are phased in over a transition period.
- The Secretary should use the hospital compensation index described above for the home health and skilled nursing facility prospective payment systems and

evaluate its use in the other Medicare fee-for-service prospective payment systems.

MedPAC notes that its index approach:

- more fully reflects true labor input costs in the market by using occupational-level data that represent all employers and reduce circularity,
- automatically captures occupational mix without any burden on providers or CMS,
- reduces year-to-year volatility and wage index cliffs, and
- eliminates the need for exceptions.

The Alliance is supportive of the general concept of the alternative index approach proposed by MedPAC, and how it seeks to more fully reflect true labor input costs in local markets, reduce circularity, reduce the burden on providers by automatically capturing occupational mix, and reduce year-to-year volatility and wage index cliffs. By developing an index that eliminates the need for exceptions and treats providers in a local market equally, SNFs could be in a better position to offer competitive wages and compete for skilled workers with inpatient hospitals in those local markets where inpatient hospitals have been reclassified. But there is no certainty that SNFs would be in a better position.

While supportive of the general concept, the Alliance is concerned that repeal of the current statutory provisions governing the hospital wage index -- and providing the Secretary with the authority to establish new wage index systems -- may reduce Congress' critical role in establishing standards and providing sufficient oversight of a key component of the acute and post-acute care prospective payment systems.

Indeed, the wage index plays a critical role in the Medicare prospective payment system. Major changes in the wage index can and have had a significant disruptive impact on the operations of acute and post-acute care provides in the past. The Alliance urges CMS to examine the alternative index approach proposed by MedPAC carefully, and before implementation thoroughly research and determine that the proposed alternative accurately captures labor cost differences for SNFs across local markets.

The Alliance requests CMS to undertake the evaluation of the alternative index approach in as transparent a manner as possible, make relevant data available to stakeholder groups, consult with and involve acute and post-acute stakeholder groups during the development and the evaluation process, and provide sufficient opportunity for stakeholders to provide comment and feedback.

As indicated above, the Alliance continues to believe that a SNF-specific wage index would be the most appropriate wage index. However, we would surmise that CMS' resources will be focused on the implementation of the new hospital wage index. Thus, as part of the evaluation process, the Alliance requests that CMS over the next year examine the application of the proposed MedPAC compensation index to the SNF

setting. In addition, the Alliance requests that CMS explore the development of a SNF-specific compensation index that would be based on the proposed MedPAC methodology but which would be supplemented with additional data from SNF Medicare cost reports and other relevant data sources. The goal is development of a valid measure that accurately captures the labor costs for SNFs.

Lastly, the Alliance is interested and willing to work with CMS as part of our shared interest in having an appropriate area wage index that accurately reflects differences in labor costs in local markets, as part of a payment system that provides appropriate reimbursement to providers.

Recommendations:

- **CMS should consider prospective adjustments over a two-year period, FY 2008 and FY 2009, to account for increased SNF costs under the new Federal minimum wage.**

- **We recommend that CMS promptly develop an area wage index for SNFs based on wage data from such facilities, as authorized by Congress in 1994 and again in 2000, to make wage index adjustments to the SNF rates.**

- **Utilizing a SNF area wage index, we recommend that CMS establish a procedure for the geographic reclassification of SNFs, as contemplated by §315 of the Benefit Improvement and Protection Act of 2000 (BIPA).**

- **Alternatively, given the purported strengths and benefits of the MedPAC compensation index, we recommend that CMS over the next year examine the application of the proposed MedPAC compensation index to the SNF setting. In addition, we request that CMS explore the development of a SNF-specific compensation index that would be based on the proposed MedPAC methodology but which would be supplemented with additional data from SNF Medicare cost reports and other relevant data sources. We are prepared to offer CMS whatever assistance we can in the development of such a more appropriate index.**

For additional comments on the impact of the increases in the Federal minimum wage, see below under **REVISING AND REBASING, Wages and salaries.**

MARKET BASKET INDEX
§III.B., Market Basket Forecast Error Adjustment
Page 25540

For our comments on the proposed amendments to the threshold for making adjustments to the SNF market basket index for projection error (§I.F.2 on page 25530), and for the effective date for these proposed amendments, see our discussion above under **BACKGROUND.**

REVISING AND REBASING
§IV., Revising and Rebasing the Skilled Nursing Facility Market Basket Index
Page 25541

CMS proposes to revise and rebase the market basket for calculating the skilled nursing facility (SNF) annual update factor. Overall, we commend CMS for addressing in a systematic manner needed changes which are long overdue. We do not have an issue with rebasing the market basket on FY 2004 cost report data. However, we are concerned with the way in which the weights for the various cost categories are proposed to be revised.

Issue 1: We believe that a Medicare data-based revision methodology is much more appropriate than an approach based on total facility data.

The NPRM (pages 25541 though 25556) outlines the methodology CMS is proposing for revising the Medicare SNF market basket. The NPRM proposes that the Medicare SNF cost reports be the primary data source for the weights, which is appropriate. However, CMS uses total allowable costs to calculate the weights as they are primarily reported in Worksheets A and B of the Medicare cost report, rather than a more accurate approach, which is to use Medicare-specific reimbursable costs.

There are also methodology problems in CMS' computation of total allowable costs as follows:

1. The nursing wages, benefits and contract labor percentages are calculated using the nursing labor costs in the SNF unit; yet for all other labor costs (support services, ancillaries, etc.), the calculation incorporates labor costs for the entire facility and for all patients. Either nursing labor costs for the entire facility should be included in computing the nursing labor percentages, or the labor costs for the support service departments should include only the portion allocated to the SNF unit and ancillary cost centers (after step-down). This revised computation would of course change the denominator "Total Medicare Allowable Costs" as well.

2. Drug costs do not include the cost for all patients. The vast majority of the drug cost reported by SNFs is related to Medicare patients alone. The State Medicaid programs require the pharmacy providers to bill directly for drug cost related to medical assistance patients, and therefore these costs are not included on the Medicare cost report. In addition, in many instances, the drug cost for both private pay and insurance patients are also billed directly by the pharmacy. In light of this fact, this component is inconsistent with the "Total Medicare Allowable Cost" approach utilized. We will further elaborate on this further in our comments.

The better alternative is to determine the percentage that each market basket component is of Medicare-specific reimbursable costs. We strongly suggest that the Medicare data from Worksheets C, D and D-1 of the cost report be used instead, in conjunction with

Worksheets A and B data, to calculate the Medicare market basket weights. While we recognize that the weights cannot be entirely calculated using Worksheet C and D data, it is crucial to use them because they display detailed Medicare–specific reimbursable amounts. The market basket is used to identify changes in the price of Medicare services and therefore should involve, to the extent possible, Medicare-specific reimbursable costs.

Proposed Methodology

The following sections detail our proposed methodology for the revision of the market basket and the data on which it should be based. While they closely parallel the CMS proposed methodology, they have several important differences.

Data

In the NPRM, CMS utilized data from the CMS SNF Master File. Similarly, our analysis was conducted using the CMS SNF Master File, as available from the CMS website. We extracted cost reports with dates beginning after September 30, 2003 and before November 1, 2004, as did CMS. We conducted our analysis on the corrected cost report file posted on June 4, 2007.[7] (The late posting of the corrected file significantly reduced the time available for our analysis of the corrected data set.)

Editing

Our editing methodology paralleled the CMS editing methodology. The data were edited for any values which would raise doubt about the accuracy of the data or distort the analysis. For example, if total costs were less than or equal to zero, the facility was not included in our analysis on a pair wise basis. Similarly, we implemented outlier edits. After these edits were completed we had data for 9,862 facilities in our analytical file.

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[7] The analysis in this paper is based on the Medicare public use files. On June 4, 2007, CMS issued an alert regarding these files stating that "(t)he ... SNF ... cost report files have been corrected. The datatype problem has been fixed." In the absence of any accompanying documentation, a comparison of the old and the new data files suggests that the problem was related to the "key" variable RPT_REC_NUM. This is the field that links the provider level information (SNF_RPT_FY2001-current.csv) to the numeric response data (SNF_RPT_NMRC_FY2001-current.csv). This linkage is critical for the proper alignment of information kept in the separate file structures. An improper linkage would cause specious problems not readily apparent.

The "new" data are approximately 3% larger than the "old" data in volume, principally due to the addition of new key variable values. Looking specifically at cost reports for cost report periods beginning during Federal fiscal year 2004, we found wide variation. We found fields that were not populated in the old data becoming populated in the new, fields that were populated in the old data becoming unpopulated in the new, and large changes in reported values, in both the positive and negative directions. The unsystematic nature of the differences between the new and old files required redoing analyses that were conducted using the old. This change effectively resulted in the loss of half the comment period for those concerned with analyzing the data and formulating recommendations.

Methodology

We calculated the weights by extracting the appropriate Medicare and total facility data from the cost report file. The exact variables and formulas we used are contained in Appendix A. Using the data and calculations described above, we duplicated the category weights published in Table 16 of the NPRM (page 25548) to assure that our data set was very similar to the one used by CMS. We were successful.

Subsequent to the publication of the NPRM, CMS made available a revised formula to include the pharmaceutical weight calculation. Table 3 shows that we were able to duplicate the CMS market basket estimate using our final data set.

TABLE 3[8,9]
NPRM Proposal and CMS Revised Pharmacy Approach: in Percents*

Cost Category	NPRM Proposal			NPRM Proposal with CMS Revised Rx Weight		
	Column 1			Column 2		
	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket
Compensation	65.458			65.458		
Wages and Salaries		53.563	1.660		53.563	1.660
Employee Benefits		11.895	0.489		11.895	0.489
Non-Medical Professional Fees	1.426	1.426	0.048	0.954	0.954	0.032
Professional Liability Insurance	1.784	1.784	0.067	1.784	1.784	0.067
Utilities	1.673			1.119		
Electricity		0.992	0.083		0.664	0.056
Fuel, Non-Highway		0.488	0.089		0.326	0.059
Water and Sewage		0.193	0.010		0.129	0.006
All Other						
Other Products	15.220			18.535		
Pharmaceuticals		3.209	0.221		10.500	0.725
Food, Wholesale Purchase		3.135	0.020		2.097	0.013
Food, Retail Purchase		3.398	0.106		2.273	0.071
Chemicals		0.636	0.103		0.425	0.069
Rubber and Plastics		1.632	0.139		1.092	0.093
Paper Products		1.504	0.059		1.006	0.040
Miscellaneous		1.706	0.026		1.141	0.017
Other Services	6.923			4.631		
Telephone Service		0.469	0.003		0.314	0.002
Postage		0.490	0.002		0.328	0.001
Labor Intensive Services		3.798	0.095		2.541	0.064
Non-labor Intensive Services		2.166	0.080		1.449	0.054
Capital Related Expenses						
Total Depreciation	2.982			2.982		
Building and Fixed Equipment		2.556	0.092		2.556	0.092
Movable Equipment		0.426	(0.000)		0.426	(0.000)
Total Interest	3.168			3.168		
For Profit SNFs		1.919	(0.072)		1.919	(0.072)
Government and Non-Profit SNFs		1.249	(0.045)		1.249	(0.045)
Other Capital Related Expenses	1.369	1.369	0.045	1.369	1.369	0.045
Total	**100.0**	**100.0**	**3.3%**	**100.00**	**100.00**	**3.5%**

* Negative numbers are in parenthesis.

The two columns above show the weights proposed in the NPRM, and the weights proposed in the NPRM with a revised CMS-provided pharmacy weight. As demonstrated in Table 4, we successfully duplicated the 3.3 percent update proposed in the NPRM (Column 1). Table 4 also shows that when the revised CMS pharmacy weight is substituted, the annual update factor for FY 2008 increases to 3.5 percent (Column 2).

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[8] We calculated Wages and Salaries, Employee Benefits, Professional Liability and Pharmaceuticals costs using the cost reports file discussed above. The variables we calculated were removed from the CMS market basket. The remaining variables were then re-proportioned to equal 100 percent. The calculated variables were then placed into the new market basket and the remaining variables were put into the market basket by taking the remaining weight and applying the re-proportioned amount to each variable. The variables we calculated are Wages and Salaries, Employee Benefits, Professional Liability and Pharmaceuticals.

[9] See notes following Tables 3 and 4.

Table 4 presents our Medicare cost-based alternative market basket calculations for FY 2008. This methodology yields a market basket update factor of 3.7 percent (Column 1). When the revised CMS pharmacy calculation is substituted, the update factor becomes 3.6 percent (Column 2).

TABLE 4[10,11]
Alternative Approaches to SNF-PPS Market Basket: in Percents*

Cost Category	Alliance Medicare Based Proposal			Alliance Proposal with CMS Revised Rx Weight		
	Column 1			Column 2		
	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket
Compensation	63.810			63.810		
Wages and Salaries		53.320	1.653		53.320	1.653
Employee Benefits		10.490	0.431		10.490	0.431
Non-Medical Professional Fees	1.108	1.108	0.038	1.205	1.205	0.041
Professional Liability Insurance	0.720	0.720	0.027	0.720	0.720	0.027
Utilities	1.300			1.414		
Electricity		0.771	0.065		0.838	0.070
Fuel, Non-Highway		0.379	0.069		0.412	0.075
Water and Sewage		0.150	0.007		0.163	0.008
All Other						
Other Products	21.843			20.649		
Pharmaceuticals		12.510	0.863		10.500	0.725
Food, Wholesale Purchase		2.436	0.016		2.649	0.017
Food, Retail Purchase		2.640	0.082		2.871	0.089
Chemicals		0.494	0.080		0.537	0.087
Rubber and Plastics		1.268	0.108		1.379	0.117
Paper Products		1.169	0.046		1.271	0.050
Miscellaneous		1.326	0.020		1.441	0.022
Other Services	5.379			5.850		
Telephone Service		0.364	0.002		0.396	0.002
Postage		0.381	0.001		0.414	0.001
Labor Intensive Services		2.951	0.074		3.209	0.080
Non-labor Intensive Services		1.683	0.062		1.830	0.068
Capital Related Expenses						
Total Depreciation	2.317			2.520		
Building and Fixed Equipment		1.986	0.071		2.160	0.078
Movable Equipment		0.331	(0.000)		0.360	(0.000)
Total Interest	2.462			2.677		
For Profit SNFs		1.491	(0.056)		1.621	(0.061)
Government and Non-Profit SNFs		0.971	(0.035)		1.055	(0.038)
Other Capital Related Expenses	1.064	1.064	0.035	1.157	1.157	0.038
Total	**100.00**	**100.00**	**3.7%**	**100.00**	**100.00**	**3.6%**

* Negative numbers are in parenthesis.

[10] We calculated Wages and Salaries, Employee Benefits, Professional Liability and Pharmaceuticals costs using the cost reports file discussed above. The variables we calculated were removed from the CMS market basket. The remaining variables were then re-proportioned to equal 100 percent. The calculated variables were then placed into the new market basket and the remaining variables were put into the market basket by taking the remaining weight and applying the re-proportioned amount to each variable. The variables we calculated are Wages and Salaries, Employee Benefits, Professional Liability and Pharmaceuticals.

[11] See notes following Tables 3 and 4.

Notes to Tables 3 and 4

1. Calculate total Medicare inpatient costs. Then calculate total Medicare ancillary costs. Add these together for total Medicare costs. Next calculate the ratio of benefits to total costs. Then calculate the total benefits portion pharmacy costs using the ratio and total pharmacy costs. Calculate total pharmacy costs excluding compensation. Calculate the drugs charged to patients benefits. Use this to calculate the overhead drug ratio and then calculate total Medicare prescription drugs costs. This as a percent of total costs represents the pharmacy weight in the market basket. Using the form WORKSHEET_COLUMN_LINE the following formulas detail the calculations used to acquire the CMS revised pharmacy numbers.

Medicare Inpatient Expenses = (B_1_C18_16/S3_1_C7_1)*S3_1_C4_1)
Medicare ancillary costs = D_1_SNF_C4_75
Total Medicare drugs = D_1_SNF_C4_30 * OHDRGRATIO
Overhead Drug Ratio (OHDRGRATIO) =
1-(SUM(B_1_C18_30,-_1_C0_30,A_C1_30,BENDRG,-PHARM)/B_1_C18_30))
Pharmaceutical Costs excluding compensation (PHARM)=
(SUM(B_1_C0_11,-A_C1_11,-BENPHARM)) * (B_1_C11_30/B_1_C11_11)
Pharmaceutical Cost Center Benefits (BENPHARM)= A_C1_11 * BENDRGRAT
Benefit Drug Ratio (BENDRGRAT)= SUM((S3_2_C3_19,S3_2_C3_20,S3_2_C3_21)/S3_2_C3_1).

2. First, calculate pharmacy salaries. This is done by multiplying drugs charged to patient salaries times the ratio of Medicare charges to total charges. Next calculate drugs charged to patients plus pharmacy non-salaries. Then multiply this by the ratio of Medicare charges to total charges. Using the form WORKSHEET_COLUMN_LINE the following formulas detail the calculations used to acquire our alternate pharmacy numbers.

Drug Salaries = A_C1_L30 * (D_Part1_C2_L30/C_C2_L30)
Drug Costs = (B_Part1_C0_L30 + B_Part1_C0_L11 – A_C1_L11) * (D_Part1_C2_L30/C_C2_L30)

Some of the category weights used by CMS are based on non-cost report data sources. For example, we accepted the CMS weights for capital without comment at this time. We accepted other category weights at a proportional level after the cost report calculations had been completed and combined with the capital weights.

Recommendations

- **We recommend the Medicare-based methodology we have proposed that yields a market basket of 3.7%.**

- **Whether our methodology is accepted or not, the current market basket weight for pharmacy is an inadequate representation of total pharmacy costs. We recommend that CMS utilize the approach developed by us. This will more accurately capture the true cost of providing prescription drugs to Medicare beneficiaries.**

Issue 2: The CMS approach erroneously assumes that Medicaid pharmaceutical costs are captured by the Medicare cost reports.

The total facility approach CMS has proposed assumes that total pharmaceutical costs for the facility are captured by the cost reports. This is not correct. The vast majority of nursing facility patients consists of dual eligibles whose FY 2004 pharmaceutical costs were directly reimbursed by Medicaid. Nursing facilities did not submit Medicaid claims for these pharmaceuticals because such claims were submitted by the dispensing local pharmacies instead. Nursing facilities did not incur costs for these pharmaceuticals and therefore could not place cost data for these pharmaceutical costs on their cost reports. Currently, in addition, pharmaceutical costs for dual eligibles in nursing facilities can often be covered by Medicare Part D and would not constitute incurred nursing facility costs for cost reporting purposes.

Research on 30 State Medicaid data sets by Muse & Associates, now United BioSource Corporation, on dually eligible Medicare beneficiaries in nursing facilities found that pharmaceuticals accounted for between 7.5 and 9.5 percent of total Medicaid payments for nursing facility residents. It is widely recognized that Medicaid patients have lower acuity levels than Medicare patients just discharged from the hospital. This research supports our estimate that 12.51 percent of Medicare patient costs are for pharmaceuticals.

Issue 3: We believe that the CMS approach to the labor weight needs to be revised.

CMS must proceed with the development and implementation of a SNF-specific area wage index.

Under §1888(e)(4)(G)(ii) of the Social Security Act, CMS has the authority to adjust for geographic variations in labor costs by using an appropriate wage index. In the past,

CMS has used hospital wage data to develop a wage index for SNFs. In the proposed rule, CMS implicitly recognized the inappropriateness of relying solely on hospital data by proposing a blend of two different proxies, but one is still based on hospital data. The proposed blend may be an improvement, but it is no substitute for using labor cost data specific to SNFs.

In 1994, Congress directed the Secretary to begin, within one year, "to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment" to the SNF payment system then in effect.[12] CMS never implemented that mandate. In view of the importance of SNFs as a major category of providers in the Medicare program, the growing number of beneficiaries receiving SNF care, and the significant proportion of total Medicare payment amounts that are accounted for by SNF care, a SNF wage index adjustment based on real SNF data is even more appropriate now than it was in 1994. CMS needs to pay SNFs on the most accurate basis possible, and has adequate authority to collect whatever data it needs for this purpose.

In the proposed rule, CMS would create a new price proxy for measuring changes in wage prices by blending the employment cost index (ECI) for Private Nursing and Residential Care Facilities, and the ECI for Civilian Hospitals. The proposed price proxy would be calculated using 50 percent of the change in the index value for each price index. CMS proposes to incorporate this blended ECI into the other changes in the SNF market basket for FY 2008.

While CMS presents other options for measuring this price change, CMS believes the blended methodology presents the fewest methodological concerns. In addition, CMS presents data showing that the historical price increases under the blended methodology have been higher than the price increases for nursing home wages as measured by the ECI for Nursing and Residential Care Facilities alone.

We have long requested that CMS consider using price proxies that accurately reflect changes in the prices of items and services SNFs purchase (see above). This ensures that the market basket update amount meets the rising costs of SNF care for Medicare beneficiaries.

The blend methodology can compensate for the inclusion of lower acuity facilities in the current wage price index, the ECI for Private Nursing and Residential Care Facilities, by adding wage price data from higher acuity facilities (hospitals) that have an occupational mix more similar to SNFs. Therefore, subject to an adjustment to account for the Federal minimum wage increases (see below), we support the proposed change to measure changes in SNF wage prices by blending the ECI for Private Nursing and Residential Care Facilities and the ECI for Civilian Hospitals. Nevertheless, we continue to request that CMS continue studying the feasibility of creating a SNF-only price index for employee wages.

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[12] See §106, "Skilled Nursing Facilities," of Pub. L. No. 103-432, the Social Security Act Amendments of 1994 (October 31, 1994). This act originated as H.R. 5252, 103d Cong., 2d Sess. (1994).

By extension, we also support (subject to a further adjustment to account for the Federal minimum wage increases) the CMS proposal to change the price index for measuring employee benefits from the ECI for Nursing and Residential Care Facilities employee benefits, to a 50-50 blend including hospital worker benefit price change data. We would reiterate our request that CMS consider the feasibility of creating a SNF-only price index for employee benefits.

Minimum Wage

Congress and the President have increased the Federal minimum wage. It will be implemented over two years in two steps. Some SNF staff in some states will benefit from this change. The proposed proxy and labor calculations do not reflect this fact. We suggest that CMS consider a prospective adjustment for the two year phase-in of the new minimum wage. (Also see our comments under ANNUAL UPDATE, above.)

The NPRM fails to take into account the impact of the minimum wage on the overall salary structure of nursing homes. It is our estimate that in FY 2008, the increase in the Federal minimum wage will increase costs to nursing homes by more than $34 million. This amount will increase to nearly $103 million in FY 2009 as the mandated increase takes full effect.[13]

This impact will be felt most in States that currently have a low wage structure for skilled labor; correspondingly, these States have the lowest value in the Area Wage Index. It is thus safe to assume that an increase in the Federal minimum wage will impact these areas to a greater extent that it will areas which are already paying the low wage earners more than the coming Federal minimum wage. Thus the Federally mandated increase in the minimum wage should be addressed in the wage index and market baskets for nursing homes prospectively. SNFs will be paying this increase but the market basket will not reflect this increase until the following year.

Recommendation:

- **CMS should consider prospective adjustments over a two-year period to account for increased SNF costs under the new Federal minimum wage.**

Issue 4: We believe that the CMS approach to the capital weight needs to be revised.

Some of the category weights used by CMS are based on non-cost report data sources. For example, we were forced to accept the CMS weights for capital largely without

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[13] We calculated the impact of the increase in the Federal minimum wage by finding the States which have a minimum wage that is lower than the Federal minimum wage. Then we estimated the number of employees who would be affected by the increase. Next we compared the current State minimum wage to the new Federal minimum wage and calculated the salary for the employees for both the State and Federal minimum wage. The difference between these two calculations is the estimated impact of the increase to the Federal minimum wage. This process was replicated for both 2008 and 2009.

comment at this time. Finally, we would also note that the lack of capital input to the SNF sector has led to the aging of nursing home facilities at a time where the baby boomer demand for such care is rising.

Issue 5: We propose that the SNF community and CMS commit to revisit the cost reports to improve their utility for a future revision of the market basket

The Medicare SNF market basket change is important to the provision of quality care in SNFs. This was reflected in the level of effort CMS put into the development of the NPRM. The full 60 days of time to analyze the data and prepare our comments were not available due to the CMS data set problems cited earlier. Similarly, CMS has only a short time to analyze and react to our comments.

Recommendation

- **We propose that CMS view the methodology in this year's final rule as an interim methodology. This will give the CMS, the Alliance, and other interested technical staff a year to develop a more refined approach. It is clear that CMS' SNF market basket methodology needs to be refined in light of experience and its demonstrated practical effects. CMS is to be commended for its willingness to develop needed changes and to entertain proposals for further refinements. The Alliance wants to cooperate with CMS by participating in this effort as constructively as possible. As with all the Medicare prospective payment systems, implementation is always a work in progress, subject to constant refinement and improvement in light of experience and changing conditions. The SNF market basket update for FY 2008 should not be regarded as the permanent answer to the need for an improved market basket methodology, but only as an interim step toward more desirable refinements beginning in subsequent years.**

CONSOLIDATED BILLING
§V., page 25555

Section 4432(b) of the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, amended various Medicare provisions of the Social Security Act to establish a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Subsequent legislation enacted a number of modifications in the consolidated billing provision.

CMS has recognized that some services that patients could receive while in a SNF Part A stay were outside the scope of SNF services. These were, according to CMS, "intensive diagnostic or invasive procedures that are specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. CMS determined that these services, "under commonly

accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs, and thus were "not subject to consolidated billing." Id.

Under this standard, CMS has excluded magnetic resonance imaging (MRI), computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic, they are not excluded.

In 1999, Congress took further steps and in §103 of the Balanced Budget Refinement Act (BBRA), Pub. L. No. 106-113, Congress also excluded from the SNF PPS numerous chemotherapeutic items, as identified by their respective "J Codes," as well as numerous chemotherapy administration services, also as identified by their respective HCPCS codes. See §1888(e)(2)(A)(iii) of the Social Security Act. In both instances, Congress explicitly recognized that items "may have been inadvertently excluded from the [exclusion] list[,]" (H.R. Conf. Rep. No. 479, 106 Cong., 1st Sess. 854 (1999)) and therefore, the amendment (along with other provisions of the statute) now authorizes the Secretary to identify "any additional chemotherapy items," "any additional chemotherapy administration services," "any additional radioisotope services," and "any additional customized prosthetic devices" to be excluded from PPS.[14]

The BBRA, however, provided the Secretary no guidance in expanding the list of items or services to be excluded in the future from the PPS. The Conference Report accompanying the legislation, however, noted that the specific chemotherapy items were excluded from PPS because "these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer." H.R. Conf. Rep. No. 479, 106th Cong., 1st Sess. 854 (1999). In a subsequent rulemaking, the Secretary, building on the report language, indicated that items or services that were of the same type as described in one of the four categories in Section 103, including chemotherapy and chemotherapy services, could qualify for exclusion from SNF PPS if (i) "they also meet the same standards of high cost and [ii] low probability [of being used] in the SNF setting." 70 Federal Register 29098, quoting 65 Federal Register 46791.

In the proposed rule for FY 2008, CMS once again invites public comments that identify codes in any of the four service categories representing recent medical advances that might meet CMS criteria for exclusion from SNF consolidated billing. However, CMS in the past has taken the position regarding various such proposals that it did not have the statutory authority to exclude such services.

Proposed legislation[15] would broaden CMS' authority to update the consolidated billing rules periodically to:

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[14] See §1888(e)(2)(A)(iii)(I) and (II) of the Social Security Act.

[15] See H.R. 6199 – Introduced by Ginny Brown-Waite (R-FL), Dave Camp (R-MI) and Shelley Moore-Capito (R-WV), and S. 3815 – Introduced by Gordon Smith (R-OR) and Blanche Lincoln (D-AR).

- Take into account the changing practice of medicine and clarify that Medicare may provide PPS-excluded services (such as MRI and radiation therapy) to SNF patients in freestanding clinics;

- Provide the Secretary with the authority to exclude high cost and low probability drugs that are used in the treatment of cancer, including antineoplastic antiemetics and supportive medications; remove the coding ranges currently in statute and provide the Secretary with full flexibility to determine exclusions; and

- Exclude ambulance services from consolidated billing under the SNF PPS.

We continue, however, to believe that CMS does have the authority to address some of our concerns. We take the opportunity to place those in the record again and ask that CMS reconsider its position on the scope of its authority:

A. Site of Service Consolidated Billing Rule

As indicated above, CMS has excluded magnetic resonance imaging (MRI), computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catherization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic, they are not excluded. In 1998, the advent of PPS, CMS was reflecting then current medical practice in its development of the rules on PPS exclusions. However, medical practice has changed, and the services in question are no longer exclusively within the purview of hospitals. While they remain outside the purview of SNFs, radiation therapy is now commonly provided in freestanding radiation therapy clinics, and MRIs are available from freestanding entities. Our understanding is that freestanding ambulatory surgery clinics have also been growing.

CMS should examine current medical practice and modify its policy of permitting certain services to be excluded only if provided in a hospital, and permit these same exclusions if services are provided suitably and appropriately in sites other than hospitals, chiefly freestanding clinics. This policy change should be considered, at a minimum, for ambulatory surgery, MRIs, and radiation therapy services. Such a modification of this policy will not increase costs to the Medicare program -- and indeed may result in cost savings. Simply put, payment will be made to the freestanding clinic instead of the hospital. There is no reason why a hospital monopoly should be retained when services can effectively, efficiently, and safely be provided in an alternative environment.

Further, there is no legal impediment to this policy change. There is no statute requiring that these CMS-provided exclusions must be provided in a hospital. As indicated above,

CMS created this policy based on two factors: (1) that these services that patients could receive while in a SNF Part A stay were outside the scope of SNF services, and (2) that at the time of implementation of the PPS, these were "intensive diagnostic or invasive procedures that [were] specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. Certain of these intensive diagnostic or invasive procedures are no longer specific to the hospital setting because of changes in medical practice and technology. However they remain outside the scope of SNF services. It is well within CMS' rulemaking authority to update the policy to include clinics, in addition to hospitals, that are now commonly furnishing these diagnostic and invasive procedures.

Moreover, and most importantly, a change in policy would enormously facilitate access to care in rural areas -- areas that now are being increasingly served by freestanding clinics. **The benefit to patients in rural areas is clear**. SNFs will not have to transport patients to distant hospitals for provision of excluded services when the services are available from closer freestanding clinics.

In the final rule of August 4, 2005, CMS reasserted its lack of authority to add services administratively to the existing exclusion list. See 70 Federal Register 45049. It also opined that advances in medical practice might even argue for removing certain exclusions. It is not clear what CMS meant by this since advances in medical practice have not made the provision of MRIs or CAT scans feasible in a SNF; and such were never included in pre-PPS SNF payments.

In addition, the rule as it now stands has unintended consequences. Some SNFs have a problem with MRIs and CAT scans performed in acute care hospital outpatient departments under contract with independent MRI/CAT scan companies. Even though these tests are in the acute hospital outpatient department and would appear to be an excludable item under Medicare PPS consolidated billing, the fact that the services are not being billed by the hospital has caused Medicare Part B to reject the claims as submitted by the contractor.

These services which were provided in a hospital should be excluded regardless of whether they were provided by hospital staff or under contract with an outside vendor. According to CMS own current rule, the important consideration should be the site of service, not whether or not the service was contracted out. Obviously, CMS should clarify that the site of service is the driving condition for such an exclusion and should re-examine freestanding MRIs clinics as a site of service acceptable for an exclusion.

The inclusion in consolidated billing of MRIs and CAT scans performed in freestanding clinics is especially unfair to Medicare beneficiaries and SNFs. In many areas, there are no acute care hospitals that provide MRIs and CAT scans. In these regions, independent clinics are the only providers. SNFs are faced with the dilemma of sending their patients to the nearest clinic and absorbing the significant cost, or using a hospital outpatient department at a distance from the facility. Given patients' frailty, the choice providers make in virtually every instance is to use the closest clinic. This exposes them to significant financial risk, as the claims are not billable under Medicare Part B.

Recommendation:

- **We urge CMS to reconsider its position on exclusions from SNF consolidated billing based on site of service and at a minimum allow MRIs and CAT scans performed for Part A SNF patients in a hospital or freestanding clinic to be excluded from the SNF consolidated billing requirement.**

B. Chemotherapy

1. Recommended Drug Exclusions

We recommend that CMS add the following chemotherapy drugs, identified by code, to the excluded chemotherapy list. They are "traditional" cytotoxic chemotherapies that meet the criteria for high cost and low probability:

Non-Excluded "J9" Chemotherapy Agents

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J9031		Bcg live intravesical vac Bacillus Calmette & Guerin	1 EA	113.57	1 dose diluted in 50ml NS weekly x 6 weeks then every 3 months thereafter	4	$454
J9165		Diethylstilbestrol injection	250 MG	12.14	500 mg daily for 5 days	2	$121
J9180		Epirubicin Hydrochloride	50MG	N/A	100-120mg/ml 3-4week cycle	28	N/A
J9190		Fluorouracil injection	500 MG	1.41	12mg/kg/d on days 1-4 non on day 5 then 6mg/kg on days 6,8 10 12 maintenance max 1g/week	4	$49
J9202		Goserelin acetate implant	3.6 MG	185.20	3.6 mg daily every 28 days	1	$185
J9209	C9428	Mesna injection	200 MG	12.98	400 mg every 6 hours for 5 days with ifosfamide	20	$519
J9213		Interferon alfa-2a inj	3 MIL UNITS	32.03	3 million IU daily for 16-24 weeks	30	$961
J9214		Interferon alfa-2b	1 MILLION UNITS	13.26	2 million IU 3 times weekly	12	$318
J9215		Interferon alfa-n3 inj	250000 IU	8.60	For venereal warts N/A	N/A	N/A
J9216		Interferon gamma 1-b inj	3000000 UNITS	272.44	1 million units/m2; 3 times per week	12	$2,287
J9217		Leuprolide acetate /7.5 MG	7.5 MG	229.85	7.5mg monthly	1	$230
J9218	C9430	Leuprolide acetate/ Per 1MG	PER 1 MG	10.76	once daily	30	$323
J9219		Leuprolide acetate implant (Viadur)	65 MG	2,314.14	65mg every 12 months	1	$193
J9260		Methotrexate sodium inj	50 MG	3.84	30-40mg/m2/week	4	$27

*Pricing was obtained from CMS Drug files and is based upon payment allowance limits subject to average sales price (ASP) methodology and is based on July 2005 ASP data.

APC Status Indicator legend: B = not paid under outpatient PPS; G = drug/biological; K = Paid under OPPS separate payment, not bundled; N = bund

2. Additional Cancer Treatment Drugs

CMS' interpretation of the statute results not only in CMS' inability to exclude traditional chemotherapy drugs that have cytotoxic properties but are outside the specific statutory

ranges, but also its inability to exclude other critical categories of drugs important in the treatment of cancer. These other drugs include antineoplastics which are new chemotherapeutic agents which are not cytotoxic but target cancer cells at various stages of reproduction and proliferation. They also include drugs that are traditionally used in combination with chemotherapy, such as antiemetics and supportive care drugs. These drugs are high-cost and low probability drugs.

Antiemetics are those high-cost drugs used to treat the extreme nausea caused by chemotherapy and not general antiemetics used for other types of nausea. These drugs represent standards of care in oncology practice and are considered part of the chemotherapy regimen by oncologists. Supportive medications maintain blood cells, rescue healthy cells from toxic effects of antineoplastic drugs, and counteract the effects of cancer disease processes that spill over to other, nonmalignant organ systems (example: zoledronic acid to treat bone lesions affected by solid tumors).

To exclude chemotherapy from consolidated billing without excluding the drugs and biologicals needed in conjunction with this treatment is to place a financial burden on SNFs, as their costs far exceed the payment received under the PPS. Additionally, hospital outpatient departments are paid extra for these drugs and biologicals, since many are given a separate ambulatory payment classification (APC). In essence, these drugs and biologicals are unbundled for hospitals, but bundled for SNFs. These drugs are administered by injection: intravenously, intramuscularly or subcutaneously.

C. Ambulance Trips

We recommend the further exclusion of ambulance services from consolidated billing under the SNF PPS. Ambulance services are fundamentally a Part B service and should be billed by Part B ambulance providers. An overall exclusion would remove consolidated billing as a source of confusion and error and thus contribute to greater focus on SNF and ambulance company compliance with fundamental Medicare Part B ambulance coverage rules. We believe that the bulk of ambulance trips for SNF Medicare Part A beneficiaries are excluded from consolidated billing. However, those remaining cause incorrect billing and administrative waste for carriers, fiscal intermediaries, ambulance providers, and SNFs.

There are various sources of exclusion in both regulation and statute. In most cases, exclusion depends on whether the individual being transported is considered by CMS a SNF "resident" at the time of transport. If the individual is not considered to be a SNF "resident" then the ambulance trip is excluded from the SNF PPS and the ambulance provider can bill Medicare directly under Part B. Determination of whether or not a SNF is a resident for the purposes of ambulance billing can be extremely complicated, and it is easy to err.

We applaud CMS' efforts to clarify the governing rules and provide every reasonable exclusion within their authority. However, we believe that a thorny and unnecessarily

arcane aspect of Medicare should be simplified at what we believe would be little cost to the Medicare program.

Recommendation:

- **We recommend that CMS exclude from SNF consolidated billing the specified additional cytotoxic chemotherapy drugs, ask that CMS address these individual drug exclusion recommendations in the final rule, and clarify any coding concerns that it might have and the relationship of the codes to the specific statutory ranges.**

- **We recommend that CMS exclude from SNF consolidated billing additional high cost, low probability drugs and biologicals used in conjunction with excluded chemotherapy drugs in the treatment of cancer.**

- **We recommend that CMS exclude from SNF consolidated billing all ambulance trips for SNF Part A beneficiaries that are not already excluded.**

PROVISIONS OF THE PROPOSED RULE
§VII.
Page 25556

These proposed amendments are intended to increase the appropriateness of Medicare payment rates for SNFs by refining the formulas and the data sources on which the payment rates are based. However, the amendments do not address an underlying real world aspect of payment rates for SNFs that distorts CMS' best efforts to achieve a fair and accurate Medicare payment system for SNF services, and that frustrates the SNF industry's reasonable, and indeed essential, expectations for a fair return for the services they furnish. We refer to the longstanding under-funding of nursing facilities by the Medicaid program. The chronic lower-than-cost returns from the Medicaid program for nursing facility care force the SNF industry to look to Medicare to attempt to compensate for the shortfall. No enterprise, including the nation's SNFs, can survive if it incurs losses in its bottom line year after year.

The model SNF market basket amendments we propose do not include a much needed adjustment for chronic Medicaid underfunding. This may be beyond the scope of this Medicare rulemaking. Nevertheless, CMS is responsible for both Medicare SNFs and Medicaid nursing facilities, which are in reality the same entities. We believe CMS needs to do more to reverse this chronic shortage of minimally adequate Medicaid funding for nursing facilities. Section 1902(a)(30)(A) of the Social Security Act provides in part that a Medicaid State plan must

> provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers

> so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

CMS must be more proactive, in its review of Medicaid State plans and their implementation, to assure that at least minimum levels of service and of quality of care are not frustrated by inadequate funding of nursing facility services by the States. Medicaid payments need to be no less accurate than Medicare payments. Fair Medicaid reimbursement would resolve much of the pressure on the design and payment rates of the Medicare SNF PPS.

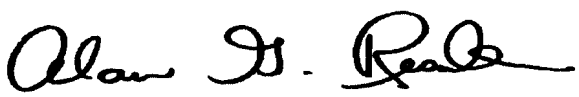
For our other comments on the proposed amendments to the threshold percentage for making adjustments to the SNF market basket index for forecasting errors, and the appropriate implementation date for these amendments (§VII on page 25556), see our discussion under **BACKGROUND,** above.

IMPACT ANALYSIS
§IX. Regulatory Impact Analysis
Page 25556

There are 15,863 nursing facilities in the United States. Most of these facilities are small enterprises, some very small, often consisting of only a single facility. On a typical day, they care for 194,266 Medicare beneficiaries and 920,688 Medicaid beneficiaries. The revenue stream in the typical nursing home is 90% from government sources. Nursing homes are an integral part of the health care continuum. Because of this fact, it is incumbent upon CMS to reimburse nursing facilities for their efforts accurately. If the recommendations above are implemented, the impact will be an additional $4.15 per Medicare patient day. These additional resources will go along way toward sustaining the nursing home community's ability to provide a needed service. Even then, the longstanding under funding of nursing facilities by the Medicaid program still remains a chronic problem that needs to be addressed as a matter of urgency.

Thank you for this opportunity to comment on the proposed amendments to the SNF PPS, especially the SNF market basket provisions. We would be happy to discuss these matters with you if you would find that useful. This includes CMS' consideration of our comments and recommendations in its planning for FY 2009, when the proposed rulemaking for that year is still in the development stage.

Sincerely,



Alan Rosenbloom
President, Alliance for Quality Nursing Home Care

Appendix A: Medicare Based Market Basket

Denominator- Medicare Reimbursable Costs

	Cost Report Worksheet	Line	Column
Medicare Routine Service Cost	D-1, Part I	19	NA
Plus:			
Medicare Ancillary Cost	D, Part I	75	4

Equals Medicare Reimbursable Costs

(1) Wages and Salaries	Cost Report Worksheet	Line	Column
Medicare Reimbursable Nursing Salaries			
Skilled Nursing	Worksheet A	16	1
Divided by:			
Medicare unit days	D-1, Part I	1	N/A
Equals Medicare Unit Nursing Salaries ppd			
Multiplied by:			
Medicare days	D-1, Part I	3	N/A
Equals Medicare Reimbursable Nursing Salaries			
Plus:			
Non-Nursing Medicare Reimbursable Salaries-Routine			
Sum of:			
Employee Benefit Salaries	Worksheet A	3	1
Admin	Worksheet A	4	1
Plant Operations	Worksheet A	5	1
Laundry and Linen	Worksheet A	6	1
Housekeeping	Worksheet A	7	1
Dietary	Worksheet A	8	1
Nursing Administration	Worksheet A	9	1
Central Service and Supplies	Worksheet A	10	1
Pharmacy	Worksheet A	11	1
Medical Records	Worksheet A	12	1
Social Services	Worksheet A	13	1
Interns and Residents	Worksheet A	14	1
Other General Service Cost	Worksheet A	15	1
Subtotal			
Divided by:			
Total Days	S-3, Part I	9	7
Equals Non-Nursing Salaries-Routine ppd			
Multiplied by:			
Medicare days	D-1	3	N/A
Equals Non-Nursing Medicare Reimbursable Salaries-Routine			
Plus:			
Medicare Reimbursable Ancillary Salaries and Contract Therapy			

Medicare Reimbursable Ancillary Salaries and Contract Therapy	Cost Report Worksheet	Line	Column
Radiology Salaries	Worksheet A	21	1
Multiplied by Medicare Charges	Worksheet D, Part I	21	2
Divided by Total Charges	Worksheet C	21	2
Lab Salaries	Worksheet A	22	1
Multiplied by Medicare Charges	Worksheet D, Part I	22	2
Divided by Total Charges	Worksheet C	22	2
IV Salaries	Worksheet A	23	1
Multiplied by Medicare Charges	Worksheet D, Part I	23	2
Divided by Total Charges	Worksheet C	23	2
Oxygen Salaries	Worksheet A	24	1
Multiplied by Medicare Charges	Worksheet D, Part I	24	2
Divided by Total Charges	Worksheet C	24	2
PT Salaries	Worksheet A	25	1
Multiplied by Medicare Charges	Worksheet D, Part I	25	2
Divided by Total Charges	Worksheet C	25	2
PT Contract=PT Total Expenses	Worksheet B, Part I	25	0
Minus:			
PT Salaries	Worksheet A	25	1
Equals PT Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	25	2
Divided by Total Charges	Worksheet C	25	2
OT Salaries	Worksheet A	26	1
Multiplied by Medicare Charges	Worksheet D, Part I	26	2
Divided by Total Charges	Worksheet C	26	2
OT Contract=OT Total Expenses	Worksheet B, Part I	26	0
Minus:			
OT Salaries	Worksheet A	26	1
Equals OT Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	26	2
Divided by Total Charges	Worksheet C	26	2
Speech Salaries	Worksheet A	27	1
Multiplied by Medicare Charges	Worksheet D, Part I	27	2
Divided by Total Charges	Worksheet C	27	2
Speech Contract=Speech Total Expenses	Worksheet B, Part I	27	0
Minus:			
Speech Salaries	Worksheet A	27	1
Equals Speech Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	27	2
Divided by Total Charges	Worksheet C	27	2
Electrocardiology Salaries	Worksheet A	28	1
Multiplied by Medicare Charges	Worksheet D, Part I	28	2
Divided by Total Charges	Worksheet C	28	2
Medical Supplies Salaries	Worksheet A	29	1
Multiplied by Medicare Charges	Worksheet D, Part I	29	2

Medicare Reimbursable Ancillary Salaries and Contract Therapy	Cost Report Worksheet	Line	Column
Divided by Total Charges	Worksheet C	29	2
Drugs Salaries	Worksheet A	30	1
Multiplied by Medicare Charges	Worksheet D, Part I	30	2
Divided by Total Charges	Worksheet C	30	2
Dental Salaries	Worksheet A	31	1
Multiplied by Medicare Charges	Worksheet D, Part I	31	2
Divided by Total Charges	Worksheet C	31	2
Support Surfaces Salaries	Worksheet A	32	1
Multiplied by Medicare Charges	Worksheet D, Part I	32	2
Divided by Total Charges	Worksheet C	32	2
Other Ancillary Salaries	Worksheet A	33	1
Multiplied by Medicare Charges	Worksheet D, Part I	33	2
Divided by Total Charges	Worksheet C	33	2

Equals Medicare Reimbursable Ancillary Salaries and Contract Therapy

Medicare Salary Percentage= (Medicare Reimbursable Nursing Salaries Plus Medicare Reimbursable Non-Nursing Salaries-Routine Plus Medicare Reimbursable Ancillary Salaries and Contract Therapy) Divided by Medicare Reimbursable Costs

(2) Benefits	Cost Report Worksheet	Line	Column
Employee Benefits	B, Part 1	3	0
Times Ratio of			
Medicare Reimbursable Salaries (from #1) to Total Salaries	Worksheet A	75	1
Equals Medicare Reimbursable Benefits			

Benefits Percentage= Medicare Reimbursable Benefits Divided by Medicare Reimbursable Costs

(3) Contract Labor	Cost Report Worksheet	Line	Column
Contract Labor Patient Related and Mgmt	S-3, Part 2	17	3
Minus:			
Contract Therapy (Lines 69, 80, and 91 above)			
Times Ratio of			
SNF Wages and Salaries Divided by	B, Part 1	16	0
SNF and NF Wages and Salaries	B, Part 1	16 and 18	0
Equals Allowable Contract Labor			

Contract Labor Percentage =Allowable Contract Labor Divided by Medicare Total Allowable Expenses (as Defined in "CMS" sheet, line 11)

(4) Drug Costs	Cost Report Worksheet	Line	Column
Drugs Charged to Patients Plus	B, Part 1	30	0
Pharmacy Non-Salary			
Pharmacy Non-Salary =Total Pharmacy	B, Part 1	11	0
Less Pharmacy Salaries	Worksheet A	11	1
Equals Drugs Plus Pharmacy Non-Salary Cost			
Multiplied by Medicare Charges	Worksheet D, Part I	30	2
Divided by Total Charges	Worksheet C	30	2
Equals Medicare Reimbursable Drug Costs			

Drug Percentage= Medicare Reimbursable Drug Costs Divided by Medicare Reimbursable Costs

(5) Malpractice	Cost Report Worksheet	Line	Column
Malpractice Premiums and Paid Losses	S-2	45	N/A
Times Ratio of			
Medicare Reimbursable Costs (See First Calculation on This Spreadsheet) to			
Total Expenses	B, Part 1	75	0
Equals Medicare Malpractice Premiums and Paid Losses			

Malpractice Percentage =Medicare Malpractice Premiums and Paid Losses Divided by Medicare Reimbursable Costs

(6) Capital	Cost Report Worksheet	Line	Column
Medicare Capital	D-1, Part I	22	N/A

Capital Percentage= Medicare Capital Divided by Medicare Reimbursable Costs

5

ahca
American Health Care Association

1201 L Street, NW, Washington, DC 20005-4046
Main Telephone: 202-842-4444
Main Fax: 202-842-3860 2nd Main Fax: 202-289-4253
Writer's Telephone: 202-898-2858
Writer's E-Mail: byarwood@ahca.org
www.ahca.org

June 29, 2007

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1545-P: Comments on *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008, Proposed Rule*, 72 Federal Register 25526 (May 4, 2007)

Dear Ms. Norwalk: Leslie

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008,* 72 Federal Register 25526 (May 4, 2007).

AHCA is the nation's leading long term care organization. AHCA and its membership are committed to performance excellence and Quality First, a covenant for healthy, affordable and ethical long term care. AHCA represents more than 10,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly, and disabled citizens who live in nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities.

Below, AHCA first furnishes an executive summary of its comments. We follow the executive summary with our specific recommendations and detailed analysis.

Executive Summary

First, on behalf of AHCA, I want to thank you for your support this past year. It was a very challenging year for the Centers for Medicare and Medicaid Services (CMS) and AHCA, especially with regard to the most innovative change to the Medicare program since its inception – Part D. You have understood our concerns and our efforts to make the transition from the Medicaid program for dual eligible beneficiaries to the far more complicated Part D environment a success for our residents.

In addition, this past year AHCA and our provider members continued our focus on quality and expended the hard work that it takes to achieve continual improvement. Indeed, quality in America's nursing homes is improving. It is also a fact substantiated by publicly-reported data that appears on CMS' Nursing Home Compare Website, which notes collective progress in quality of care made since the 2002 start of the Nursing Home Quality Initiative (NHQI). More recently, AHCA worked with CMS and a broad-based coalition of providers, consumers, quality experts, medical professionals and government agencies to launch the *Advancing Excellence in America's Nursing Homes* campaign, which builds on that progress.

You have acknowledged our efforts indicating that nursing home providers have been on the leading edge of this quality movement and that quality measurement has worked in nursing homes. These quality efforts, however, could not have been successful without some semblance of stability and predictability in the financing of the care that we provide.

We struggle with the disparity between Medicare and Medicaid, and payment volatility and inadequacy in the Medicaid arena. We face dramatic cost increases in key areas including labor, energy, liability, and capital. The shortage of nurses and other direct care workers, coupled with the fact that long term care must compete with other employers both within and outside the health care sector for these employees, contributes significantly to increasing labor costs. In addition, we must adjust to the ripple effect that the minimum wage increase will surely have throughout our profession. We struggle to recruit and retain qualified care givers, modernize and refurbish aging physical plants and equipment, acquire and implement new technologies to accommodate advances in medical practices, and meet the increasingly complex care needs of an aging population.

Thus, we deeply appreciate the recognition that accompanied the issuance of the SNF prospective payment system (PPS) proposed rule regarding the necessity of adequate and stable Medicare rates which states:

> *These new payment rates reflect our commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the nursing home industry. This represents yet another step to enable nursing homes and the Medicare program to continue to move forward in providing quality services for patients who need post-acute care.*

For our part, we pledge to continue and enhance our efforts to improve quality, staffing, and our plants, to embrace health care technology, and to evolve into the next generation of skilled nursing homes.

We also share the CMS vision that postacute care will one day be seamless and that all beneficiaries will receive care in the most clinically appropriate and cost effective environment. We know that CMS is striving mightily even now to move toward that vision, and you have our complete support. We know that, in the interim, CMS will continue its efforts to improve the accuracy of each payment system and to consider proposals for further refinement of each system.

AHCA wants to work with CMS and participate in these efforts -- both the small and the large -- as constructively as possible on a continuing basis. As with all the Medicare prospective payment systems, implementation of the SNF PPS is always a work in progress, subject to constant refinement and improvement in light of experience and changing conditions. We hope CMS will continue to work with AHCA and other affected parties to develop a more permanent solution to assuring fair and reasonable Medicare reimbursements to SNFs.

In our comments on the proposed rule, AHCA offers analysis and recommendations in the following areas.

The Forecast Error Correction

In the FY 2008 SNF PPS proposed rule, CMS noted that there was a forecast error of 0.3 percent for FY 2006. Under its current rules, CMS should provide a positive forecast error correction of 0.3 percent since that is above the 0.25 percent threshold. However, CMS is proposing to raise the threshold to 0.5 percent and considering a threshold of as high as 1.0 percent. Under the higher thresholds, there would not be a 0.3 percent forecast error correction to the market basket, as would be provided under current policy. Thus under the proposed rule, the payment rates for FY 2008 would not include a forecast error adjustment, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2006 (the most recently available fiscal year for which there is final data) does not exceed the proposed 0.5 percentage point threshold.

CMS invites comments on increasing the forecast error adjustment threshold and its effective date. CMS proffers three reasons as a basis for its proposal to change the threshold: (1) that adjustments should be reserved only for exceptional errors; (2) that according to MedPAC analysis, freestanding SNFs have received Medicare payments that exceeded costs by 10.8 percent or more since 2001, and Medicare margins are projected to be 11 percent in 2007; and (3) that a change in policy would be more consistent with the Medicare inpatient capital PPS forecast error correction policies.

We know that CMS is striving on many fronts to achieve an accurate and effective SNF PPS. AHCA respectfully suggests, however, that the proposed change in the forecast

error correction threshold would be a very big step in the wrong direction and should not be adopted. None of the reasons proffered by CMS sufficiently support the proposed change in the forecast error threshold. Indeed, in its analysis of the proposed rule, AHCA has reached the conclusion that even a 0.25 percent threshold is tolerable only if a correction is made when the forecast error cumulatively reaches 0.25 percent.

Based on our analysis, AHCA strongly recommends that CMS implement neither a 0.5 percent nor a 1.0 percent forecast error correction threshold for FY 2008 or any future year. An increased threshold would dramatically undermine the accuracy of the PPS rates. In addition, AHCA strongly recommends that CMS:

- Provide a forecast correction of 0.702 percent for FY 2008, representing the cumulative loss for the industry which has now exceeded 0.25 percent;
- At a minimum, provide a forecast correction of 0.3 percent for FY 2008 – although that is not as full and accurate an adjustment as a 0.702 percent change;
- Retain the forecast error correction threshold at 0.25 percent annually; and
- Apply a cumulative correction when the 0.25 percent threshold is reached on a cumulative basis.

We believe that these recommendations will go far to helping CMS achieve its desired goal of payment accuracy and effectiveness.

The SNF Market Basket

As part of the FY 2008 SNF PPS proposed rule, CMS has proposed to revise and rebase the market basket for calculating the SNF annual update factor. AHCA commends CMS for addressing in a systematic manner many of the market basket related issues that we and others have raised over the past few years. After many years of encouragement, AHCA is pleased to see that CMS has developed and included a professional liability insurance component in the market basket. We support the inclusion of the professional liability insurance and postage components in the SNF market basket methodology and annual update factor.

In the proposed rule, CMS describes the proposed market basket update methodology, which uses Medicare SNF cost reports as the primary data source. However, the CMS methodology for computing the labor and pharmacy components, that would use total allowable costs to calculate the weights, is very problematic. For example, the labor component methodology uses a less appropriate mix of SNF and total facility costs, while the pharmacy component methodology incorrectly assumes that the Medicare cost reports reflect total facility pharmacy costs rather than costs for Medicare patients only, and thereby consistently and significantly underestimates the weight related to SNF pharmacy spending.

We are proposing a more accurate alternative methodology for computing the labor and pharmacy components of the SNF market basket that would more appropriately use Medicare-specific reimbursable costs. The various Medicare SNF cost report elements

and formulas are detailed in Appendix B of our comments, and the individual proxy weights and our estimate of their contribution to the market basket update are illustrated in Table 3 and Table 4 for the CMS proposed rule and AHCA's proposal, respectively.

CMS also proposes a number of changes to the price proxies used to monitor the rate of change in wage and price proxies for the 23 expenditure categories that make up the proposed market basket. While most of the price proxies are the same as those used in the 1997-based SNF market basket, CMS is proposing new proxies for wages and salaries, employee benefits, professional liability insurance, chemicals, postage, and capital. AHCA has long requested that CMS utilize price proxies that accurately reflect changes in the prices of items and services purchased by SNFs. For the SNF wage and salary price proxy and the SNF benefit price proxy, CMS has proposed a 50-50 blend of the employment cost indexes (ECI) for Private Nursing and Residential Care Facilities and the ECI for Civilian Hospitals for wages and salaries, and benefits, respectively. The proposed blended proxies appear to be an improvement from the current methodology. While we are supportive of the usage of the proposed blended proxies, the proposed proxies are far from sufficient. As such, we continue to request that CMS identify or develop more appropriate and accurate price indexes for tracking changes in prices in the SNF setting, particularly as they relate to SNF wages and salaries, and benefits.

Program and policy changes, such as the recently passed increase in the federal minimum wage, can have a dramatic impact on SNF costs. Such program and policy changes can also have a dramatic impact on the relative weights of the market basket, can test the ability of proxies to track wage and price changes, and contribute to substantial errors in forecasting market basket updates. The forthcoming increase in the federally mandated minimum wage will dramatically raise SNF wage and salary related costs in affected states both directly and indirectly as labor markets respond to the compression effect. Furthermore, while SNFs carry the cost of the increase immediately, the market basket update for the SNF PPS will not reflect the increase in costs for several years. Although AHCA is supportive of the increase in the federal minimum wage, CMS should develop an adjustment to the PPS that would prospectively adjust for forthcoming major program and policy changes, such as the increase in the federal minimum wage, that affect Medicare reimbursement to affected providers. In addition to improving the prospective payment system accuracy, such a prospective adjustment would also reduce market basket forecasting errors.

Lastly, given the complexity and breadth of the proposed revision and rebasing of the market basket, AHCA proposes that CMS treat the proposed market basket methodology as an interim methodology. This would give CMS, AHCA, and others the opportunity to further refine and improve market basket component methodologies and to further refine and improve wage and price proxies more appropriate for the SNF setting.

The SNF Area Wage Index

In the FY 2008 SNF PPS proposed rule, CMS again continues to use inpatient hospital wage data to create the SNF area wage index. AHCA has commented in the past that a

SNF-specific area wage index is needed to improve the accuracy of SNF payments to providers to better reflect differences in local labor market conditions. In 1994, through the Omnibus Reconciliation Act (OBRA), Congress directed CMS to develop a SNF-specific area wage index using SNF wage data. CMS has yet to implement the Congress' directive. AHCA continues to request that CMS develop a SNF-specific area wage index.

The wage index plays a critical role in the SNF PPS. The current Medicare cost report-based hospital wage index methodology has a number of inherent deficiencies, but inpatient hospitals in affected local markets may request geographic reclassification to receive a more appropriate wage index. While Congress gave CMS the authority to allow SNFs to be reclassified, it required that a SNF-specific wage index be in place. CMS' inaction continues to prevent the establishment of a geographic reclassification system for SNFs.

With the Tax Relief and Health Care Act of 2006 (TRHCA), Congress mandated that the Secretary revise the wage index for the inpatient hospital PPS in FY 2009. The TRHCA also mandated a Medicare Payment Advisory Commission (MedPAC) report, and required CMS to consider specific issues of concern to Congress.

AHCA is supportive of the general concept of the alternative index approach and how it seeks to more fully reflect true labor input costs in local markets. However, AHCA urges CMS to carefully examine the alternative wage index approach and thoroughly research and ensure that the proposed alternative would achieve actual improvements before implementation. CMS should also examine the application of the proposed alternative to the SNF setting and explore the development of a SNF-specific compensation index.

Consolidated Billing

In the proposed rule for FY 2008, CMS invites public comments that identify codes in any of the four service categories representing recent medical advances that might meet CMS criteria for exclusion from SNF consolidated billing. CMS had proffered such an invitation before, and AHCA had responded.[1] However, CMS previously took the position that it did not have the statutory authority to exclude certain recommended services.

AHCA is cognizant of CMS' interpretation of the limits of its authority regarding consolidated billing. To that end, as CMS is aware, AHCA worked with lawmakers in the 109th Congress to have legislation, The Long Term Care Quality And Modernization Act, introduced to broaden CMS' authority.[2] The legislation did not get enacted, but we expect it will be introduced again in this Congress.

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[1] See for example, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006, Proposed Rule,* 70 Federal Register 29070, May 19, 2005 CMS-1282-P and AHCA Comments On The Proposed Rule , July 12, 2005.

[2] See H.R. 6199 – Introduced by Ginny Brown-Waite (R-FL), Dave Camp (R-MI) and Shelley Moore-Capito (R-WV), and S. 3815 – Introduced by Gordon Smith (R-OR) and Blanche Lincoln (D-AR).

The goal of the legislation overall is to enhance long term care by: encouraging investment in capital improvements and health information technology; supporting the creation of a stable and well-trained long term care workforce; addressing pressing access and financing concerns; and ensuring essential rehabilitation services are available to those who need it most. This legislation empowers long term care providers to furnish the highest quality care possible by removing certain existing barriers to continued improvements. Several of these barriers exist with regard to consolidated billing. The legislation would require CMS to update the consolidated billing rules periodically to:

- Take into account the changing practice of medicine and clarify that Medicare may provide PPS-excluded services (such as MRI and radiation therapy) to SNF patients in freestanding clinics;

- Provide the Secretary with the authority to exclude high cost and low probability drugs that are used in the treatment of cancer, including antineoplastic antiemetics and supportive medications; remove the coding ranges currently in statute and provide the Secretary with full flexibility to determine exclusions in these areas without any statutory code constraints; and

- Exclude ambulance services from consolidated billing under the SNF PPS.

We continue, however, to believe that CMS does have the authority to address some of our concerns. Therefore, we ask that CMS reconsider its position on the scope of its authority. Our recommendations address consolidated billing site of service issues, cancer treatment drugs and ambulance services.

Conclusion

We again express our appreciation to CMS for its work on improvements to the market basket and express our hope that CMS will find our observations helpful. As we all know, it is costly and labor-intensive to deliver quality long term care. Adequate and stable financing enables SNFs to improve quality of care and retain a skilled workforce.

Thank you for your consideration of our recommendations on how to enhance accuracy and stability in the SNF PPS system.

Sincerely,

Bruce Yarwood
President and CEO

We appreciate the opportunity to work with you

AHCA Recommendations In Brief

AHCA Recommendations on the Forecast Error Correction Threshold:

- *CMS should not implement either a 0.5 percent or a 1.0 percent forecast error correction threshold for FY 2008 or FY 2009 or ever implement such high thresholds since both dramatically harm the accuracy of the PPS rates;*

- *CMS should adhere to the precedent followed in its 2003 actions underscoring the critical importance of accuracy in payment decisions and acting decisively when the cumulative impact of errors erode rates by:*

    - *Providing a forecast correction of 0.702 percent for FY 2008, representing the cumulative loss for the industry which has now exceeded 0.25 percent;*

    - *At a minimum, providing a forecast correction of 0.3 percent for FY 2008 – although that is not as full and accurate an adjustment as a 0.702 percent change;*

    - *Retaining the forecast error correction threshold at 0.25 percent annually; and*

    - *Applying a cumulative correction when the 0.25 percent threshold is reached on a cumulative basis.*

AHCA Recommendations on Revising and Rebasing the SNF Market Basket Index

- *Rather than use the proposed CMS total allowable Medicare cost methodology for the calculation of the labor component of the market basket, CMS should review, replicate, analyze, and adopt the alternative AHCA Medicare-specific reimbursable cost methodology;*

- *Rather than use the proposed CMS total allowable Medicare cost methodology for the calculation of the pharmacy component of the market basket, CMS should review, replicate, analyze, and adopt the alternative AHCA Medicare-specific reimbursable cost methodology;*

- *CMS should reexamine and reconsider the alternative CMS cost-to-charge ratio based methodology for the calculation of the pharmacy component of the market basket over the inappropriate proposed CMS methodology;*

- *CMS should continue efforts to identify and develop more appropriate and accurate price indexes for tracking price changes in the SNF setting, particularly*

as they relate to SNF wages and salaries, benefits, professional liability insurance, and capital;

- *CMS should develop an adjustment to the PPS that would prospectively adjust for forthcoming major program and policy changes such as the increase in the federal minimum wage; and*

- *CMS should view the market basket methodology for FY 2008 as an interim methodology to allow for additional time to further refine and improve the market basket component methodologies and the wage and price proxies for the SNF setting.*

AHCA Recommendations on the SNF Area Wage Index:

- *CMS should develop a SNF-specific wage index;*

- *CMS should conduct the evaluation of the alternative index approach proposed by MedPAC in a transparent manner, and provide opportunity for acute and post-acute care stakeholders to obtain relevant data, to be consulted on the development of the alternative index, and to have sufficient opportunity to provide comment and feedback;*

- *Over the next year, CMS should examine the application of the proposed MedPAC alternate wage compensation index to the SNF setting; and*

- *CMS should explore the development of a SNF-specific alternate wage index that would be based on the proposed MedPAC methodology but which would be supplemented with additional data from SNF Medicare cost reports and other relevant data sources.*

AHCA Recommendations on Consolidated Billing:

- *CMS should correct the site of service problem and permit exclusion of affected intensive diagnostic or invasive procedures when provided in a freestanding clinic;*
- *CMS should exclude the high cost and low probability cytoxic chemotherapy drugs recommended for exclusion by AHCA;*

- *AHCA requests that CMS support SNFs in our efforts to achieve legislation that would support the highest quality cancer treatment for Medicare beneficiaries; i.e., that CMS support us in our effort to have Congress provide the Secretary with the broadest authority to exclude high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications; to remove the coding ranges currently in statute and to*

provide the Secretary with full flexibility and authority to determine exclusions in these areas without any statutory code constraints; and

- *AHCA requests CMS' support for the legislative exclusion of all ambulance services from consolidated billing under the SNF PPS.*

AHCA Comment Analysis
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AHCA Comment Analysis

I. Forecast Error Correction

In 2003, CMS instituted an adjustment to account for market basket forecast error.[3] The initial adjustment applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. The adjustment resulted in a 3.26 percentage point addition to the market basket update. CMS also provided for subsequent adjustments in succeeding fiscal years. These adjustments take into account the forecast error from the most recently available fiscal year for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a 0.25 percentage point threshold.

In the FY 2008 SNF PPS proposed rule, CMS noted that there was a forecast error of 0.3 percent for FY 2006. Under its current rules, CMS should provide a positive forecast error correction of 0.3 percent since that is above the 0.25 percent threshold. However, CMS is proposing to raise the threshold to 0.5 percent, and the agency is considering a threshold of as high as 1.0 percent. Under the higher thresholds, there would be no 0.3 percent forecast error correction to the market basket as would be provided under current policy. The proposed payment rates for FY 2008 would not include a forecast error adjustment, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2006 (the most recently available fiscal year for which there is final data) does not exceed the proposed 0.5 percentage point threshold.

CMS invites comments on increasing the forecast error adjustment threshold and its effective date. CMS proffers three reasons as a basis for its proposal to change the threshold: (1) that adjustments should be reserved only for exceptional errors; (2) that according to MedPAC analysis, freestanding SNFs have received Medicare payments that exceeded costs by 10.8 percent or more since 2001, and Medicare margins are projected to be 11 percent in 2007; and (3) that a change in policy would be more consistent with the Medicare inpatient capital PPS forecast error correction policies.

None of the reasons proffered by CMS are sufficient to support the proposed change in the forecast error threshold. Indeed, in its analysis of the proposed rule, AHCA has reached the conclusion that even a 0.25 percent threshold is tolerable only if correction is made when the forecast error cumulatively reaches 0.25 percent. Based on our analysis below, AHCA strongly recommends that CMS not adopt a 0.5 percent or 1 percent forecast error correction threshold for FY 2008 or any future year. Both thresholds would dramatically hurt the accuracy of the PPS rates. In addition, AHCA strongly recommends that CMS:

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[3] CMS proposed the adjustment in the June 10, 2003, supplemental proposed rule (68 Federal register 34768) and finalized it in the August 4, 2003, final rule (68 Federal Register 46067). See 42 CFR 413.337(d)(2).

- Provide a forecast correction of 0.702 percent for FY 2008 representing the cumulative loss for the industry which has now exceeded 0.25 percent;
- At a minimum, CMS should provide a forecast correction of 0.3 percent for FY 2008 – although that is not as full and accurate an adjustment as a 0.702 percent change;
- Retain the forecast error correction threshold at 0.25 percent annually; and
- Apply a cumulative correction when the 0.25 percent threshold is reached on a cumulative basis.

A. SNF PPS Rates Should be Accurate and Corrected For Errors

In the June 10, 2003 supplemental proposed rule, CMS acknowledged that the agency had the authority under Section 1888 to adjust for forecast errors in the market basket.[4] It pointed to three provisions which, taken together, provide the authority for CMS to compute the payment rate for a fiscal year again after the end of a fiscal year to reflect later acquired, actual data regarding changes in the market basket, and that this recomputed rate could then be used in determining updates to the SNF payment rate for the subsequent fiscal year.[5] In addition, it supported the need for accuracy:

> We believe that establishing an adjustment factor for forecast error in prior years could help to further ensure that the payment rates appropriately reflect changes over time in the price of goods and services. 68 Federal Register 34769.

The fact that forecast errors have been smaller after FY 2002 than before should not change CMS' position that there is a need for appropriate payments and that CMS has the authority and the responsibility to be accurate.

In 2003, CMS chose a threshold of 0.25 percent, contrary to AHCA's position in public comments submitted responding to the regulatory change that there be no threshold. The threshold has functioned as CMS intended, and forecast errors less than 0.25 percent have been permitted to remain standing. While originally not in favor of the 0.25 percent threshold, the industry has accepted the process and the threshold. At the same time, we believe CMS in the 2003 rule making set a precedent that the agency understood the cumulative erosive impact of forecast errors over time, and by its actions adjusting for the cumulative impact of multi-year errors acknowledged the agency's obligation to correct errors.

We are concerned that the very first time the threshold is surpassed, CMS is proposing to change the threshold to avert a payment update. In fact, the policy adopted in 2003 recognized the cumulative impact of forecast errors in prior years, and set the precedent for corrective action when over a multi-year period the errors compound.

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[4] 68 Federal Register 34769.

[5] See 68 Federal Register 34969.

CMS does not provide a solid reason for the proposed policy change. CMS appears to rely solely on a concept that "minor variances" somehow do not merit fixing. The agency refers to the forecast errors since the cumulative fix, as minor variances and seeks recognition "that a certain level of imprecision is inherently associated with measuring statistics." Further, CMS states that the threshold amount for a forecasting error adjustment should represent "an amount that is sufficiently high to screen out the expected minor variances in a projected statistical methodology, while at the same time appropriately serving to trigger an adjustment in those instances where it is clear that the historical price changes are not being adequately reflected."[6]

The problems with this reasoning are multiple. Setting PPS rates should not be thought of as merely an exercise in "forecasting." Further, it is not clear what constitutes a "minor" variance. Moreover, so-called minor variances accumulate into much larger "major" variances, which have a powerful cumulative effect.

In addition, CMS' reasoning runs counter to the statutory principles underlying the Federal Data Quality Act ("DQA")[7] and related OMB circulars that have been published mandating Federal agencies to be diligent in their financial projections. The DQA requires that agencies maximize the quality and integrity of information, including statistical information, that the agencies disseminate. As the DQA requirements pertain to CMS,[8] any information released by CMS is to have been "developed from reliable data sources using accepted methods for data collection and analysis" and "based on thoroughly reviewed analyses and models."

The policy also provides that "CMS reviews the quality (including the objectivity, utility, and integrity) of information before it is disseminated and treats information quality as integral to every step of the development of information, including the creation, collection, maintenance and dissemination." These standards specifically apply to Medicare payment updates. By relying on inappropriate data to support the proposed forecasting policy, CMS has failed to meet the standards for information integrity. No where in the preamble or regulatory analysis does the agency adequately explain why its proposed actions fall outside of these mandates.

1. The Role of Forecasting In Payment Models

Minor variances in a projected statistical methodology are to be expected. However, in a payment system, forecasting should be used solely as a temporary approach to achieving the next fiscal year's inflation factor, and verified cost data should be used as soon as it becomes available. CMS has recognized this twice: first, under cost-based reimbursement when it provided a forecast correction factor for routine cost limits of 0.3

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[6] 72 Federal Register 25530.

[7] Public Law 106-554, amending Paperwork Reduction Act, 44 U.S.C. Sections 3501 et seq.

[8] See http://aspe.hhs.gov/infoQuality/Guidelines/CMS-9-20.shtml.

percent, and second, when it provided a forecast correction error of 0.25 percent for SNF PPS market basket updates.[9]

Forecasting seeks to minimize the risk of decision making for the future; "...forecasting is concerned with what the future will look like..." -- it is in essence guessing at the future.[10] Many decisions cannot be undone if the forecast is in error, but payment decisions can be corrected. Thus, the use of forecasting in a payment system should automatically be coupled with error correction.

What level of error should be tolerated? According to the experts:

> Forecast accuracy is compared by measuring. In general, the error measure should be the one that most likely relates to the decision being made. Ideally it should allow you to compare the benefit from improved accuracy with the costs for obtaining the improvement.[11]

Unfortunately, CMS does not discuss error measurement or provide comparisons of the costs of the costs of obtaining various levels of improvements. We would conclude that the administrative costs of applying various forecast error corrections are *de minimis* overall and vary very little with the degree of correction, while the benefit to achieving accuracy is enormous.

Further, CMS demonstrates a certain inconsistency in its hesitation in correcting forecast errors in the market basket. CMS does strive to be accurate – witness the changes it has provided in the market basket determination in the proposed rule. Likewise, it is concerned about payment accuracy issues related, for example, to the MDS, to the time resource basis of the system itself, and to cost allocation accuracy. While such corrections may require significant ongoing efforts, a forecast error correction that maximizes market basket accuracy is a relatively simple way to contribute to the overall accuracy of the PPS.

There also is a systematic bias in the CMS forecasting methods and thus forecasting errors – an absolutely consistent underestimation of the market basket which we will address in greater detail below. There should be no tolerance for a consistent bias – whether it be a bias toward underestimating or overestimating. AHCA respectfully submits that CMS should be very concerned with the current systematic bias, and that this bias is further reason for CMS to pursue accurate correction. Forecasting itself may

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[9] AHCA has commented before that a routine cost limit forecast error correction of 0.3 percent may have been acceptable under cost-based reimbursement because of the higher accuracy of cost-based reimbursement but is not acceptable for the SNF PPS system which by its very nature is far less accurate than cost-based reimbursement.

[10] *Principles of Forecasting: A Handbook for Researchers and Practitioners*, Copyright 1997-2006 by J. Scott Armstrong, http://www.forecastingprinciples.com/abstracts/interval.html , Answers to Frequently-Asked Questions, http://forecastingprinciples.com/FAQ.html.

[11] Id. Q and A F. 2.

have various parameters of error, but, again, once verified cost data becomes available that can correct such errors, it should be used.

2. Variance Impact

Under current policy, CMS implied that a forecast error under 0.25 percent was "minor." CMS now appears to believe that a forecast error of 0.5 percent or even as high as 1.0 percent are "minor." AHCA submits that in reality none of these thresholds are minor.

The initial adjustment applied to the update of the FY 2003 rate for FY 2004 took into account the cumulative forecast error for the period from FY 2000 through FY 2002, and resulted in a 3.26 percentage point addition to the market basket update. Since 2003 there has been no forecast error correction because, according to CMS, the forecast errors were under 0.25 percent. However, as indicated in Table 1 below, every year the error was an underestimate of cost inflation. These errors are now cumulatively more than 0.25 percent. We strongly believe the agency has an obligation to correct the cumulative error in light of the clear data.

Table 1 -- SNF PPS Forecast Error History

Federal Register Providing Actual Market Basket Updates	**FY**	**Predicted Update Percents**	**Actual Market Basket**	**Percentage Difference**
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2000	3.1	4.1	1.0
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2001	3.161	5.1	1.939
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	FY 2002	3.3	3.4	0 .1
June 10, 2003 68 FR 34770 August 4, 2003 68 FR 46057	Forecast Error Correction for FY 2000 through FY 2002			Rates adjusted by **3.26 percent** (cumulative forecast error correction)
July 30, 2004 69 FR 45778	FY 2003	3.1	3.3	0 .2
May 19, 2005 70 FR 29074	FY 2004	3.0	3.1	0.1
July 31, 2006 71 FR 43162	FY 2005	2.8	2.9	0.1
May 4, 2007 72 FY 25530	FY 2006	3.1	3.4	0.3

The total cumulative forecasting error for FY 2003 through FY 2006 is 0.702 percent.[12] Since this is a cumulative figure, it is difficult to illustrate in dollars. However, as an example, an underestimation error of 0.702 percent would translate into a loss of $147 million in relation to the current 3.3 percent market basket and the related estimated increase in aggregate payments of $690 million. Based on the estimated increase in aggregate payments for FY 2008, the impact of the various forecast error thresholds are as follows:

Table 2 – Estimated Dollar Impact of Forecast Errors

Forecast Underestimation Error	Dollar Impact
0.25 percent	$ 53M
0.30 percent	$ 63M
0.50 percent	$105M
0.702 percent (cumulative since 2003)	$147M
1.00 percent	$210M

We do not believe a threshold of 0.25 percent ($53 million) is appropriate, but it is the least harmful of the alternatives presented. Underpaying nursing homes by $63 million is unsupportable. It is quite clear that an underpayment of $105 million to $210 million on an overall increase of $690 million significantly undercuts the rate increase. Lastly, uncorrected errors of underestimation of these proportions repeated year after year could be considered confiscatory.

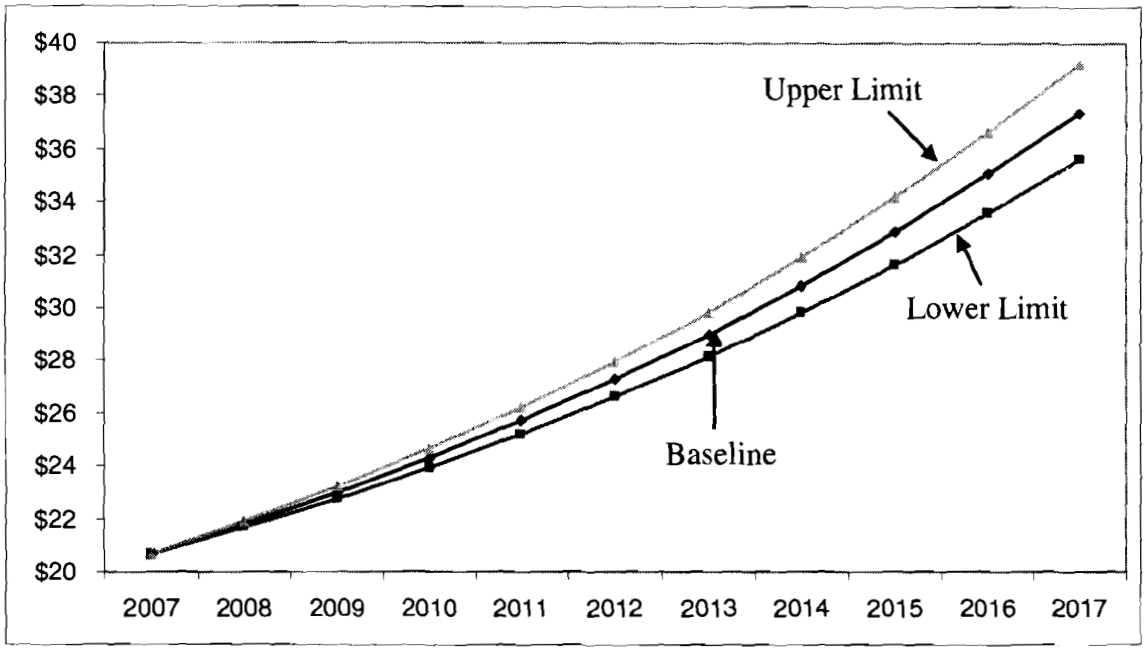
To reiterate, a threshold amount of 1.0 percent would allow for a total possible unrecovered error of plus or minus $210 million dollars in FY 2008. This is equal to approximately one percent of total Medicare expenditures for skilled nursing homes in that year. If such a figure were an underestimation, nursing homes would be at risk for underpayments of $210 million whereas an overestimation would put the government at risk for overpayments of $210 million.

Chart 1, below, details the impact of an error threshold of 0.5 percent over the ten year Congressional scoring window. The chart shows that the scope of the error grows each year as the impact is compounded. Over ten years, the potential loss increases to plus or minus $8.4 billion. To reiterate, this figure is derived in the manner of a ten year Congressional scoring window. It is indeed a huge figure but one that is derived precisely from the threshold methodology that CMS is itself advocating.

CMS cannot respond to this calculation by implying that such an outcome is not plausible. A payment forecast error correction threshold must consider all outcomes under the methodology as plausible and acceptable. If not, then the methodology should not be implemented. Thus, if an $8.4 billion swing in underpayments or overpayments to nursing homes is not acceptable to CMS, then CMS' proposal to change the threshold should not be implemented.

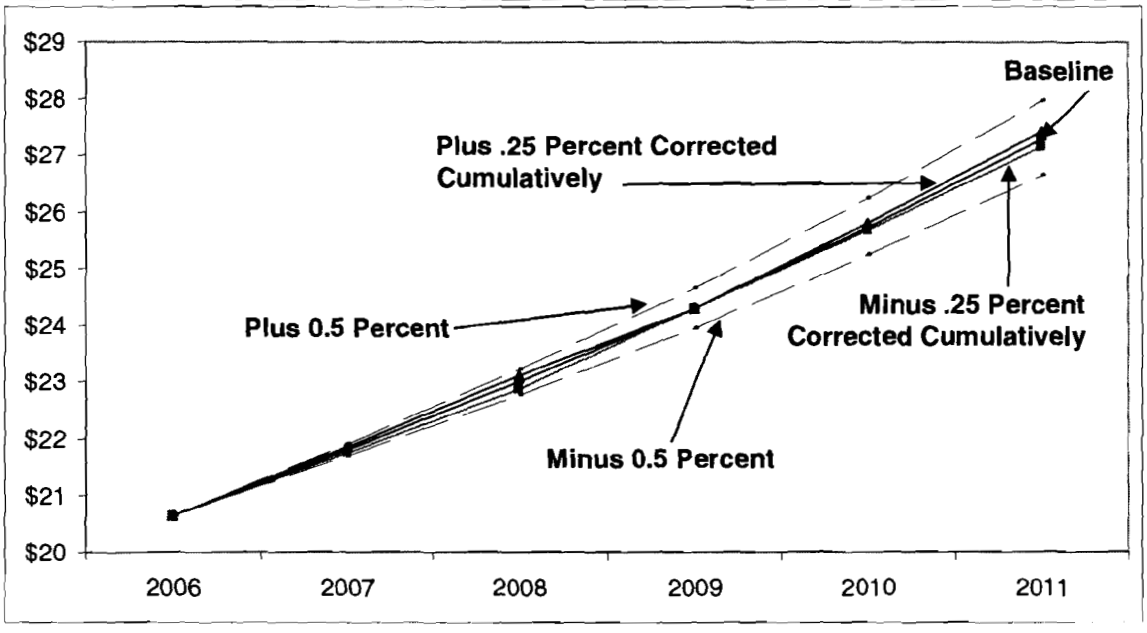
[12] 1.002x1.001x1.001x1.003 = 1.0072

Chart 1 - Range of Dollar Impact if the Forecast Error Correction Formula is Set at 0.5 Percent and the Error is Plus or Minus .49 Per Year – In Billions of Dollars



In contrast, as demonstrated in Chart 2 below, the forecast error threshold is set at 0.25 percent and is corrected cumulatively, the margin of error is very small in comparison to the alternatives proposed by CMS – perhaps no more than $700 million over ten years. Clearly, CMS should prefer the latter to the former on behalf of both the stability of SNFs and the integrity of the public fisc.

Chart 2 – Estimated Forecast Error Threshold Set at 0.25 Percent and Corrected



B. SNF PPS Medicare Profit Margins Do Not Justify Payment System Inaccuracy

At one point in the preamble to the proposed rule, CMS states:

> Further, according to MedPAC analysis, we note that freestanding SNFs (which represent more than 80 percent of all SNFs) have received Medicare payments that exceeded costs by 10.8 percent or more since 2001, and Medicare margins are projected to be 11 percent in 2007. 86 Federal Register 25530

CMS appears to be offering this observation in support of abandoning the 0.25 percent threshold – as if a profit margin justifies the tolerance of forecast error. Industry profit margins should have no bearing on forecast error corrections. Obviously, CMS should strive for Medicare payment accuracy for all industry sectors, whatever the profit margin of Medicare. There simply is no connection.

We wish, however, to be very clear: the Medicare profit margins proffered by MedPAC regarding Medicare distort the fiscal realities of the nursing home sector. MedPAC has consistently refused to look at margins for all beneficiaries who are dependent on CMS for benefits. What MedPAC calculates is not only a poor indicator of the overall profit margin for the nursing home sector, but also is terribly misleading in terms of the ability of the industry to continually muster the resources to provide and improve quality. Indeed, historically, SNF PPS margins overall have run 2 to 3 percent before taxes.

Notwithstanding this distortion, the critical factor regarding payment accuracy is not SNF industry Medicare margins versus its overall margins versus any other margins. CMS' observation on margins is simply off point. **The bottom line is that CMS must do everything it can to eradicate error and inaccuracy in payment system methodology.**

C. The Inpatient Hospital Capital Forecast Error Correction Threshold Is Not Relevant

In considering a higher threshold for the forecast error adjustment of up to 1.0 percentage point, CMS indicates that such a percentage would be consistent with the relative magnitude of forecast error that is addressed by the inpatient hospital capital PPS forecast error adjustment.

Both the SNF and inpatient hospital capital PPS forecast error adjustments currently utilize a 0.25 percent threshold. However, the inpatient hospital capital PPS average annual forecasted market basket update from FY 1996 through FY 2006 (the period of historical data used for forecast error adjustments to date) was approximately 0.9 percent. In contrast, the SNF PPS average annual forecasted market basket update from FY 2000 through FY 2006 (the period of historical data used for forecast error adjustments to date) was approximately 3.1 percent.

Thus, the 0.25 percentage point threshold addressed forecast errors equaling 28 percent or more of the average annual forecasted market basket update under the inpatient hospital capital PPS, compared with 8 percent of the average annual forecasted market basket update under the SNF PPS. CMS indicates that utilizing a 1.0 percentage point forecast error adjustment threshold under the SNF PPS would address forecast errors equaling 32 percent or more of the average annual forecasted market basket update, which is more consistent with the relative magnitude of forecast error for which adjustment is made under the inpatient hospital capital PPS.

This comparison is not useful. The justification put forth in the proposed rule focuses on inpatient *hospital capital* costs compared to *total SNF* costs. The analysis then compares "the relative magnitude" of the forecast error for these two forecasts. This is counter-intuitive, to say the least. As a measure of the "relative magnitude" of growth, it would be one thing to compare, for example, the growth of total SNF costs to the growth of total hospital costs, or alternatively, to compare the growth SNF capital costs to the growth of inpatient hospital capital costs. But the only relation that the growth of inpatient hospital capital costs seems to bear to the growth of total SNF costs is perhaps that it would produce a predetermined desired outcome. For a statistics-based pricing system such as the SNF PPS, surely a more defensible justification would be appropriate, especially as the Government is committed, in the words of the *Federal Data Quality Act*, to "ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by the agency...."[13]

Determining total inpatient hospital capital costs has been problematic in the past. CMS is currently undertaking a very significant revision in this area as evidenced by its current proposed rule on the inpatient hospital PPS, in which it discusses the inadequacies of past measurements of inpatient hospital capital costs and proposes extensive changes. (See "V. Proposed Changes to the PPS for Capital-Related Costs," 72 Federal Register 24818 - 24823). It hardly seems appropriate to adopt as a standard of comparison a new system which is unproven and in such a state of flux.

Further, inpatient hospital capital is a small fraction of hospital costs. Medicare SNF payments are a much larger proportion of nursing home funding and therefore have a much greater effect. If the total CMS policy on market basket errors for hospitals is examined, rather than just its capital component, another picture would emerge.

Moreover, the proposed rule selects data from FY 1996 through FY 2006 for PPS hospital capital costs and compares them to FY 2000 through FY 2006 total cost data for SNFs. This flawed comparison also makes the analysis appear more favorable to CMS' proposed change than would a comparable time period comparison.

[13] 113 STAT. 2763A-154.

D. Implementing the Proposed Change in the Forecast Error Correction Threshold For FY 2008 is Inequitable

CMS invites comment on whether the proposed change in the forecast error correction should be implemented for FY 2008 or FY 2009. First, AHCA does not believe that the proposed change to either 0.5 percent or 1.0 percent should be implemented at all We are opposed to the proposed changes.

SNFs have already anticipated FY 2008 revenues under the current regulation in their budget planning and their contracting for services. Commitments have been made in the context of the anticipated forecast of the growth of SNF costs, as computed under the current regulation, with the expectation that these costs would be reimbursed under the FY 2008 SNF rates, as computed under the current regulation. Implementation of the proposed amendments in FY 2008 would therefore effectively be unfair and possibly a retroactive policy change, to the significant detriment of SNFs and ultimately to the beneficiaries whom they serve.

It is arguable that the change may be impermissibly retroactive since its implementation negates the current applicable rule and violates the historic precedent set by the agency in its previous corrective action. Following the logic set forth in the preamble, the agency could assert authority to change the threshold every year in the proposed rule and argue that this could be done for the very next fiscal year. CMS could in effect avoid implementing any prior final rule threshold. In short, the agency could change the threshold on an annual basis, depriving providers of any sustained expectation whatsoever.

We strongly believe CMS should adhere to the precedent followed in is 2003 actions underscoring the critical importance of accuracy in payment decisions and acting decisively when the cumulative impact of errors erode rates. Based on this principle and the analysis provided above, AHCA is recommending that CMS:

- Provide a forecast correction of 0.702 percent for FY 2008, representing the cumulative loss for the industry which has now exceeded 0.25 percent;
- At a minimum, provide a forecast correction of 0.3 percent for FY 2008 – although that is not as full and accurate an adjustment as a 0.702 percent change;
- Retain the forecast error correction threshold at 0.25 percent annually; and
- Apply a cumulative correction when the 0.25 percent threshold is reached on a cumulative basis.

AHCA Recommendations on the Forecast Error Correction Threshold:

- *CMS should not implement either a 0.5 percent or a 1.0 percent forecast error correction threshold for FY 2008 or FY 2009 or ever implement such high thresholds since both dramatically harm the accuracy of the PPS rates;*

- *CMS should adhere to the precedent followed in its 2003 actions underscoring the critical importance of accuracy in payment decisions and acting decisively when the cumulative impact of errors erode rates by:*

    - *Providing a forecast correction of 0.702 percent for FY 2008, representing the cumulative loss for the industry which has now exceeded 0.25 percent;*

    - *At a minimum, providing a forecast correction of 0.3 percent for FY 2008 – although that is not as full and accurate an adjustment as a 0.702 percent change;*

    - *Retaining the forecast error correction threshold at 0.25 percent annually; and*

    - *Applying a cumulative correction when the 0.25 percent threshold is reached on a cumulative basis.*

II. Revising and Rebasing the SNF Market Basket Index

As noted in the proposed rule (72 Federal Register 25540), Section 1888(e)(5)(A) of the Social Security Act requires the Secretary to establish a SNF market basket index that reflects the changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. CMS last revised and rebased the SNF market basket in 2001 for FY 2002 using FY 1997 data. With this year's proposed rule for FY 2008, CMS is proposing to revise and rebase the market basket index using FY 2004 data.

The market basket update is critical to the viability and sustainability of the industry. As such, CMS, AHCA and other stakeholders have a keen interest in ensuring that the methodology underlying the market basket weights and choice of price proxies are appropriate, accurate, and reflective of SNF Medicare costs and of changes in the price of goods and services purchased by SNFs used to provide quality care to the nation's elderly, frail, and disabled. In order to help achieve accuracy, we offer the following comments and recommendations.

A. Proposed Additions to the Market Basket Components

AHCA commends CMS for addressing in a systematic manner many of the market basket related issues that AHCA and others have raised over the past few years. After many years of encouragement, AHCA is pleased to see that CMS has developed and included a professional liability insurance component in the market basket. We support the inclusion of the professional liability insurance and postage components in the proposed FY2004-based SNF market basket methodology and annual update factor.

B. Proposed Alternative to the Labor Component Methodology

In the proposed rule, CMS describes the proposed market basket update methodology, which uses Medicare SNF cost reports as the primary data source. AHCA has a number of concerns with the proposed CMS methodologies, particularly for the labor and pharmacy components, and would like to offer recommendations for CMS to utilize more-appropriate alternative methodologies.[14]

For the labor component, the proposed CMS methodology uses total allowable costs to calculate the weights. As described in the proposed rule, nursing wages, benefits and contract labor percentages for the labor component would be computed using nursing labor costs in the SNF unit, while other labor costs (support services, ancillaries, etc) would be calculated for the entire facility and for all patients. AHCA believes that, if CMS' "total allowable cost" methodology is utilized, either nursing labor costs for the

[14] With input from Eljay LLC and provider members of AHCA and the Alliance for Quality Nursing Home Care (the Alliance), United BioSource Corporation (UBC) undertook research and analysis on behalf of the profession to replicate market basket methodologies, estimate weights, and analyze the impact on the profession. A description of the data and methodology used by UBC to estimate the market basket weights is described in Appendix A. AHCA and the Alliance share the concerns outlined in this section.

entire facility should be included in the computation for the nursing labor weight or that labor costs for the support service departments should only include the portion allocated to the SNF unit and ancillary cost centers (after step-down).

As detailed in Appendix B, we believe that the better, more appropriate and accurate alternative is to compute the labor components using Medicare-specific reimbursable costs methodology. Under our proposed labor component methodology, Medicare data from Worksheets C, D and D-1, in conjunction with data from Worksheets A and B, would be used to calculate the market basket weights. While we recognize that the weights cannot be entirely calculated using Worksheet C and D data, it is crucial to use the elements from these worksheets to obtain the appropriate Medicare–specific reimbursable amounts.

C. Proposed Alternative to the Pharmacy Component Methodology

For the pharmacy component, the proposed CMS methodology would use "non-salary costs from the Pharmacy cost center and the Drugs Charged to Patients' cost center located on Worksheet B." CMS notes that "[since] these drug costs were attributable to the entire SNF and not limited to Medicare allowable services," that they "adjusted the drug costs by the ratio of Medicare allowable pharmacy total costs to total pharmacy costs using Worksheet B part 1, column 11."

The total facility assumption and approach that CMS has proposed is neither correct nor appropriate. The vast majority of drug costs reported on the SNF cost report are related to Medicare patients alone. Since state Medicaid programs require pharmacies to bill the Medicaid program directly for the drugs of Medicaid residents, Medicaid paid drug costs do not appear on the Medicare SNF cost reports. Similarly, drug costs for private pay and privately insured residents are also billed directly by the pharmacy. In addition, pharmaceutical costs of dual eligibles covered under Medicare Part D would also not be captured on the Medicare SNF cost reports. Given that the vast majority, if not all, of the drug costs reported on the SNF cost report are related to Medicare patients alone, the proposed CMS methodology is inappropriate given that the underlying cost assumptions are inaccurate.

As detailed in Appendix B, we believe that the better, more appropriate and accurate alternative is to compute the pharmacy component using a Medicare-specific reimbursable costs methodology. Under our proposed alternative methodology the pharmacy weight would increase from 3.209 percent to about 12.51 percent. This estimate is consistent with research conducted by Muse and Associates on dually eligible Medicare beneficiaries in nursing facilities.[15] This alternative will more accurately capture the true cost of providing prescription drugs to Medicare beneficiaries.

[15] The research conducted by Muse and Associates (now part of United BioSource Corporation) on dually eligible Medicare beneficiaries using data from 30 state Medicaid agencies. Muse and Associates found that pharmaceuticals accounted for between 7.5 and 9.5 percent of total Medicaid payments for nursing facility residents.

In addition to the Medicare allowable cost methodology, CMS also describes in the proposed rule an alternative methodology for calculating the pharmacy component of the SNF market basket index. Under this CMS alternative methodology, the pharmacy component was estimated using cost-to-charge ratios and computed as Medicare drug costs as a percentage of Medicare total cost. CMS further notes that the pharmacy component using this alternative was nearly three times higher than the proposed methodology, and noted that the cost-to-charge ratios for freestanding SNFs differed greatly from for hospital-based SNFs that were used to validate the results.

Table 3: Estimated Market Basket Component Weights and Their Contribution to the Market Basket for the Proposed CMS Methodology and CMS Alternative Pharmacy Component Methodology [16]

Cost Category	NPRM Proposal			NPRM Proposal with CMS Alternative Rx Methodology		
	Column 1			Column 2		
	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket
Compensation	65.458			65.458		
Wages and Salaries		53.563	1.660		53.563	1.660
Employee Benefits		11.895	0.489		11.895	0.489
Non-Medical Professional Fees	1.426	1.426	0.048	0.954	0.954	0.032
Professional Liability Insurance	1.784	1.784	0.067	1.784	1.784	0.067
Utilities	1.673			1.119		
Electricity		0.992	0.083		0.664	0.056
Fuel, Non-Highway		0.488	0.089		0.326	0.059
Water and Sewage		0.193	0.010		0.129	0.006
All Other						
Other Products	15.220			18.535		
Pharmaceuticals		3.209	0.221		10.500	0.725
Food, Wholesale Purchase		3.135	0.020		2.097	0.013
Food, Retail Purchase		3.398	0.106		2.273	0.071
Chemicals		0.636	0.103		0.425	0.069
Rubber and Plastics		1.632	0.139		1.092	0.093
Paper Products		1.504	0.059		1.006	0.040
Miscellaneous		1.706	0.026		1.141	0.017
Other Services	6.923			4.631		
Telephone Service		0.469	0.003		0.314	0.002
Postage		0.490	0.002		0.328	0.001
Labor Intensive Services		3.798	0.095		2.541	0.064
Non-labor Intensive Services		2.166	0.080		1.449	0.054
Capital Related Expenses						
Total Depreciation	2.982			2.982		
Building and Fixed Equipment		2.556	0.092		2.556	0.092
Movable Equipment		0.426	(0.000)		0.426	(0.000)
Total Interest	3.168			3.168		
For Profit SNFs		1.919	(0.072)		1.919	(0.072)
Government and Non-Profit SNFs		1.249	(0.045)		1.249	(0.045)
Other Capital Related Expenses	1.369	1.369	0.045	1.369	1.369	0.045
Total	**100.0**	**100.0**	**3.3%**	**100.00**	**100.00**	**3.5%**

- Negative numbers are in parenthesis.
- Estimated market basket weights and their contribution to the market basket are in percentages.

[16] See Appendix A for a description of the data and methodology used by UBC to estimate and reapportion the market basket weights. See Appendix C for a description of the CMS alternative pharmacy component methodology.

Table 4: Estimated Market Basket Component Weights and Their Contribution to the Market Basket for the Alternative AHCA Methodology and with the CMS Alternative Pharmacy Component Methodology [17]

Cost Category	Alternative AHCA Methodology			Alternative AHCA Methodology With CMS Alternative Rx Methodology		
	Column 1			Column 2		
	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket	Cost Category Subtotals	Individual Proxy Weights	Contribution to Market Basket
Compensation	63.810			63.810		
Wages and Salaries		53.320	1.653		53.320	1.653
Employee Benefits		10.490	0.431		10.490	0.431
Non-Medical Professional Fees	1.108	1.108	0.038	1.205	1.205	0.041
Professional Liability Insurance	0.720	0.720	0.027	0.720	0.720	0.027
Utilities	1.300			1.414		
Electricity		0.771	0.065		0.838	0.070
Fuel, Non-Highway		0.379	0.069		0.412	0.075
Water and Sewage		0.150	0.007		0.163	0.008
All Other						
Other Products	21.843			20.649		
Pharmaceuticals		12.510	0.863		10.500	0.725
Food, Wholesale Purchase		2.436	0.016		2.649	0.017
Food, Retail Purchase		2.640	0.082		2.871	0.089
Chemicals		0.494	0.080		0.537	0.087
Rubber and Plastics		1.268	0.108		1.379	0.117
Paper Products		1.169	0.046		1.271	0.050
Miscellaneous		1.326	0.020		1.441	0.022
Other Services	5.379			5.850		
Telephone Service		0.364	0.002		0.396	0.002
Postage		0.381	0.001		0.414	0.001
Labor Intensive Services		2.951	0.074		3.209	0.080
Non-labor Intensive Services		1.683	0.062		1.830	0.068
Capital Related Expenses						
Total Depreciation	2.317			2.520		
Building and Fixed Equipment		1.986	0.071		2.160	0.078
Movable Equipment		0.331	(0.000)		0.360	(0.000)
Total Interest	2.462			2.677		
For Profit SNFs		1.491	(0.056)		1.621	(0.061)
Government and Non-Profit SNFs		0.971	(0.035)		1.055	(0.038)
Other Capital Related Expenses	1.064	1.064	0.035	1.157	1.157	0.038
Total	**100.00**	**100.00**	**3.7%**	**100.00**	**100.00**	**3.6%**

- Negative numbers are in parenthesis.
- Estimated market basket weights and their contribution to the market basket are in percentages.

Estimates of the market basket component weights and their contribution to the market basket are illustrated in Tables 3 and 4. Table 3 illustrates the weights of the proposed CMS methodology without and with the CMS alternative pharmacy component methodology. Table 4 illustrates weights of the alternative AHCA methodology without and with the CMS alternative methodology for the pharmacy component. UBC estimated the weight using the CMS alternative pharmacy methodology at 10.5 percent. This

[17] See Appendix A for a description of the data and methodology used by UBC to estimate and reapportion the market basket weights. See Appendix B for a description of the alternative LTC profession methodology. See Appendix C for a description of the CMS alternative pharmacy component methodology.

estimate is consistent with and further validates the estimated pharmacy weight using the alternative AHCA methodology.

CMS cites large inconsistencies between freestanding and hospital-based SNFs, including the substantial difference in the drug cost-to-charge ratios, as well as the dissimilarity in the relationships of those ratios to the cost-to-charge ratios for all ancillary cost centers by SNF type in dismissing the CMS alternative methodology for the pharmacy component. The primary reason for the difference in cost-to-charge ratios between freestanding and hospital-based SNFs is likely related once again to the allocation of overhead issue.

MedPAC and others have described in detail the overhead allocation in hospital-based SNFs issues. The March 2007 MedPAC Report to Congress[18] notes that the -85 percent margin for hospital-based SNFs is in part an artifact of overhead allocation of hospital costs. In addition to noting the role of the allocation of overhead, the June 2007 MedPAC Report to Congress[19] also notes that costs for non-therapy ancillary services (i.e. drugs, supplies, lab, and respiratory therapy) are considerably higher in hospital-based SNFs than in freestanding facilities perhaps due to differences in the complexity of some patients. Further, CMS acknowledges in the proposed rule that it is not appropriate and therefore does not use hospital-based SNF data for market basket related calculations, but rather uses only freestanding SNF data because it reflects "the actual cost structure faced by the SNF itself."[20] Given the overhead cost allocation issue and other factors, CMS should not dismiss the CMS alternative pharmacy component methodology because analysis with flawed hospital-based SNF data does not validate findings using freestanding SNF data.

Both the alternative AHCA methodology and the CMS alternative methodology for the pharmacy component are better at reflecting the true Medicare pharmacy costs and superior to the proposed CMS methodology. The alternative AHCA pharmacy component methodology has the advantage of using Medicare-specific reimbursable costs.

D. Proposed Price Proxies to Measure Cost Category Growth

CMS proposes a number of changes to the price proxies used to monitor the rate of change in wages and prices for the 23 expenditure categories that make up the proposed market basket. While most of the price proxies are the same as those used in the 1997-based SNF market basket, CMS is proposing new proxies for wages and salaries, employee benefits, professional liability insurance, chemicals, postage, and capital.

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[18] Report To The Congress, *Medicare Payment Policy*, MedPAC, March 2007.

[19] Report To The Congress, *Promoting Greater Efficiency in Medicare*, MedPAC, June, 2007.

[20] The proposed rule notes that "expense data for a hospital-based SNF reflect the allocation of overhead over the entire institution. Due to this method of allocation, total expenses will be correct, but the individual components' expenses may be skewed. If data from hospital-based SNFs were included, the resultant cost structure might be unrepresentative of the costs that a typical SNF experiences." (72 Federal Register 25542)

AHCA has long requested that CMS utilize price proxies that accurately reflect changes in the prices of items and services purchased by SNFs. For the SNF wage and salary price proxy and the SNF benefit price proxy, CMS has proposed a 50-50 blend of the employment cost indexes (ECI) for Private Nursing and Residential Care Facilities and the ECI for Civilian Hospitals for wages and salaries, and benefits, respectively.

The proposed blended proxies appear to be an improvement for the SNF setting from the current methodology. The blend methodology appears to compensate for the inclusion of lower acuity facilities in the current wage price index -- the ECI for Private Nursing and Residential Care Facilities -- by adding wage price data from higher acuity facilities (hospitals) that have an occupational mix more similar to SNFs. Therefore, subject to an adjustment to account for the increase in the federal minimum wage (see below), we support the proposed change to measure changes in SNF wage prices by blending the ECI for Private Nursing and Residential Care Facilities and the ECI for Civilian Hospitals.

While we are supportive of the usage of the proposed blended proxies, the proposed proxies are far from sufficient. As such, we continue to request that CMS identify or develop more appropriate and accurate price indexes for tracking changes in prices in the SNF setting, particularly as they relate to SNF wages and salaries, benefits, professional liability insurance, and capital.

E. Prospective Adjustment to the Market Basket for Significant Program and Policy Changes (The Federal Minimum Wage)

Program and policy changes, such as the recently passed increase in the federal minimum wage, can have a dramatic impact on SNF costs. Such program and policy changes can also have a dramatic impact on the relative weights of the market basket, test the ability proxies to track wage and price changes, and can contribute to substantial errors in forecasting market basket updates.

The forthcoming increase in the federally mandated minimum wage is but one policy example that will dramatically raise SNF wage and salary related costs in affected states. UBC estimates that the increase in the federal minimum wage will increase nursing home staffing costs by more than $34 million in FY 2008, and by nearly $103 million in FY 2009 as the mandated increase takes full effect.[21] Wage and salary related costs are expected to increase still more in affected states as SNFs respond to the minimum wage increase induced wage compression effect for those staff with wages just above the new federal minimum wage.

[21] UBC calculated the impact of the increase in the federal minimum wage by finding the states which have a minimum wage that is lower than the federal minimum wage. UBC estimated the number of employees who would be affected by the increase, and then compared the current state minimum wage to the new federal minimum wage and calculated the salary for the employees for both the state and federal minimum wage. The difference between these two calculations is the estimated impact of the increase to the federal minimum wage. This process was replicated for both 2008 and 2009.

Furthermore, while SNFs carry the cost of the increase immediately, the market basket update for the SNF PPS will not reflect the increase in costs for several years.

Although AHCA is supportive of the increase in the federal minimum wage, CMS should develop an adjustment to the PPS that would prospectively adjust for forthcoming major program and policy changes, such as the increase in the federal minimum wage, that affect Medicare reimbursement to affected providers. In addition to improving the various PPSs, such a prospective adjustment would also reduce market basket forecasting errors.

F. Interim Market Basket Methodology

As noted previously, the market basket update is critical to the viability and sustainability of the industry, and as such, CMS, AHCA and other stakeholders have a keen interest in ensuring that the methodology underlying the market basket weights and choice of price proxies are appropriate, accurate, and reflective of SNF costs and changes in the price of goods and services purchased by SNFs to provide quality care to the nation's elderly, frail, and disabled. The importance of the market basket is in part reflected by the level of effort that CMS put into the proposed revision and rebasing of the market basket index.

Evaluation of the proposed market basket changes by AHCA and other stakeholders were, however, hampered by issues with the Medicare SNF cost report public use files data. On June 4, 2007, CMS issued an alert stating that "the ... SNF ... cost report files have been corrected. The data type problem has been fixed." While we were pleased that corrected data was made available as expeditiously as possible, the correction effectively cut the comment period in half for our internal and external research and analysis efforts.

We propose that CMS view the market basket methodology in this year's final rule as an interim methodology. This would give CMS, AHCA, and other stakeholders the opportunity over the next year to further refine and improve market basket component methodologies and the wage and price proxies for the SNF setting without locking in the methodology for several years.

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

- *Rather than use the proposed CMS total allowable Medicare cost methodology for the calculation of the labor component of the market basket, CMS should review, replicate, analyze, and adopt the alternative AHCA Medicare-specific reimbursable cost methodology;*

- *Rather than use the proposed CMS total allowable Medicare cost methodology for the calculation of the pharmacy component of the market basket, CMS should review, replicate, analyze, and adopt the alternative AHCA Medicare-specific reimbursable cost methodology;*

- *CMS should reexamine and reconsider the alternative CMS cost-to-charge ratio based methodology for the calculation of the pharmacy component of the market basket over the inappropriate proposed CMS methodology;*

- *CMS should continue efforts to identify and develop more appropriate and accurate price indexes for tracking price changes in the SNF setting, particularly as they relate to SNF wages and salaries, benefits, professional liability insurance, and capital;*

- *CMS should develop an adjustment to the PPS that would prospectively adjust for forthcoming major program and policy changes such as the increase in the federal minimum wage; and*

- *CMS should view the market basket methodology for FY 2008 as an interim methodology to allow for additional time to further refine and improve the market basket component methodologies and the wage and price proxies for the SNF setting.*

III. SNF Wage Index Adjustments To The Federal Rate

In the proposed rule, CMS notes that Section 1888(e)(4)(G)(ii) of the Act requires that federal rates be adjusted to account for differences in area wage levels, using an appropriate wage index. (72 Federal Register 25535.) Since the inception of a PPS for SNFs, in the absence of SNF-specific wage data, CMS has argued that it is appropriate and reasonable to use inpatient hospital wage data in developing a wage index to be applied to SNFs. For FY 2008, CMS again proposes to continue to use inpatient hospital wage data for the SNF wage index.

A. SNF-Specific Area Wage Index

The use of hospital wage data to create an area wage index for SNFs is inappropriate. As AHCA and others have commented in the past, a SNF-specific area wage index is needed to improve the accuracy of SNF payments to providers to better reflect differences in local labor market conditions. The use of the hospital wage index in place of a SNF area wage index fails to fully capture differences in the features, operations and services in particular local markets, and the differences in skills and activities of staff providing those services. While in many respects SNFs compete with other types of providers for staff, in other respects they may be significantly different. For example, nurse shortages may in fact be much harder for SNFs to overcome than hospitals, which, given incentives in the system, may be fundamentally more attractive to nurses. Given these and other differences in the labor force and labor markets that hospitals and SNFs draw upon, a geographic area wage index reflecting hospital wage data is in AHCA's view not appropriate for the SNF setting.

In addition, despite having been directed in 1994 "to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under Section 1888(a)(4) of the Social Security Act," not later than 1 year after the date of the enactment of the Omnibus Budget Reconciliation Act (H.R. 5252), CMS has yet to develop an appropriate area wage index for the SNF setting.

The problems with the usage of inappropriate hospital wage data for the SNF wage index is further compounded by the ability of inpatient hospitals to obtain geographic reclassification to address numerous deficiencies in the hospital area wage index methodology, while SNFs cannot. Inpatient hospitals have long had the opportunity to request geographic reclassification for a growing list of exceptions. In FY2007, nearly 40 percent of inpatient hospitals benefited from the exceptions process. The underlying issues that reclassifications seek to address for inpatient hospitals in most cases also exist for SNFs in affected local markets. While reclassification may have remedied the underlying problems for inpatient hospitals, SNFs do not have the option to request reclassification to address the same types of underlying issues.

Under Section 315 of the Benefits and Improvement Protection Act of 2000 (BIPA), CMS has the authority to establish and use a geographic reclassification methodology to

allow SNFs to request reclassification to an alternate more appropriate area that would better reflect local labor market conditions.[22] By statute, a SNF geographic reclassification system, however, cannot be implemented until CMS has collected the data necessary to establish a SNF-specific area wage index. Thus, in addition to using an inappropriate hospital wage data based SNF index, CMS' inaction continues to prevent the establishment of a reclassification system for SNFs. Consequently, SNFs continue to struggle with local market issues that inpatient hospitals have been able to resolve through their reclassification system.

In addition to built-in disadvantages in the payment system that impede the ability of SNFs to offer comparative wages to inpatient hospitals, the inability to request geographic reclassification in turn puts SNFs at an additional disadvantage in offering competitive wages and competing vis-à-vis inpatient hospitals for labor -- particularly skilled labor -- in local markets where the hospitals have been reclassified.

CMS must address the underlying problem with the current area wage index system affecting the various Medicare PPS systems and the additional inequities and comparative and competitive disadvantage that the hospital reclassification system has imposed on SNFs and other affected postacute care settings. High quality direct care staff are critical for delivering high quality care to SNF beneficiaries. SNFs continue to struggle to compete for skilled labor with inpatient hospital. Geographic reclassification that benefits acute care providers at the expense of post-acute care providers has exasperated the problem. Given the competitive disadvantage that inpatient hospital-only geographic reclassification has created, it should come as no surprise to CMS that vacancy and turnover rates for direct care staff that are critical to providing high quality care are higher in SNFs and other postacute care settings, and that this in turn could have an impact on quality of care.

AHCA continues to request that CMS develop a SNF-specific wage index. We believe that CMS has the data that is necessary to do this and should request the resources from Congress to do so.

B. New Area Wage Index Methodology

With the Tax Relief and Health Care Act of 2006 (TRHCA), the Congress mandated the Secretary to revise the wage index for the inpatient hospital PPS in FY 2009. The

[22] The Medicare Geographic Classification Review Board (MGCRB) was established by Congress in 1989. Section 6003(h) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Pub. L. No. 101-239) created the panel, and set forth criteria for the MGCRB to use in issuing its decisions concerning the geographic reclassification, or redesignation, of hospitals as rural or urban for prospective payment purposes, Soc. Sec. Act §1886(d)(10). Hospitals may be reclassified from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purpose of using the other area's standardized amount for inpatient operating costs, wage index value, or both, 42 CFR §412.230(a). Groups of hospitals may request reclassification of all PPS hospitals located in a county, as long as all of the PPS hospitals in the county or NECMA agree to the request. 42 CFR §412.252(b). Furthermore, 304(b) of BIPA (Pub. L. No 106-554), provided that a statewide entity, consisting of all PPS hospitals within a state, could apply for reclassification for a statewide wage index. 42 CFR § 412.235.

TRHCA also requires that CMS consider specific issues of concern to the Congress such as eliminating exceptions, minimizing variation in the wage index across county borders, and using the hospital wage index in other settings. MedPAC) in its June 2007 report[23] made recommendations on alternatives to the current wage index. Specifically MedPAC recommended that:

- Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems;

- The Secretary should establish a hospital compensation index that:
    - uses wage data from all employers and industry specific occupational weights;
    - is adjusted for geographic differences in the ratio of benefits to wages,
    - is adjusted at the county level and smooths large differences between counties; and
    - is implemented so that large changes in wage index values are phased in over a transition period.

- The Secretary should use the hospital compensation index described above for the home health and skilled nursing facility prospective payment systems and evaluate its use in the other Medicare fee-for-service prospective payment systems.

MedPAC notes that its index approach:

- More fully reflects true labor input costs in the market by using occupational-level data that represent all employers;
- Reduces circularity;
- Automatically captures occupational mix without any burden on providers or CMS;
- Reduces year-to-year volatility in the wage index and wage index cliffs; and
- Eliminates the need for exceptions.

AHCA is supportive of the general concept of the alternative index approach proposed by MedPAC, and how it seeks to more fully reflect true labor input costs in local markets, reduce circularity, reduce the burden on providers by automatically capturing occupational mix, and reduce year-to-year volatility and wage index cliffs. By developing an index that eliminates the need for exceptions and treats providers in a local market equally, SNFs could be in a better position to offer competitive wages and compete for skilled workers with inpatient hospitals in those local markets where inpatient hospitals have been reclassified, although there is no guarantee of this outcome.

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[23] Report To The Congress, *Promoting Greater Efficiency in Medicare*, MedPAC, June, 2007.

While supportive of the general concept, AHCA is concerned that repeal of the current statutory provisions governing the hospital wage index -- and providing the Secretary with the authority to establish new wage index systems -- may reduce Congress' critical role in establishing standards and providing sufficient oversight of a key component of the acute and post-acute care prospective payment systems.

Indeed, the wage index plays a critical role in the Medicare prospective payment system. Major changes in the wage index can and have had a significant disruptive impact on the operations of acute and postacute care provides in the past. AHCA urges CMS to examine the alternative index approach proposed by MedPAC carefully, and, before implementation, thoroughly research and determine that the proposed alternative accurately captures labor cost differences for SNFs across local markets.

AHCA requests that CMS undertake the evaluation of the alternative index approach in as transparent a manner as possible, make relevant data available to stakeholder groups, consult with and involve acute and post-acute stakeholder groups during the development and the evaluation process, and provide sufficient opportunity for stakeholders to provide comment and feedback.

As indicated above, AHCA continues to believe that a SNF-specific wage index would be the most appropriate wage index. However, we would surmise that CMS' resources will be focused on the implementation of the new hospital wage index. Thus, as part of the evaluation process, AHCA requests that CMS over the next year examine the application of the proposed MedPAC compensation index to the SNF setting. In addition, AHCA requests that CMS explore the development of a SNF-specific compensation index that would be based on the proposed MedPAC methodology but which would be supplemented with additional data from SNF Medicare cost reports and other relevant data sources. The goal is development of a valid measure that accurately captures the labor costs for SNFs.

Lastly, AHCA is interested in and willing to work with CMS as part of our shared interest in having an appropriate area wage index that accurately reflects differences in labor costs in local markets.

AHCA Recommendations on the Area Wage Index:

- *CMS should develop a SNF-specific wage index;*

- *CMS should conduct the evaluation of the alternative index approach proposed by MedPAC in a transparent manner, and provide opportunity for acute and post-acute care stakeholders to obtain relevant data, to be consulted on the development of the alternative index, and to have sufficient opportunity to provide comment and feedback;*

- *Over the next year, CMS should examine the application of the proposed MedPAC compensation index to the SNF setting; and*

- *CMS should explore the development of a SNF-specific compensation index that would be based on the proposed MedPAC methodology but which would be supplemented with additional data from SNF Medicare cost reports and other relevant data sources.*

IV. Consolidated Billing

Section 4432(b) of the Balanced Budget Act of 1997 (BBA), Pub. L. 106-113, established a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Subsequent legislation enacted a number of modifications in the consolidated billing provision.

For some years now, AHCA has communicated to CMS aspects of consolidated billing that should be modified and improved. CMS did listen to AHCA and early on recognized that some services that patients could receive while in a SNF Part A stay were outside the scope of SNF services. These were, according to CMS, "intensive diagnostic or invasive procedures that are specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. CMS determined that these services, "under commonly accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs, and thus were "not subject to consolidated billing." Id.

Over time, under this standard, CMS has excluded magnetic resonance imaging (MRI), computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catherization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic, they are not excluded.

In 1999, Congress took further steps and in Section 103 of the Balanced Budget Refinement Act (BBRA),[24] Congress excluded from the SNF PPS stem for skilled nursing facilities numerous chemotherapeutic items, as identified by their respective "J Codes," as well as numerous chemotherapy administration services, also as identified by their respective HCPCS codes. In both instances, Congress explicitly recognized that items "may have been inadvertently excluded from the [exclusion] list[,]" (H.R. Conf. Rep. 479, 106 Cong., 1st Sess. 854 (1999)) and therefore, BBRA authorized the Secretary to identify "any additional chemotherapy items" and "any additional chemotherapy administration services" to be excluded from PPS. BBRA § 103(a)(2), amending the Social Security Act by adding new paragraphs at 1888(e)(2)(A)(iii)(I) and (II), codified at 42 U.S.C. § 1395yy(e)(2)(A)(iii)(I) and (II).

The BBRA provided the Secretary no guidance in expanding the list of items or services to be excluded in the future from the PPS. The Conference Report accompanying the legislation, however, noted that the specific chemotherapy items were excluded from PPS because "these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer." H. Conf. Rep. 479, 106th Cong., 1st Sess. 854 (1999). In a subsequent rulemaking, the

[24] Pub. L. 106-113.

Secretary, building on the report language, indicated that items or services that were of the same type as described in one of the four categories in Section 103, including chemotherapy and chemotherapy services, could qualify for exclusion from SNF PPS if (i) "they also meet the same standards of high cost and [ii] low probability [of being used] in the SNF setting." 70 Federal Register 29098 quoting 65 Federal Register 46791.

In the proposed rule for FY 2008, CMS invites public comments that identify codes in any of the four service categories representing recent medical advances that might meet CMS criteria for exclusion from SNF consolidated billing. CMS had proffered such an invitation before, and AHCA had responded.[25] However, CMS took the position regarding various services that it did not have the statutory authority to exclude such services.

AHCA is cognizant of CMS' interpretation of the limits of its authority regarding consolidated billing and, as CMS is aware, AHCA worked with lawmakers in the 109th Congress to have legislation, The Long Term Care Quality And Modernization Act, introduced to broaden CMS' authority.[26] The legislation did not get enacted, but we expect it will be introduced again in this Congress. The legislation will require CMS to update the consolidated billing rules periodically to:

- Take into account the changing practice of medicine and clarify that Medicare may provide PPS-excluded services (such as MRI and radiation therapy) to SNF patients in freestanding clinics;

- Provide the Secretary with the authority to exclude high cost and low probability drugs that are used in the treatment of cancer, including antineoplastic antiemetics and supportive medications; remove the coding ranges currently in statute and provide the Secretary with full flexibility to determine exclusions in these areas without any statutory code constraints; and

- Exclude ambulance services from consolidated billing under the SNF PPS.

AHCA continues to believe that CMS does have the authority to address some of our concerns, however. We take the opportunity to place those in the record again and ask that CMS reconsider its position on the scope of its authority.

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[25] See for example, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006, Proposed Rule,* 70 Federal Register 29070, May 19, 2005 CMS-1282-P and AHCA Comments On The Proposed Rule , July 12, 2005.

[26] See H.R. 6199 – Introduced by Ginny Brown-Waite (R-FL), Dave Camp (R-MI) and Shelley Moore-Capito (R-WV), and S. 3815 – Introduced by Gordon Smith (R-OR) and Blanche Lincoln (D-AR).

A. Site of Service Consolidated Billing Rule

As indicated above, CMS has excluded magnetic resonance imaging (MRI), computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catherization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic, they are not excluded.

In 1998, the advent of PPS, CMS was reflecting then current medical practice in its development of the regulatory PPS exclusions. However, medical practice has changed, and the services in question are no longer exclusively within the purview of hospitals. While they remain outside the purview of SNFs, radiation therapy is now commonly provided in freestanding radiation therapy clinics, and MRIs are available from freestanding entities. Our understanding is that freestanding ambulatory surgery clinics have also been growing.

CMS should examine current medical practice and modify its policy of permitting certain services to be excluded only if provided in a hospital and permit these same exclusions if services are provided suitably and appropriately in sites other than hospitals, chiefly freestanding clinics. This policy change should be considered, at a minimum, for ambulatory surgery, MRIs, and radiation therapy services. Such a modification of this policy will not increase costs to the Medicare program -- and indeed may result in cost savings. Simply put, payment will be made to the freestanding clinic instead of the hospital. There is no reason why a hospital-only requirement should be retained when services can effectively, efficiently, and safely be provided in an alternative environment.

Further, there is no legal impediment to this policy change. There is no statute requiring that these CMS-provided exclusions must be provided in a hospital. As indicated above, CMS created this policy based on two factors: (1) that these services that patients could receive while in a SNF Part A stay were outside the scope of SNF services, and (2) that at the time of implementation of the PPS, these were "intensive diagnostic or invasive procedures that [were] specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. Certain of these intensive diagnostic or invasive procedures are no longer specific to the hospital setting because of changes in medical practice and technology. However, they remain outside the scope of SNF services. It is well within CMS' regulatory purview to update the policy to include providers, in addition to hospitals, who now commonly provide these intensive diagnostic and invasive procedures.

Moreover, and most importantly, a change in policy would enormously facilitate access to care in rural areas -- areas that now are being increasingly served by freestanding clinics. The benefit to patients in rural areas is clear. SNFs will not have to transport patients to distant hospitals for provision of excluded services when the services are available from closer freestanding clinics.

In the final rule of August 4, 2005, CMS reasserted its lack of authority to add services administratively to the existing exclusion list. See 70 Federal Register 45049. It also opined that advances in medical practice might even argue for removing certain exclusions. It is not clear what CMS meant by this since advances in medical practice have not made the provision of MRIs or CT scans feasible in a SNF; and such were never included in pre-PPS SNF payments.

In addition, the rule as it now stands has other unintended consequences. We refer CMS to the comments that are being submitted by the AHCA State Affiliate, the Massachusetts Extended Care Federation (MECF). The SNFs in Massachusetts continue to have a problem with MRIs and CT scans performed in acute care hospital outpatient departments under contract with independent MRI/CT scan companies. Even though these tests are in the acute hospital outpatient department and would appear to be an excludable item under Medicare PPS consolidated billing, the fact that the services are not being billed by the hospital has caused Medicare Part B to reject the claims as submitted by the contractor.

These services, which were provided in a hospital, should be excluded regardless of whether they were provided by hospital staff or under contract with an outside vendor. According to CMS' own current rule, the important consideration should be the site of service, not whether or not the service was contracted out. Many of MECF's members who sent their patients out for what they believed were radiological tests in an acute hospital outpatient department and therefore excludable from consolidated billing are receiving substantial bills for these services. CMS should clarify that the site of service is the driving condition for such an exclusion and should re-examine freestanding MRIs clinics as a site of service acceptable for an exclusion.

MECP also points out that the inclusion in consolidated billing of MRIs and CT scans done in freestanding clinics is especially unfair to Medicare beneficiaries and SNFs in Massachusetts. In many regions of Massachusetts, there are no acute care hospitals that provide MRIs and CT scans. In these regions, independent clinics are the only providers. SNFs are faced with the dilemma of sending their patients to the nearest provider and absorbing the significant cost or using a hospital outpatient department at a distance from the facility. Given patients' frailty, the choice providers make in virtually every instance is to use the closest provider. This exposes them to significant financial risk, as the claims are not billable under Medicare Part B.

We urge CMS to reconsider its position on this issue and permit exclusion when the affected services are provided in a freestanding clinic; at a minimum allow MRIs and CT scans provided to nursing facility Part A patients in a hospital or freestanding clinic to be excluded from the consolidated billing requirement.

B. Chemotherapy

As indicated above, we are working with Members of Congress to propose legislation that would provide the Secretary with broad authority to exclude high cost and low

probability drugs that are used in the treatment of cancer. The legislation is intended to overcome the limitation that CMS perceives in the BBRA prohibiting it from excluding antineoplastic antiemetics and supportive medications which while not chemotherapeutic agents are in themselves necessary to the treatment of cancer. The proposed legislation would also remove the coding ranges currently in statute, and provide the Secretary with full flexibility to determine exclusions in these areas without any statutory code constraints.

1. Recommended Drug Exclusions

In the interim, we take this opportunity to recommend that CMS add the following chemotherapy drugs, identified by code, to the excluded chemotherapy list. They are "traditional" cytoxic chemotherapies that meet the criteria for high cost and low probability. We ask that CMS address these individual drug exclusion recommendations in the final rule and clarify any coding concerns that the agency might have and the relationship of the codes to the specific statutory ranges.

Non-Excluded "J9" Chemotherapy Agents

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J9031		Bcg live intravesical vac Bacillus Calmette & Guerin	1 EA	113.57	1 dose diluted in 50ml NS weekly x 6 weeks then every 3 months thereafter	4	$454
J9165		Diethylstilbestrol injection	250 MG	12.14	500 mg daily for 5 days	2	$121
J9180		Epirubicin Hydrochloride	50MG	N/A	100-120mg/ml 3-4week cycle	28	N/A
J9190		Fluorouracil injection	500 MG	1.41	12mg/kg/d on days 1-4 non on day 5 then 6mg/kg on days 6,8 10 12 maintenance max 1g/week	4	$49
J9202		Goserelin acetate implant	3.6 MG	185.20	3.6 mg daily every 28 days	1	$185
J9209	C9428	Mesna injection	200 MG	12.98	400 mg every 6 hours for 5 days with ifosfamide	20	$519
J9213		Interferon alfa-2a inj	3 MIL UNITS	32.30	3 million IU daily for 16-24 weeks	30	$961
J9214		Interferon alfa-2b	1 MILLION UNITS	13.26	2 million IU 3 times weekly	12	$318
J9215		Interferon alfa-n3 inj	250000 IU	8.60	For venereal warts N/A	N/A	N/A
J9216		Interferon gamma 1-b inj	3000000 UNITS	272.44	1 million units/m2; 3 times per week	12	$2,287
J9217		Leuprolide acetate /7.5 MG	7.5 MG	229.85	7.5mg monthly	1	$230
J9218	C9430	Leuprolide acetate/ Per 1MG	PER 1 MG	10.76	once daily	30	$323
J9219		Leuprolide acetate implant (Viadur)	65 MG	2,314.14	65mg every 12 months	1	$193
J9260		Methotrexate sodium inj	50 MG	3.84	30-40mg/m2/week	4	$27

*Pricing was obtained from CMS Drug files and is based upon payment allowance limits subject to average sales price (ASP) methodology and is based on July 2005 ASP data.

APC Status Indicator legend: B = not paid under outpatient PPS; G = drug/biological; K = Paid under OPPS separate payment, not bundled; N = bundled.

2. Additional Cancer Treatment Drugs

CMS' interpretation of the statute results not only in CMS' inability to exclude traditional chemotherapy drugs that have cytotoxic properties but are outside the specific statutory ranges but also its inability to exclude other critical categories of drugs important in the treatment of cancer. These other drugs include antineoplastics which are new chemotherapeutic agents which are not cytotoxic but target cancer cells at various stages of reproduction and proliferation. They also include drugs that are traditionally used in combination with chemotherapy, such as antiemetics and supportive care drugs. These drugs are high cost and low probability drugs.

Antiemetics are those high-cost drugs used to treat the extreme nausea caused by chemotherapy and not general antiemetics used for other types of nausea. These drugs represent standards of care in oncology practice and are considered part of the chemotherapy regimen by oncologists. Supportive medications maintain blood cells, rescue healthy cells from toxic effects of antineoplastic drugs, and counteract the effects of cancer disease processes that spill over to other, nonmalignant organ systems (example: zoledronic acid to treat bone lesions affected by solid tumors).

To exclude chemotherapy from consolidated billing without excluding the drugs and biologicals needed in conjunction with this treatment is to place a financial burden on SNFs, as their costs far exceed the payment received under the PPS. Additionally, hospital outpatient departments are paid extra for these drugs and biologicals, since many are given a separate ambulatory payment classification (APC). In essence, these drugs and biologicals are unbundled for hospitals, but bundled for SNFs. These drugs are administered by injection: intravenously, intramuscularly or subcutaneously.

We ask that CMS support SNFs in our efforts to achieve legislation that would support the highest quality cancer treatment for Medicare beneficiaries; i.e., support us in our effort to have Congress provide the Secretary with the authority to exclude high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications. Congress should remove the coding ranges currently in statute and provide the Secretary with full flexibility and authority to determine exclusions in these areas without any statutory code constraints.

C. Ambulance Services

AHCA asks for CMS' support for the exclusion of ambulance services from consolidated billing under the SNF PPS. Ambulance services are fundamentally a Part B service and should be billed by Part B ambulance providers. This overall exclusion will remove consolidated billing as a source of confusion and error and thus contribute to greater focus on SNF and ambulance provider compliance with fundamental Medicare Part B ambulance coverage rules. We believe that the bulk of ambulance trips for SNF Medicare Part A beneficiaries are excluded from consolidated billing. However, those remaining cause incorrect billing and administrative waste for carriers, fiscal intermediaries, ambulance providers, and SNFs.

SNFs have to be alert to the general Medicare ambulance rules in order to assure that use of an ambulance for transport is covered under the federal regulations and meets the test

for emergency and nonemergency trips. However, there is the added set of arcane and complex rules that determine whether an ambulance trip can be billed to Medicare under Part B by the ambulance service provider or whether payment for the trip must be made to the ambulance provider by the SNF under SNF consolidated billing rules.

There are various sources of exclusion in both regulation and statute. In most cases, exclusion depends on whether the individual being transported is considered by CMS to be a SNF "resident" at the time of transport. If the individual is not considered to be a SNF "resident" then the ambulance trip is excluded from the SNF PPS and the ambulance provider can bill Medicare directly under Part B. Determination of whether or not a SNF is a resident for the purposes of ambulance billing can be extremely complicated, and it is easy to err.

We applaud CMS' efforts to clarify the governing rules and provide very reasonable exclusion within their authority. However, we believe that a thorny and unnecessarily arcane aspect of Medicare should be simplified at what we believe would be little cost to the Medicare program. We ask for CMS's support in this effort.

AHCA Recommendations on Consolidated Billing:

- *CMS should correct the site of service problem and permit exclusion of affected intensive diagnostic or invasive procedures when provided in a freestanding clinic;*
- *CMS should exclude the high cost and low probability cytoxic chemotherapy drugs recommended for exclusion by AHCA;*
- *AHCA requests that CMS support SNFs in our efforts to achieve legislation that would support the highest quality cancer treatment for Medicare beneficiaries; i.e., that CMS support us in our effort to have Congress provide the Secretary with the broadest authority to exclude high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications; to remove the coding ranges currently in statute and to provide the Secretary with full flexibility and authority to determine exclusions in these areas without any statutory code constraints; and*
- *AHCA requests CMS' support for the legislative exclusion ofall ambulance services from consolidated billing under the SNF PPS.*

Appendix A:

With input from Eljay LLC and provider members of AHCA and the Alliance, United BioSource Corporation (UBC) undertook research and analysis on behalf of the profession to replicate market basket methodologies, estimate weights, and analyze the impact on the profession. A description of the data and methodology used by UBC to estimate the market basket weights for the proposed CMS methodology and alternative methodologies is described below.

Data

In the NPRM, CMS utilized data from the CMS SNF Master File. Similarly, the UBC analysis was conducted using the CMS SNF Master File, as available from the CMS website. UBC extracted cost reports with dates beginning after September 30, 2003 and before October 1, 2004, as did CMS. UBC conducted its analysis on the corrected cost report file posted on June 4, 2007.[27] (The late posting of the corrected file significantly reduced the time available for our analysis of the corrected data set.)

Editing

UBC's editing methodology paralleled the CMS editing methodology. The data were edited for any values which would raise doubt about the accuracy of the data or distort the analysis. For example, if total costs were less than or equal to zero, the facility was not included in the analysis on a pair wise basis. Similarly, UBC implemented outlier edits. After these edits were completed there were 9,862 facilities in the analytical data file.

Methodology

UBC calculated the weights by extracting the appropriate Medicare and total facility data from the cost report file. The exact variables and formulas we used are contained in

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[27] The analysis in this paper is based on the Medicare public use files. On June 4, 2007, CMS issued an alert regarding these files stating that "(t)he ... SNF ... cost report files have been corrected. The datatype problem has been fixed." In the absence of any accompanying documentation, a comparison of the old and the new data files suggests that the problem was related to the "key" variable RPT_REC_NUM. This is the field that links the provider level information (SNF_RPT_FY2001-current.csv) to the numeric response data (SNF_RPT_NMRC_FY2001-current.csv). This linkage is critical for the proper alignment of information kept in the separate file structures. An improper linkage would cause specious problems not readily apparent.

The "new" data are approximately 3% larger than the "old" data in volume, principally due to the addition of new key variable values. Looking specifically at cost reports for cost report periods beginning during federal fiscal year 2004, we found wide variation. We found fields that were not populated in the old data becoming populated in the new, fields that were populated in the old data becoming unpopulated in the new, and large changes in reported values, in both the positive and negative directions. The unsystematic nature of the differences between the new and old files required redoing analyses that were conducted using the old. This change effectively resulted in the loss of half the comment period for those concerned with analyzing the data and formulating recommendations.

Appendix B. Using the data and calculations described above, we duplicated the category weights published in Table 16 of the NPRM (page 25548) to assure that the analytical data file was very similar to the one used by CMS (See column 1 of Table 4).

Subsequent to the publication of the proposed rule, CMS made available a revised methodology for the computation of the CMS alternative for the pharmacy component. Column 2 of Table 4 shows the UBC estimates. The exact variables and formulas we used are contained in Appendix C.

UBC did not estimate the market basket weights for all 23 market basket components. Weights were calculated for the proposed CMS methodology and the alternative LTC profession methodology for the following components only: Wages and Salaries, Employee Benefits, Professional Liability Insurance and Pharmaceuticals. The weights for wages and salaries, employee benefits, and pharmaceuticals were determined by the particularly methodology, and the weight for capital was kept constant. The weights for the remaining components were consequently reapportioned so that the sum of all 23 market basket weight components summed to 100%

Appendix B:

Appendix B: Medicare Based Market Basket

Denominator- Medicare Reimbursable Costs	**Cost Report Worksheet**	**Line**	**Column**
Medicare Routine Service Cost	D-1, Part I	19	NA
Plus:			
Medicare Ancillary Cost	D, Part I	75	4
Equals Medicare Reimbursable Costs			
(1) Wages and Salaries	**Cost Report Worksheet**	**Line**	**Column**
Medicare Reimbursable Nursing Salaries			
Skilled Nursing	Worksheet A	16	1
Divided by:			
Medicare unit days	D-1, Part I	1	N/A
Equals Medicare Unit Nursing Salaries ppd			
Multiplied by:			
Medicare days	D-1, Part I	3	N/A
Equals Medicare Reimbursable Nursing Salaries			
Plus:			
Non-Nursing Medicare Reimbursable Salaries-Routine			
Sum of:			
Employee Benefit Salaries	Worksheet A	3	1
Admin	Worksheet A	4	1
Plant Operations	Worksheet A	5	1
Laundry and Linen	Worksheet A	6	1
Housekeeping	Worksheet A	7	1
Dietary	Worksheet A	8	1
Nursing Administration	Worksheet A	9	1
Central Service and Supplies	Worksheet A	10	1
Pharmacy	Worksheet A	11	1
Medical Records	Worksheet A	12	1
Social Services	Worksheet A	13	1
Interns and Residents	Worksheet A	14	1
Other General Service Cost	Worksheet A	15	1
Subtotal			
Divided by:			
Total Days	S-3, Part I	9	7
Equals Non-Nursing Salaries-Routine ppd			
Multiplied by:			
Medicare days	D-1	3	N/A
Equals Non-Nursing Medicare Reimbursable Salaries-Routine			
Plus:			
Medicare Reimbursable Ancillary Salaries and Contract Therapy			

Medicare Reimbursable Ancillary Salaries and Contract Therapy	Cost Report Worksheet	Line	Column
Radiology Salaries	Worksheet A	21	1
Multiplied by Medicare Charges	Worksheet D, Part I	21	2
Divided by Total Charges	Worksheet C	21	2
Lab Salaries	Worksheet A	22	1
Multiplied by Medicare Charges	Worksheet D, Part I	22	2
Divided by Total Charges	Worksheet C	22	2
IV Salaries	Worksheet A	23	1
Multiplied by Medicare Charges	Worksheet D, Part I	23	2
Divided by Total Charges	Worksheet C	23	2
Oxygen Salaries	Worksheet A	24	1
Multiplied by Medicare Charges	Worksheet D, Part I	24	2
Divided by Total Charges	Worksheet C	24	2
PT Salaries	Worksheet A	25	1
Multiplied by Medicare Charges	Worksheet D, Part I	25	2
Divided by Total Charges	Worksheet C	25	2
PT Contract=PT Total Expenses	Worksheet B, Part I	25	0
Minus:			
PT Salaries	Worksheet A	25	1
Equals PT Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	25	2
Divided by Total Charges	Worksheet C	25	2
OT Salaries	Worksheet A	26	1
Multiplied by Medicare Charges	Worksheet D, Part I	26	2
Divided by Total Charges	Worksheet C	26	2
OT Contract=OT Total Expenses	Worksheet B, Part I	26	0
Minus:			
OT Salaries	Worksheet A	26	1
Equals OT Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	26	2
Divided by Total Charges	Worksheet C	26	2
Speech Salaries	Worksheet A	27	1
Multiplied by Medicare Charges	Worksheet D, Part I	27	2
Divided by Total Charges	Worksheet C	27	2
Speech Contract=Speech Total Expenses	Worksheet B, Part I	27	0
Minus:			
Speech Salaries	Worksheet A	27	1
Equals Speech Contract			
Multiplied by Medicare Charges	Worksheet D, Part I	27	2
Divided by Total Charges	Worksheet C	27	2
Electrocardiology Salaries	Worksheet A	28	1
Multiplied by Medicare Charges	Worksheet D, Part I	28	2
Divided by Total Charges	Worksheet C	28	2
Medical Supplies Salaries	Worksheet A	29	1
Multiplied by Medicare Charges	Worksheet D, Part I	29	2

Medicare Reimbursable Ancillary Salaries and Contract Therapy	**Cost Report Worksheet**	**Line**	**Column**
Divided by Total Charges	Worksheet C	29	2
Drugs Salaries	Worksheet A	30	1
Multiplied by Medicare Charges	Worksheet D, Part I	30	2
Divided by Total Charges	Worksheet C	30	2
Dental Salaries	Worksheet A	31	1
Multiplied by Medicare Charges	Worksheet D, Part I	31	2
Divided by Total Charges	Worksheet C	31	2
Support Surfaces Salaries	Worksheet A	32	1
Multiplied by Medicare Charges	Worksheet D, Part I	32	2
Divided by Total Charges	Worksheet C	32	2
Other Ancillary Salaries	Worksheet A	33	1
Multiplied by Medicare Charges	Worksheet D, Part I	33	2
Divided by Total Charges	Worksheet C	33	2

Equals Medicare Reimbursable Ancillary Salaries and Contract Therapy

Medicare Salary Percentage= (Medicare Reimbursable Nursing Salaries Plus Medicare Reimbursable Non-Nursing Salaries-Routine Plus Medicare Reimbursable Ancillary Salaries and Contract Therapy) Divided by Medicare Reimbursable Costs

(2) Benefits	**Cost Report Worksheet**	**Line**	**Column**
Employee Benefits	B, Part 1	3	0
Times Ratio of			
Medicare Reimbursable Salaries (from #1) to			
Total Salaries	Worksheet A	75	1
Equals Medicare Reimbursable Benefits			

Benefits Percentage= Medicare Reimbursable Benefits Divided by Medicare Reimbursable Costs

(3) Contract Labor	**Cost Report Worksheet**	**Line**	**Column**
Contract Labor Patient Related and Mgmt	S-3, Part 2	17	3
Minus:			
Contract Therapy (Lines 69, 80, and 91 above)			
Times Ratio of			
SNF Wages and Salaries Divided by	B, Part 1	16	0
SNF and NF Wages and Salaries	B, Part 1	16 and 18	0
Equals Allowable Contract Labor			

Contract Labor Percentage =Allowable Contract Labor Divided by Medicare Total Allowable Expenses (as Defined in "CMS" sheet, line 11)

(4) Drug Costs	Cost Report Worksheet	Line	Column
Drugs Charged to Patients Plus	B, Part 1	30	0
Pharmacy Non-Salary			
Pharmacy Non-Salary =Total Pharmacy	B, Part 1	11	0
Less Pharmacy Salaries	Worksheet A	11	1
Equals Drugs Plus Pharmacy Non-Salary Cost			
Multiplied by Medicare Charges	Worksheet D, Part I	30	2
Divided by Total Charges	Worksheet C	30	2

Equals Medicare Reimbursable Drug Costs

Drug Percentage= Medicare Reimbursable Drug Costs Divided by Medicare Reimbursable Costs

(5) Malpractice	Cost Report Worksheet	Line	Column
Malpractice Premiums and Paid Losses	S-2	45	N/A
Times Ratio of			
Medicare Reimbursable Costs (See First Calculation on This Spreadsheet) to			
Total Expenses	B, Part 1	75	0
Equals Medicare Malpractice Premiums and Paid Losses			

Malpractice Percentage =Medicare Malpractice Premiums and Paid Losses Divided by Medicare Reimbursable Costs

(6) Capital	Cost Report Worksheet	Line	Column
Medicare Capital	D-1, Part I	22	N/A

Capital Percentage= Medicare Capital Divided by Medicare Reimbursable Costs

Appendix C:

Description of the Alternative LTC Profession's Methodology for the Pharmacy Component

- Calculate pharmacy salaries. This is done by multiplying drugs charged to patient salaries times the ratio of Medicare charges to total charges.
- Next calculate drugs charged to patients plus pharmacy non-salaries.
- Then multiply this by the ratio of Medicare charges to total charges.

Using the form WORKSHEET_COLUMN_LINE the following formulas detail the calculations used to acquire the alternative LTC profession's methodology for the pharmacy component:

Drug Salaries = A_C1_L30 * (D_Part1_C2_L30 / C_C2_L30)

Drug Costs = SUM(B_Part1_C0_L30, B_Part1_C0_L11, –A_C1_L11) *
(D_Part1_C2_L30 / C_C2_L30)

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PROVIDENCE
Health & Services

June 29, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

REF: CMS-1545-P

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2008; Proposed Rule

Dear Ms. Norwalk:

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide our comments on the changes proposed by the Centers for Medicare and Medicaid Services (CMS) to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing. CMS published these changes as part of its Notice of Proposed Rule Making (NPRM) in the *Federal Register* on May 4, 2007. Providence Health & Services is a faith-based, non-profit health system that includes 26 hospitals, more than 34 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 45,000 employees and numerous other health, housing and educational services in Alaska, Washington, Montana, Oregon, and California.

As a Catholic health care system striving to meet the health needs of people as they journey through life, Providence is pleased to submit comments on several areas related to the proposed changes to the SNF PPS which were published in the *Federal Register* (Vol. 72, No. 86, pages 25526-25600) on May 4, 2007. We have long considered SNFs to be an integral component of the continuum of care we've developed over the past 150 years and a vital care setting for those patients with intense and specialized rehabilitation needs following a hospitalization. Our skilled nursing facilities provided 552,131 patient days of care in 2006, many of which were provided to Medicare beneficiaries.

We applaud the efforts of CMS to refine the SNF PPS to improve both the performance and appropriateness of payments and we support several changes being proposed:

- Updating the payment rates;
- Rebasing the market basket base year; and
- Revising the market basket.

Other provisions in the Proposed Rule are welcome changes; however, Providence has some specific comments and concerns as outlined below.

Background – Forecast Error Adjustment

In the SNF PPS final rule for FY 2004, CMS instituted a forecast error adjustment process to adjust for differences between the projected and actual market basket update. The policy reason for instituting a forecast error adjustment is to account for exceptional, unanticipated major increases in wages and benefits as opposed to adjusting for smaller variances that typically occur from year to year. Currently the threshold for this adjustment is 0.25 percentage point and CMS is proposing to raise this threshold to 0.5 or even 1.0 percentage point. CMS believes it is appropriate to specify a threshold that will distinguish between the major forecast errors that gave rise to this policy initially and the far more typical minor variances that have consistently occurred in each of the succeeding years.

While we recognize the simplicity of creating a forecast error process substantially similar as to the process used for the hospital inpatient PPS system, Providence Health & Services is concerned about such a high threshold having a devastating cumulative effect on SNFs. For instance, if the threshold is set at 0.5 percentage point, and for two years in a row the difference between forecast and actual market basket increase equals 0.4 percentage point, no error adjustments would be made. Such cumulative effects would fail to adjust for variances that are, in fact, major forecast errors.

Recommendation:

Providence Health & Services urges CMS to further study and analyze market basket data to determine the appropriate forecast error threshold before any changes in the current 0.25 percentage point threshold are made. If CMS proceeds with raising the existing threshold to 0.5 or 1.0 percentage point, we urge CMS to institute a separate threshold that would recognize cumulative forecast errors over a two or three year period.

Revising and Rebasing the SNF Market Basket Index

We are cognizant of the fact that the statute creating the SNF PPS is very prescriptive with respect to the creation and use of a SNF market basket. Section 1888(e)(5)(A) of the Act requires CMS to establish a market basket that reflects the changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. The last time CMS revised and rebased the SNF market basket was in 2001 when FY 1997 was used as the base year. This year, CMS is proposing to revise and rebase the SNF market basket to a base year of FY 2004.

Recommendation:

Providence supports the proposal by CMS to rebase the SNF market basket to a base year of FY 2004. We urge CMS to consider more frequent rebasing, at least every four years, to establish an accurate SNF market basket that is responsive to real changes in input prices and the relative mix of goods and services characterizing SNF care. More frequent rebasing is an important policy tool that CMS should utilize – in addition to adjusting for forecast error – to assure the overall adequacy of the SNF market basket.

Consolidated Billing

Under consolidated billing requirements, a SNF is responsible for virtually all of the services that SNF residents receive, except for services that have been specifically excluded under the rules. Section 103 of the BBRA amended the consolidated billing provisions by excluding a number of individual high-cost, low-probability services (identified by HCPCS codes) within the categories of chemotherapy and its administration, radioisotope services, and customized prosthetic devices. The Secretary has been granted the authority to designate additional, individual services for exclusion within each of the categories specified by the BBRA in an effort to avoid devastating financial impacts to SNFs when the costs of these services far exceed the payments received under the PPS.

Providence Health & Services appreciates the willingness of CMS to consider suggestions for identification of services that might appropriately be excluded from the consolidated billing requirements of the SNF PPS. We have several recommendations to offer for consideration:

1. Epoetin Alfa for non-ESRD use (HCPCS: J0885): This injection is often given to SNF residents prior to or concurrently with ordered chemotherapy. While the chemotherapy drugs are excluded from consolidated billing, this expensive treatment is not and SNFs absorb the costs under their daily PPS rate. Because of the high costs associated with this particular medication (up to $500 per injection), the payment rates provided to SNFs for residents who require this medication are grossly inadequate. We urge CMS to add HCPCS J0885 to the consolidated billing exclusion list when this medication is provided to SNF residents in conjunction with chemotherapy.

2. Darbepoetin Alfa for non-ESRD use (HCPCS: J0881): This injection is also often used for SNF residents receiving chemotherapy. Currently, costs associated with this drug are part of the SNF daily rate which is entirely inadequate to cover the costs of care. Providence Health & Services urges CMS to exclude HCPCS J0881 from consolidated billing requirements when this medication is used in coordination with chemotherapy for SNF residents.

3. Radiation Therapy (HCPCS: 77280-77421): While these services are excluded from consolidated billing when provided at a hospital or hospital outpatient setting, many SNF residents receive these services from free-standing clinics. In several communities where Providence offers SNF services, the only setting available for radiation services is at a free-standing clinic and thus, the services are part of consolidated billing. The costs incurred for residents requiring these types of services is not captured under the daily PPS rate. While Providence understands that Congress must act to grant CMS the authority to exclude these services, we urge CMS to engage the Congress in discussions to address the plight of these residents and the providers who struggle with the fiscal reality of serving them. There are many SNF residents who require radiation therapy services; however without excluding these services from consolidated billing when provided in freestanding clinics, Medicare beneficiaries are at risk for lacking adequate access to care.

In closing, thank you for the opportunity to review and comment on the Proposed Changes to the Medicare Program SNF Prospective Payment System and Consolidated Billing for Fiscal Year 2008 NPRM. Please contact Beth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about any of the material in this letter.

Sincerely,

John Koster MD

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services