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Issues-Medicare-Non-therapy Anciliary Services - 11/98

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TODD SUMMERS BOX 5 (five)

Office of National AIDS Policy
736 Jackson Place, NW

Issues -- Medicare Non Therapy Ancillary Services 11/98
Issues -- Medicare – League of Women's Voters
Issues -- Needle Exchange Advocates Information
Issues -- Needle Exchange Announcement Rollout
Issues – Needle Exchange – Coburn Amendment
Issues -- Needle Exchange Congressional Black Caucus
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Issues – Needle Exchange – FY 98 Appropriations Language
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Issues – Needle Exchange Legislation – Coverdell (S. 1959)
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Issues – Needle Exchange Programs – Alexandria, VA
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Issues – Needle Exchange – Vancouver
Issues – Needle Exchange Studies – CDC
Issues – Needle Exchange Studies – Larry Gostin
Issues – Needle Exchange Studies – Hurley
Issues – Needle Exchange Studies – Peter Lurie
Issues – Needle Exchange Studies – NIH
Issues – Needle Exchange Studies – NY City Planning Council

OA # 21080
VARA #18301

Issues – Needle Exchange Studies Summary
Issues – Needle Exchange Studies USCF (costs)
Issues – NIH Treatment Guidelines
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Issues – Ricky Ray Hemophilia Act
Issues – Ryan White Reauthorization CARE Act
Issues – Ryan White Reauthorization CARE Act – Title II
Issues – Ryan White Reauthorization CARE Act -- Titles I and III
Issues – SAMHSA Reform

GOVERNMENT AND PUBLIC RELATIONS

THE Sheridan GROUP

FAX TRANSMITTAL

DATE: 11/6/98

TO: Todd Summers

FAX #: 456-2438

FROM:

5 **PAGES INCLUDING COVER SHEET**

1808 SWANN STREET NW • WASHINGTON DC 20009
phone 202.462.7288 *fax* 202.483.1964

Congress is expressing its explicit and implicit view that--

1. HCFA's PPS plan does not satisfy threshold Congressional provisions about the adequacy of data and methodology for case-mix adjusting

2. HCFA has the authority to make modification

Senate Approps
? House Ways and Means
? Lott
Gingrich
Daschle, Breaux, Harkin
? Hatch, Grassley
WA delegation re AIDS

HCFA's rationale of "operational impediment" for flexibility in implementing other BBA Medicare provisions should apply to this point

For purposes of beginning PPS on July 1, HCFA did not have either adequate data or adequate methodology to case-mix adjust for non-therapy ancillaries in manner sufficient to satisfy the intent of Congress

> BBA -> "The Secretary shall provide for an appropriate adjustment to account for case mix...that accounts for the relative resource utilization of different patient types...based on...data that the Secretary considers appropriate" (section 1888(e)(4)(G)(i))
>
> Conferees -> "The Conferees note that under the proposed SNF prospective payment system, services and supplies provided to residents will be included in pre-determined per diem payment rates. To ensure that the frail elderly residing in SNFs receive needed and appropriate medication therapy, the Secretary should consider the results of studies conducted by independent organizations including those which examine appropriate payment mechanisms and payment rates for medication therapy under a prospective payment system for SNFs. It is the intent of the Conferees that the Secretary develop case mix adjusters that reflect the needs of such patients." (p. 758 of H.Rept. 105-217)

HCFA's recently completed contract (? Abt Associates) and recently let contract regarding non-therapy ancillaries are an implicit concession about the adequacy of its interim final rulemaking on this point

HCFA's handling of non-therapy ancillaries was the major point of objection in the public comments on the interim final rulemaking

Only a retrospective modification is possible because the payment system began before comment period on the rulemaking was completed.

For the new payment system beginning July 1, HCFA published interim final rulemaking on May 12. The comment period was initially open until July 13 and later extended to September 11.

HCFA's rulemaking waived the following two provisions of the Administrative Procedures Act

- No notice of proposed rulemaking and comment period -- with subsequent agency review and response before final rulemaking
- No 60-day period for Congressional review before major rules can become effective

Further, it should be noted be that in BBA Congress specifically approved use of interim final regulations for some health provisions, but SNF PPS was not one of them.

With specific regarding to non-therapy ancillaries, it should be noted that the interim final rulemaking did not produce data or methodology for non-therapy handling

In *American Lithotripsy Society v. Sullivan*, a Medicare rule was remanded for reconsideration because HCFA failed to publish relevant research information upon which the rule was based and did not provide the public a chance to comment on the methodology used to derive payment.

The following is an excerpt from the Court's decision:

> "This Circuit has made it clear that the public must have an opportunity to comment on information that is material to an agency's decision in a rulemaking *before* the final rule is published...One of the primary reasons for having a comment period is to provide an opportunity for 'adversarial discussion among the parties.'...Similarly, the agency itself cannot function properly without having the benefit of such comments before it makes any final decisions.
>
> There is no such adversarial comment in the present record because...information crucial to the final notice was never put in the record in sufficient time to allow comment. The agency must publish the data and other information it is relying on in setting a rate and allow time for comment before issuing final notice, which is to be done promptly. The current notice is stayed pending publication of a final notice pursuant to the remand."

The nature of interim final rulemaking is that interim modifications are possible and likely. [HCFA needs to complete the interim final rulemaking process by responding to comments and making appropriate adjustments before proposed rulemaking for FY 2000 is published.]

HCFA maintains that preferred approach of revising the FY 1999 rates is not operationally possible, and so a "lookback" is proposed with the rates used for cash-flow purposes.

HCFA is inconsistent in granting itself flexibility to implement a less than 100% case-mix adjusted system while seeking to insist on a 100% prospective system.

Flat rate payment is used for an average of more than 43% of the total payment for the 30 non-rehab RUGs.

A flat rate of $55.88 would be paid to urban SNFs and $56.95 to rural SNFs for "non-case mix component". This component covers many routine costs (e.g., food, housekeeping and utilities) and capital cost.

Therapy costs for most of SNF patients would be paid on a flat rate basis. For the 30 of the 44 RUGs which are not in the rehab category, a flat rate of $10.91 would be paid for urban SNFs and $11.66 for rural SNFs for "therapy non-case mix component". Although there are 14 rehab RUGs for urban and rural SNFs, there are only 5 adjustments for their "therapy component."

[HCFA makes the rebuttal claim that its use of flat rates is supported by data, but provides no showing of supporting data.]

HCFA view that separate consideration of non-therapy ancillary costs within the PPS would somehow be an impressible "unbundling" of the rate is not supported by fact or logic.

We are not contending that non-therapy ancillaries be made a "services exclude" under section 1888(e)(2)(A)(ii).

We are proposing a different distribution of payments for non-therapy ancillaries within the same total payment budget.

Furthermore, the proposed modification would only be for one year.

NON-LEGISLATIVE ACTION ON MEDICARE NURSING HOME NON-THERAPY ANCILLARY SERVICES

Correcting the problem of the new Medicare prospective payment system (PPS) -- overpaying for light care patients and underpaying for heavy care patients -- should be achievable administratively.

Health Care Financing Administration's (HCFA) first line of defense is, "We don't have the statutory authority."

Many key Republicans and Democrats have tried to tell Secretary Shalala what the Balanced Budget Act (BBA) provision says and means.

Also, attached is legal opinion from a former HHS General Counsel finding an alternative interpretation of BBA to support a short-term transition for non-therapy ancillaries until HCFA has adequate data for case-mix adjustment.

HCFA's resistance may trigger a legal challenge to the entire PPS regualtion because of a pattern of HCFA abuse of power and procedure. Most notably, HCFA's use of "interim final" rulemaking violated Medicare statute which prohibits this shortcut when HCFA has more than 150 days to use the normal proposed regulations stage.

A judicial remand of the PPS regulations, combined with HCFA's Year 2000 computer mess, could endanger almost $5 billion in expected two year savings.

Calendar No. 539

105TH CONGRESS
2d Session

SENATE

REPORT
105–300

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATION BILL, 1999

SEPTEMBER 8 (legislative day, AUGUST 31), 1998.—Ordered to be printed

Mr. SPECTER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany S. 2440]

The Committee on Appropriations reports the bill (S. 2440) making appropriations for Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 1999, and for other purposes, reports favorably thereon and recommends that the bill do pass.

Amount of budget authority

Total bill as reported to Senate	$287,592,472,000
Amount of adjusted appropriations, 1998	262,257,417,000
Budget estimates, 1999	286,606,839,000
The bill as reported to the Senate:	
Over the adjusted appropriations for 1998	25,335,055,000
Over the budget estimates for 1999	985,633,000

50–712 cc

needs. This is expressly not in keeping with congressional intent to prohibit the mandatory enrollment of children with special health care needs in Medicaid managed care until such time as it can reasonably assure special needs children's access to appropriate care.

In this report, the Committee has requested the Social Security Administration to carry out a multistate demonstration testing the feasibility of providing one-stop shopping for health care benefits to low-income Medicare beneficiaries, by allowing Medicare beneficiaries to apply for qualified Medicare beneficiary and specified low-income Medicare beneficiary benefits at Social Security offices. The Committee expects that HCFA will cooperate fully with the Social Security Administration in implementing this demonstration.

The Committee is concerned that the current Medicare DRG payment system may not adequately cover the costs of a significant new technology to assist quadriplegics. The freehand system allows quadriplegics to regain functional hand motion, thus increasing independence. The Committee urges HCFA to examine the adequacy of its payment for the implantation of this new technology and make adjustments, such as a new DRG, as appropriate to assure patient access.

The Committee has heard concerns regarding the equity of the new Medicare SNF prospective payment system as it relates to nontherapy ancillaries. The demonstration upon which the new system was based did not include this class of items and services. Due to the lack of sufficient data to make these changes, the new system may provide a windfall for some providers while seriously impairing the ability of others to treat patients requiring more intensive care. Therefore, the Committee urges HCFA to reexamine this policy an make budget-neutral changes this year to assure continued access to services for high cost patients pending the gathering of sufficient data on which to base permanent reforms.

The Committee has been informed that new Medicare payment policies for hospital-based psychiatric units have created financial problems for rural hospitals providing mental health services to elderly patients. Their patients tend to be older, have complicating medical conditions, and long lengths of stay. Beneficiaries receiving mental health services in units in urban and suburban hospitals are younger and have shorter stays. Thus the cost of care in the rural hospital is higher; however, the new payment formula is weighted to the lower costs of the urban and suburban institutions. The Committee is aware of concerns that rural hospitals will no longer be able to provide psychiatric care to their elderly patients and recommends that HCFA consider taking steps to develop a separate payment rate for rural hospitals that better reflects their true costs of providing mental health care to elderly beneficiaries. HCFA should report back to the Committee by February 1, 1999, on its actions with respect to this matter.

The Committee is concerned that in developing a prospective payment system [PPS] for hospitals certified to participate in the Medicare program as long-term care hospitals under section 1886(d) of the act, that HCFA may be developing a payment system based on resource utilization groups [RUG's] used to make Medicare payments to skilled nursing facilities.

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FOX, BENNETT & TURNER
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SUITE 1100
WASHINGTON, D. C. 20006

TERRY S. COLEMAN

TELEPHONE: 202-778-2300
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MEMORANDUM

DATE: September 28, 1998

RE: HCFA's Authority Under the Skilled Nursing Facility Prospective Payment System

This memorandum analyzes the question of whether the Health Care Financing Administration (HCFA) has the authority under the prospective payment system (PPS) for skilled nursing facilities (SNFs) established by § 1888(e) of the Social Security Act to pay for non-therapy ancillary costs on a cost reimbursement basis for a period of time until better data are developed. The memorandum concludes that HCFA does have such authority.

Background

The Balanced Budget Act of 1997 requires HCFA to establish a PPS for SNFs effective for cost reporting periods beginning on or after July 1, 1998. The statute requires HCFA to establish payment rates that are adjusted for a facility's case mix, and the statute includes a phase-in period during which a federal rate is increased in proportion to a facility-specific rate in determining the rate for each SNF. Interim final rules were issued, without opportunity for prior public comment, on May 12, 1998 (63 Fed. Reg. 26252). The PPS adopted by HCFA included an adjustment for case mix based on a resource utilization group (RUG)

classification system. HCFA allowed the public to submit comments with respect to the interim rules through September 11, 1998.[1]

Comments opposed HCFA's treatment of non-therapy ancillary costs (such as drugs and laboratory services) under the PPS. HCFA's demonstration project on case mix had not incorporated those costs into its PPS, and the comments opposed HCFA's decision to incorporate them at this time. There is substantial concern that nursing facilities treating patients with high non-therapy ancillary costs will be seriously disadvantaged by the PPS that HCFA has adopted and that patient access will also be adversely affected. The comments urged HCFA to continue paying for non-therapy ancillary costs on a pass-through (reasonable cost) basis until research has been completed and an adequate payment methodology developed.

HCFA has apparently questioned whether it has the statutory authority to pay for non-therapy ancillary costs on a time-limited, pass-through basis. As discussed below, HCFA does have this authority, and therefore it is within HCFA's discretion to pay for such costs on a pass-through basis.

Analysis of the Statute

Section 1888(e)(4)(A)-(F) sets forth the method for calculating the federal per diem rate. After the basic, unadjusted federal rate is calculated in the specified manner, HCFA is required by § 1888(e)(4)(G)(i) to compute an "adjusted Federal per diem rate" for each SNF for the fiscal year. In making that computation, the statute requires the following:

> "The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident

[1] 63 Fed. Reg. 37498 (July 13, 1998).

> classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate."

This provision is sufficient authority for HCFA to adopt a case-mix adjustment that takes the form of a pass-through of non-therapy ancillary costs in addition to an adjustment of the rate based on the RUG classification system. Each element of the statutory provision can be reconciled with this approach.

First, the statute requires that case mix be taken into account through an "adjustment" of the rate, which raises the question whether payment of certain costs on a pass-through basis can be characterized as an "adjustment" of the rate. The term "adjustment" does not have a fixed meaning, and it can have a very broad scope.[2] Since payment of certain costs on a pass-through basis would literally be an "adjustment" of the otherwise applicable rate, this requirement of the statute would be satisfied.

Second, the statute calls the end result after the adjustment "an adjusted Federal per diem rate." Although the term includes the words "per diem," making a portion of the payment to SNFs on a cost pass-through basis is not inconsistent with that term, since it is not defined in the statute. The statute does not mandate, either directly or through a definition of that term, that the entire payment be made on the basis of days.

Third, under the statute the case-mix adjustment must be based on a "resident classification system" and "resident assessment data and other data that the Secretary considers

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[2] See, e.g., Texaco, Inc. v. Department of Energy, 460 F. Supp. 339, 344 (D.D.C. 1978) (holding that the term "adjustment" in a statute allowing adjustments to rules and regulations was not clear on its face and giving it a very broad reading in light of the statutory context).

appropriate." The RUG system would remain a part of the case-mix adjustment, and thus these provisions would be satisfied. Nothing in this language requires that the resident classification system and resident assessment data must be the exclusive basis for the case-mix adjustment.

Finally, nothing in this adjustment would be inconsistent with the rules in § 1888(e)(4)(A)-(F) for calculation of the unadjusted federal per diem rate. That rate can continue to be calculated as proposed, including the adjustment for case mix under § 1888(e)(4)(C)(ii). The statute does not require that the adjustment for case-mix variation used to standardize the rates under subparagraph (C)(ii) must be the same method used to calculate the adjusted Federal per diem rate under subparagraph (G)(i).[3]

Budget neutrality is assured by the express requirement in § 1888(e)(4)(F) that HCFA calculate the unadjusted Federal per diem rate to take into account any projected change in aggregate payments resulting from the case-mix adjustment adopted under subparagraph (G)(i). Thus, if HCFA believes that paying non-therapy ancillary costs on a pass-through basis would affect aggregate payments, the statute clearly authorizes a countervailing modification of the federal rate.

Since there is no obstacle in the language of the statute, the issue is whether HCFA concludes that paying for non-therapy ancillary costs on an interim basis is an appropriate method "to account for case mix" as the statute requires. If HCFA so determines, then it can adopt the cost pass-through. By exempting a significant portion of the payment rate from a case-mix adjustment in the interim rules, HCFA has itself shown that § 1886(e)(4)(G)(i) authorizes

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[3] Thus, as a simplified example, if the unadjusted Federal per diem rate is now $100, that rate would remain at $100, but the average adjusted Federal per diem rate might be $80 per day plus non-therapy ancillary costs.

great flexibility in how the rates may be adjusted to account for case mix. This flexibility can also encompass a cost pass-through for non-therapy ancillary costs.

A case-mix adjustment of this type would be consistent with congressional intent. The congressional committee reports refer to the demonstration project conducted by HCFA with a RUG-based payment method.[4] Since the demonstration project paid for non-therapy ancillary costs on a pass-through basis, it is entirely reasonable to assume that Congress envisioned a continuation of the same payment method, or at least that it would view the same payment method as an appropriate case-mix adjustment.

HCFA Precedent

Continuing to pay certain costs outside the fixed rate is not inconsistent with a prospective payment system. In implementing the PPS for inpatient hospital services, HCFA relied on the exceptions and adjustments authority[5] in that statutory provision to create special, non-prospective payment mechanisms:

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[4] H.R. Rep. No. 149, 105th Cong., 1st Sess. 1315 (1997); H.R. Rep. No. 217, 105th Cong. 1st Sess. 754 (1997).

[5] As originally enacted, the provision read:

> "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate (including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)."

Social Security Act, § 1886(d)(5)(C)(iii), as added by § 601(e), Pub. L. No. 98-21. The provision continues to exist in modified form as § 1886(d)(5)(I)(i), 42 U.S.C. § 1395ww(d)(5)(I)(i).

- The costs of harvesting organs for transplantation are exempt from PPS and paid on a reasonable cost basis.[6] When it issued the regulation, HCFA characterized this policy as an "adjustment to prospective payment."[7] The policy, which was originally applicable only to kidney acquisition, has subsequently been extended so that Medicare also pays on a reasonable cost basis for hospitalizations related to procurement of hearts, lungs, and livers for transplantation.[8]
- Although services incident to physicians' services were required by the PPS legislation to be included in the PPS payment amounts, HCFA created a "time-limited exception" to this requirement for the services of anesthetists employed by physicians.[9] These services were to be paid on a reasonable charge basis for the first two years.[10]
- HCFA exempted a number of cancer hospitals from PPS altogether for reasons related to their case mix. Because these hospitals had cases that were "legitimately more costly" than the cases on which the payment rates

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[6] 42 C.F.R. § 412.2(e)(4).

[7] 48 Fed. Reg. 39783 (Sept. 1, 1983).

[8] 55 Fed. Reg. 35990, 36068 (Sep. 4, 1990); 59 Fed. Reg. 45330, 45342, 45396 (Sep. 1, 1994).

[9] 48 Fed. Reg. 39752, 39794 (Sep. 1, 1983).

[10] Congress subsequently changed the law to establish special cost reimbursement rules for anesthetists. See 42 C.F.R. § 412.112(c).

were based, their continued viability depended on continued cost-based reimbursement, and HCFA acted accordingly.[11]

These examples illustrate that the authority to grant adjustments to prospective payment rates includes authority to pay certain costs on a cost-reimbursement or other non-prospective basis. While the adjustments in the hospital PPS were of lesser magnitude than a cost pass-through of non-therapy ancillary costs would be in the SNF PPS, the principle is the same, and the adjustment would be authorized.

Effective Date of Changes

HCFA not only has the authority to pay for non-therapy ancillary costs on a pass-through basis, but it also has the authority to make that change retroactive to July 1, 1998, when the PPS was instituted. As noted above, HCFA issued the interim rules without prior opportunity for public comment. The agency waived proposed rulemaking on the ground that the nine months between enactment of the legislation and the deadline for publication of the rules was insufficient to allow it to complete development of the PPS and allow public comment.[12]

This publication of interim rules without prior opportunity for comment was clearly impermissible under the Administrative Procedure Act and the Medicare statute. It is well-established that tight statutory deadlines for publication of rules are by themselves not a

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[11] 48 Fed. Reg. 39752, 39782 (Sep. 1, 1983). The statute was later amended to codify the regulatory exemption.

[12] 63 Fed. Reg. 26302-03 (May 12, 1998).

lawful basis for waiver of proposed rulemaking.[13] There must also be specific statutory authority for such a waiver. The Medicare statute, however, allows waiver of the opportunity for prior public comment only when a law establishes a deadline for regulations less than 150 days after enactment.[14] In this case, the Balanced Budget Act included no authority for interim rules on the SNF PPS, and the publication deadline (May 1, 1998) was more than 150 days after enactment (August 5, 1997). Accordingly, the interim rules were not lawfully promulgated.

If the interim rules had been authorized, HCFA may well have the discretion to make any changes prospective only.[15] Since the waiver of proposed rulemaking was not authorized in this case, however, there is no legitimate basis on which HCFA could decline to make a retroactive change in response to public comments. The need for retroactive revisions is particularly strong here since, with a comment period that extended through September 11, 1998, there was not even a theoretical opportunity for HCFA to make changes based on the comments prior to the July 1, 1998 effective date.

Conclusion

HCFA has the authority to adjust the federal payment rate for SNFs to account for case mix by paying non-therapy ancillary costs on a pass-through (cost reimbursement) basis.

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[13] See, e.g., Asiana Airlines v. FAA, 134 F.3d 393, 397-98; New Jersey v. EPA, 626 F.2d 1038, 1045 (D.C. Cir. 1980).

[14] Social Security Act § 1871(b), 42 U.S.C. § 1395hh(b).

[15] See, e.g., Methodist Hospital v. Shalala, 38 F.3d 1225 (D.C. Cir. 1994).

Moreover, such a change should be made retroactive to the initiation of the PPS, since HCFA did not provide an opportunity for public comment prior to issuance of the regulations.

Terry Coleman

S.RES. 314
EXPRESSING THE SENSE OF THE SENATE REGARDING SKILLED NURSING FACILITIES

Mr. HATCH. Mr. President, today I introduce S. Res. 314 which expresses the sense of the Senate regarding the authority of the Secretary of Health and Human Services to make adjustments in payments made to skilled nursing facilities under the Medicare program.

As my colleagues are aware, pursuant to the Balanced Budget Act of 1997, Congress directed the Health Care Financing Administration to create a new prospective payment system, or PPS, for Medicare-certified skilled nursing facilities, or SNFs, as they are called.

Skilled nursing facilities are now in the process of moving from the historical cost-based reimbursement system to the new prospective payment system.

This new system combines costs associated with nursing services, capital investment, and other medical services bundled together and then adjusted to reflect the needs of the patients.

Congress rightly sought this new system as a way of getting skilled nursing facility operators to manage both the quality and costs of health care for seniors qualified under Medicare.

As this system has been developed quickly since the enactment of the BBA, there has been a problem identified with adjustments for services considered "non-therapy" services.

These include respiratory therapy, pharmaceutical products, parenteral and enteral products, laboratory and x-ray services, and other covered medical supplies.

While I believe that HCFA has done a remarkable job in getting this system in place over the past year, I am concerned that the adjustment in payment for these specific services has not yet been developed.

This is especially true for a patient who is very ill-those with multiple disease conditions treated in a SNF. There is simply not adequate provisions for ensuring that the prospective payment made each day appropriately reflects the higher medical costs that these patients may need.

As a result of this new system, many nursing homes cannot afford to treat certain types of patients. That was never our intent.

HCFA officials have acknowledged that they needed more data to fix the problem. They commissioned a study last year to assist them to make corrections.

However, the data was not yet available in time for the first year to implement some corrections. While I am certain that HCFA will correct this system, I want to ensure that services to our most vulnerable seniors in nursing homes getting complex medical services will continue to get their care.

I do not want bureaucratic delays in any way to impede their care.

The PPS theory of paying according to average does not work when the rates are not based on solid data and the case-mix adjustment for non-therapy ancillaries is based on very little data. This is obviously not what Congress intended with the BBA.

In March, the Medicare Payment Assessment Commission advised the Congress that "the RUG-III system may not adequately differentiate among Medicare SNF patients ... this may lead to significant overpayment and under payment for patients within a RUG group."

In September, the Appropriations Committee report for the Department of Health and Human Services included the following:

> The Committee has heard concerns regarding the equity of the new Medicare SNF prospective payment system as it relates to nontherapy ancillaries. The demonstration upon which the new system was based did not include this class of items and services. Due to the lack of sufficient data to make these changes, the new

system may provide a windfall for some providers while seriously impairing the ability of others to treat patients requiring more intensive care. Therefore, the Committee urges HCFA to reexamine this policy and make budget-neutral changes this year to assure continued access to services for high cost patients pending the gathering of sufficient data on which to base permanent reforms.

Mr. President, unless relief is provided and this anomaly in the payment system is corrected, a major impediment will remain for certain patients with high non-therapy ancillary costs to receive Medicare services in nursing facilities.

An immediate transitional modification is needed before irreparable harm is done to quality care and access for high costs patients. Some facilities have already begun PPS coverage although HCFA apparently will not begin making actual PPS payments until December, or later. However, on January 1 about 60 percent of the SNFs will begin coverage under the PPS.

We must, therefore, develop longer term solutions for these crucial services, but first we must do no harm in the interim.

Providers can quickly change operations to maximize light care and minimize heavy care. Specialty staff, such as respiratory therapists, will be let go; special physical plant and equipment, such as air flow equipment for "clean room" level infection control will be dismantled; and hospital referral arrangements will be changed.

Accordingly, I am submitting today S. Res. 314 expressing the sense of the Senate that the Secretary, pursuant to section 1888(e)(4)(G)(i), has the authority to provide for an appropriate adjustment to account for case mix which reflects a patient's medical needs requiring non-therapy ancillary services.

HCFA has acknowledged the shortcomings of the current RUG-III system. The RUG-III demonstration project had treated these costs as a pass-through because the system did not have the data available to include such costs.

My resolution will clarify and reaffirm Congressional intent that the Secretary has the administrative flexibility to make appropriate adjustments to the case-mix of SNFs to reflect the costs of these services.

One approach, which accommodates HCFA's operational impediment of Year 2000 computer software problems, would be to make payment adjustments to reflect the relative resource utilization of non-therapy ancillaries by different patient types based on a SNF's cost report for the first year under the PPS.

The resolution calls upon the Secretary to gather sufficient data on the provisions of non-therapy ancillaries in order to develop the appropriate adjustments. And, it also urges the Secretary to periodically report to Congress on the development of the appropriate adjustment.

Mr. President, this issue is one of quality and access for America's seniors to community based skilled care. And, while it was my hope that the Senate could pass this resolution today, I trust my remarks and the language of the resolution will serve to further define the complex issues associated with this important matter.

I am encouraged that the distinguished Chairman of the Finance Committee, Senator Roth, and the distinguished Minority Member, Senator Moynihan, have indicated their interest, and look forward to working with them early next year to address this issue in the Finance Committee.

S.RES. 314
EXPRESSING THE SENSE OF THE SENATE REGARDING SKILLED NURSING FACILITIES

Mr. HATCH submitted the following resolution; which was refered to the Committe on Finance:

S.Res.314

Resolved,

SECTION 1. SENSE OF THE SENATE REGARDING AUTHORITY OF SECRETARY, COLLECTION OF DATA, AND REPORT TO CONGRESS.

(a) AUTHORITY.-It is the sense of the Senate that the Secretary of Health and Human Services, in making payments under the prospective payment system for skilled nursing facilities pursuant to section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), has the authority under section 1888(e)(4)(G)(i) of such Act to provide for an appropriate adjustment to account for case mix which reflects a patient's medical needs requiring the provision of non-therapy ancillary services (such as respiratory therapy, pharmacy, laboratory, X-ray, and parenteral and enteral services, and covered durable medical supplies).

(b) DATA.-It is the sense of the Senate that the Secretary of Health and Human Services should gather sufficient data on the provision of non-therapy ancillary services by skilled nursing facilities that are paid under the prospective payment system pursuant to section 1888(e) of the Social Security Act in order to develop the appropriate adjustment for case mix under section 1888(e)(4)(G)(i) of such Act.

(c) REPORT TO CONGRESS.-It is the sense of the Senate that the Secretary of Health and Human Services should periodically report to Congress on the development of the appropriate adjustment for case mix under section 1888(e)(4)(G)(i) of the Social Security Act which reflects a patient's medical needs requiring the provision of non-therapy ancillary services.

THOMAS DASCHLE
SOUTH DAKOTA

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September 4, 1998

The Honorable Nancy-Ann DeParle
Administrator
Health Care Financing Administration
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. DeParle:

It has come to our attention that there is a flaw in the skilled nursing facility (SNF) prospective payment rates that could jeopardize SNF access and proper care for certain Medicare beneficiaries. We are concerned that payments for non-therapy ancillary services built into the prospective payment system (PPS) for skilled nursing facilities (SNFs) may not adequately account for the variance in utilization and costs associated with these services, and that the ultimate effect of the new system could be to create access barriers for high acuity patients. This was obviously not the intent of the PPS legislation, and we believe that, for the sake of Medicare beneficiaries, it is a concern that must be taken quite seriously.

We understand PPS payments for non-therapy ancillaries are based on a simple average that is adjusted only by the nursing and wage indexes, and that these adjustments do not necessarily track to the actual variation in non-therapy ancillary costs across patients. Because there is also variation across facilities in the concentration of high use patients, the PPS system may chronically over-pay some SNFs and chronically underpay others. We understand there are no outlier payments built into the SNF system to correct for cases that clearly fall outside a reasonable cost range. In the absence of such a system, and if in fact the basic PPS rates systematically underpay for certain types of patients, then SNFs clearly would have a strong incentive to under-serve or turn these patients away.

This obviously is a serious concern. In the Balanced Budget Act Conference Report, Congress acknowledged the need to protect access to non-therapy ancillary services such as medication therapy for high acuity patients and the link between this objective and accurate reimbursement. The language of the report is clear:

> "To ensure that the frail elderly residing in SNFs receive needed and appropriate medication therapy, the Secretary should consider the results of studies conducted by independent organizations including those which examine appropriate payment mechanisms and payment rates for medication therapy under a prospective payment system for SNFs."

We are concerned that the current PPS payment structure will place patients at risk. We are therefore requesting that you carefully re-examine the new SNF payments and make budget-neutral adjustments this year to assure continued access to services for high cost patients pending the gathering of sufficient data on which to base permanent reforms. Attached is such an adjustment that would protect patients and preserve the intent of the Balanced Budget Act.

As the new PPS system becomes effective October 1, it is important that quick action be taken. Thank you for your consideration.

Sincerely,

Tom Daschle
United States Senate

Tom Harkin
United States Senate

John Breaux
United States Senate

NON-THERAPY ANCILLARY SERVICES
PROPOSAL FOR TEMPORARY ADJUSTMENT TO SNF PPS SYSTEM

For a SNF's first year under PPS, the fiscal intermediary would review their cost report, and, within 30 days of submission, perform a lookback of actual reasonable costs for non-therapy ancillaries to recover 100% of any overpayments and pay 99% of any underpayments. HCFA could make additional adjustments to ensure budget neutrality.

Newt Gingrich
Sixth District
Georgia

(202) 225-0600

Office of the Speaker
United States House of Representatives
Washington, DC 20515

September 18, 1998

The Honorable Nancy-Ann DeParle
Administrator, Health Care Financing Administration
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. DeParle:

I was recently made aware of an issue related to the implementation of the Medicare prospective payment system for skilled nursing facilities (SNFs). It appears that a more sophisticated system should be developed to account for the high care and high cost incurred from the use of non-therapy ancillary services, such as drugs and medical supplies. Such a system would ensure a more adequate adjustment for the variation in costs for non-therapy ancillaries.

Consumer groups that work with these patients have expressed three main areas of concern regarding non-ancillaries:

1. that it is not based on actual cost data and clinical variations;

2. that there is no outlier-type method to handle high cost patients within a case-mix category; and

3. that the plan overpays for the care of low cost patients at the expense of more complex patients.

Congress and the Department share a desire to protect the most vulnerable population in the health care system. I look forward to working with you toward a budget-neutral plan that ensures Medicare beneficiaries are guaranteed access to proper services under the new SNF payment system.

Sincerely,

Newt

Newt Gingrich
Speaker of the House

JENNIFER DUNN
6TH DISTRICT, WASHINGTON
REPUBLICAN CONFERENCE VICE CHAIRMAN
COMMITTEE ON WAYS AND MEANS
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September 25, 1998

Nancy Ann Min-DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue SW
Washington, D.C. 20201

Dear Ms. Min-DeParle:

I am writing to follow up on a letter I sent on July 7th of this year regarding the Bailey-Boushay House in Seattle, Washington and some concerns I have about the new prospective payment system (PPS) for skilled nursing facilities (SNFs).

As I mentioned in my previous letter, the new PPS rules do not take into account the high cost of non-therapy ancillary services, such as medication or respiratory care, that are necessary in providing adequate services for more acute care patients. I am extremely concerned about an inadequate reimbursement level leading to reduced care or increased hospitalization, either of which are unacceptable from a quality and fiscal standpoint. It was never Congress's intent to create a disincentive for facilities to provide these necessary and life-saving Medicare services.

Since the SNF reimbursement pilot project had treated non-therapy ancillary costs as separate from the bundled rate, and there is currently an in-depth study being done to identify these costs, I urge you to suspend the implementation of the PPS rule as it applies to non-therapy ancillary costs and create a temporary pass-through for these services. Quality health care delivery for this portion of the Medicare population it too important to risk while the facts are still being analyzed.

Thank you for your attention to this urgent matter. I look forward to receiving your reply.

Best regards,

Jennifer Dunn
Member of Congress

JD/dqb

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UNITED STATES
HOUSE OF REPRESENTATIVES

ASSISTANT MAJORITY WHIP
COMMITTEE ON
WAYS AND MEANS
SUBCOMMITTEE ON
OVERSIGHT
SUBCOMMITTEE ON
SOCIAL SECURITY

October 12, 1998

The Honorable Newt Gingrich
Speaker of the House
H-232, The Capitol
Washington, D.C. 20515

Dear Speaker Gingrich:

I am writing to request immediate action on an issue that threatens to negatively impact Medicare beneficiaries in skilled nursing facilities (SNFs). The Health Care Financing Administration's (HCFA) prospective payment system (PPS) methodology for non-therapy ancillary services-- like pharmacy and medical supplies-does not adequately account for cost variations at SNFs.

Specifically, the SNF PPS does not appropriately consider the variance in utilization and costs associated with such services. Clearly, the intent of the Balanced Budget Act (BBA) was to ensure streamlined payments in Medicare without jeopardizing access to high quality care for Medicare beneficiaries.

As you may know, CBO and OMB have worked out a one year, "stop gap" provision for Medicare non-therapy ancillaries that is **budget neutral**. The President supports the provision as an amendment to an omnibus appropriations package. There is strong bipartisan, House and Senate, support for the provision.

Although there is little time left in this legislative session, this is an important issue for which I believe we can achieve positive results for Medicare beneficiaries and health care providers in Illinois and across the nation. If we act now, this can be accomplished in a bipartisan fashion while maintaining budget neutrality. Next year, the issue can be revisited, thus allowing Chairman Thomas's Subcommittee to work out a long term solution to the problem.

Mr. Speaker, I thank you in advance for your attention to this urgent matter.

Sincerely,

Jerry Weller
Member of Congress

TALKING POINTS ON NON-THERAPY ANCILLARIES

There are serious problems with the implementation of the Medicare prospective payment system for skilled nursing facilities (SNFs) by the Health Care Financing Administration (HCFA). The proposed payment for non-therapy ancillaries, such as drugs, oxygen, medical supplies and lab work is fundamentally flawed.

Non-therapy ancillaries involve patients who are the most sick and vulnerable in our system -- among them, the elderly, AIDS and cancer patients.

HCFA's plan is to compensate for these ancillary services in one "average cost," per diem rate with no accommodation for facilities which provide care to patients with extreme medical conditions and needs. This "average cost" overpays for light care at the expense of heavy care patients. There are 1044 facilities with an average spending of $10 or less for non-therapy ancillaries and 925 facilities with an average spending of $100 or more.

So-called "outlier" facilities which provide high-cost care, to AIDS patients for example, would no longer be able to serve Medicare patients if the HCFA plan is instituted. This would not only jeopardize the care these patients need, but also will steer them into alternative sources of care, primarily more expensive hospitalization.

The "average cost" payment which HCFA proposes does not average out over the long term because it is not based on actual cost data and actual variation in the mix of patients served by skilled nursing facilities.

Solution: Delay including non-therapy ancillaries in the proposed payment system for one year to develop an adequate database of costs and patient mix.

In addition, to address HCFA's concerns about programming its computers, for the first year under the payment system, a facility's cost report would be reviewed, and within 30 days, a lookback would be performed of actual costs for non-therapy ancillaries to recover 100% of an overpayment and pay 99% of an underpayment.

Why does this make sense?

-- It conforms to the intent of Congress in the Balanced Budget Act to change nursing home reimbursement from cost-based to a prospective payment system.

-- It is budget neutral.

-- It does not require adjustments to HCFA's computers.

-- It provides sound data upon which to base a fair payment system.

until it's over
AIDS ACTION

July 8, 1998

Nancy-Ann Min DeParle
Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA-1913-IFC
P.O. Box 26688
Baltimore, Maryland 21207-0488

Dear Ms. Min DeParle:

I am writing on behalf of AIDS Action, the national voice on AIDS, representing all Americans affected by HIV/AIDS and 2,400 community-based service organizations that serve them, in response to the Health Care Financing Administration's interim final rule implementing the prospective payment system for skilled nursing facilities (Federal Register, 5/12/98). Of primary concern is the fact that the PPS regulations do not address the needs of facilities which provide care to patients with demanding health care needs.

The Bailey-Boushay House in Seattle, Washington is a unique skilled nursing facility that provides high-quality nursing home care to AIDS patients – patients who would otherwise receive more costly hospital care. The intense nursing requirements and high pharmaceutical costs of such patients distinguish facilities such as the Bailey-Boushay House from the traditional SNFs for which the PPS rules were designed.

The Balanced Budget Act provisions change the nursing home reimbursement procedure from cost-based to a PPS, case-mixed adjustment system. They consolidate billing for most services, including prescription drug costs, into one global, per diem rate. As published, these rules make no accommodation for outlier facilities that offer a disproportionate number of services and medications to meet the acute needs of their patients.

Applying the new rules without addressing extreme outlier facilities such as Bailey-Boushay would reduce the payment for Medicare residents there by nearly 70%. A cut of this magnitude means that SNFs such as Bailey-Boushay will no longer be able to provide care for Medicare patients. Not only does this jeopardize the care needed by these patients, it also forces them into more costly forms of alternative care such as acute care hospitals.

Congress explicitly identified the importance of addressing the needs of SNFs which house patients with extreme medical conditions. The Conference Report says, "It is the intent of the Conferees that the Secretary develop case-mix adjusters that reflect the needs of such patients [those with significant medical requirements]." After adopting a case-mix reimbursement method for Medicaid nursing home payment earlier this year, Washington's state legislature

response to AIDS. The Northwest AIDS Foundation participated in the development of Bailey-Boushay House because we recognized the need for a special facility that could meet the complex needs of AIDS patients. Bailey-Boushay House, the first skilled nursing facility of its kind in the nation, was built to provide an economic and social solution to the unique needs of people living with AIDS.

The implementation of the PPS for Medicare patients will weaken the integrity of the continuum of care that has been established in the Northwest. The rules will deny Medicaid beneficiaries with AIDS access to cost-effective and specialized care at Bailey-Boushay House. We strongly urge you to adopt modifications to these proposed rules to allow for Bailey-Boushay House to continue to meet the special needs of people with AIDS.

Ms. DeParle, we recognize that the Balanced Budget Act has placed fiscal constraints on the Health Care Financing Administration. However, we believe that this proposal will likely result in greater expense to the Medicare program while adversely impacting people living with AIDS in King County. We would appreciate the opportunity to meet with a representative from your office, together with the Bailey-Boushay House, in order to discuss this important issue.

Please do not hesitate to contact either one of use if we can provide additional information or to arrange a meeting date.

Sincerely,

Terry M. Stone
Executive Director

Steven B. Johnson
Director of Public Policy and Communications

cc: Washington State Congressional Delegation
Sandra Thurman, Director, National Office of AIDS Policy
Governor Gary Locke
Christine Lubinski, Deputy Executive Director for Programs, AIDS Action Council
Christine Hurley, Executive Director, Bailey-Boushay House

NORTHWEST AIDS FOUNDATION

July 10, 1998

Nancy-Ann Min DeParle
Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA - 1913 - IFC
P.O. Box 26688
Baltimore, MD 21207-0488

RE: Medicare Prospective Payment System Implementation

Dear Ms. Min DeParle:

As the largest AIDS service organization in Washington State, we are concerned regarding the impact of proposed rules for the implementation of the Medicare prospective payment system (PPS) on skilled nursing facilities (Federal Register, 5/12/98). In particular, we believe that these changes will dramatically impede the ability of our local skilled nursing facility, the Bailey Boushay House, to provide quality care for individuals living with AIDS in the Seattle region. We urge you to adopt modifications to these proposed rules which will take into consideration the unique situations and costs posed by HIV/AIDS care.

Prospective payment, while well-intentioned for most nursing homes, is ill-matched with the profile of care received at Bailey-Boushay House. AIDS care requires intensive amounts of skilled nursing hours in comparison to more routine nursing home care. In addition, medications for the treatment and management of AIDS symptoms are complex and costly. The additional nursing care and the very high cost of medications are fundamental aspects of AIDS care. These realities are not considered within the proposed rules for the Medicare prospective payment system.

The financial burden of the proposed PPS rules will prohibit Bailey-Boushay House from caring for individuals with Medicare coverage. Without modifications, Bailey-Boushay's Medicare residents will have to return to other care facilities, including costly hospital in-patient care. This shift would, in effect, result in greater expense to the Federal Government.

When including the PPS rules in the Balanced Budget Act, Congress explicitly identified the importance of addressing the needs of skilled nursing facilities which house patients with extreme medical conditions. The Conference Report says, "It is the intent of the Conferees that the Secretary develop case-mix adjusters that reflect the needs of such patients [those with significant requirements]." After adopting a case-mix reimbursement method for Medicare nursing home payments earlier this year, the Washington State Legislature exempted Bailey-Boushay House from the change. Instead, a special payment system will be used in recognition of the unique demands with which Bailey-Boushay House is confronted.

In Seattle, we have built a comprehensive continuum of HIV prevention and care services for people living with HIV/AIDS. Bailey-Boushay House plays an integral role in our community

127 Broadway East Suite 200 Seattle, WA 98102-5788 phone 206-329-6823 TDD 206-323-2865 fax 206-325-7451

response to AIDS. The Northwest AIDS Foundation participated in the development of Bailey-Boushay House because we recognized the need for a special facility that could meet the complex needs of AIDS patients. Bailey-Boushay House, the first skilled nursing facility of its kind in the nation, was built to provide an economic and social solution to the unique needs of people living with AIDS.

The implementation of the PPS for Medicare patients will weaken the integrity of the continuum of care that has been established in the Northwest. The rules will deny Medicaid beneficiaries with AIDS access to cost-effective and specialized care at Bailey-Boushay House. We strongly urge you to adopt modifications to these proposed rules to allow for Bailey-Boushay House to continue to meet the special needs of people with AIDS.

Ms. DeParle, we recognize that the Balanced Budget Act has placed fiscal constraints on the Health Care Financing Administration. However, we believe that this proposal will likely result in greater expense to the Medicare program while adversely impacting people living with AIDS in King County. We would appreciate the opportunity to meet with a representative from your office, together with the Bailey-Boushay House, in order to discuss this important issue.

Please do not hesitate to contact either one of use if we can provide additional information or to arrange a meeting date.

Sincerely,

Terry M. Stone
Executive Director

Steven B. Johnson
Director of Public Policy and Communications

cc: Washington State Congressional Delegation
Sandra Thurman, Director, National Office of AIDS Policy
Governor Gary Locke
Christine Lubinski, Deputy Executive Director for Programs, AIDS Action Council
Christine Hurley, Executive Director, Bailey-Boushay House

HCFA's Plan for SNF Non-Therapy Ancillaries

Information Packet

INDEX

HCFA's Plan for SNF Non-Therapy Ancillaries: Perverse, Unfair and Not Congressional Intent

Background

Long term care for the elderly that addresses quality, access and cost is a major concern today. Just recently the Senate Aging Committee held hearings about problems with nursing home care, particularly in California. One issue Congress may hear about soon, unless HCFA cooperates, is the issue of "non-therapy ancillaries for high cost patients" that are associated with the new prospective payment system that began on July 1, 1998 for Skilled Nursing Facilities (SNF's).

Non-therapy ancillaries involve those patients that are the most sick and vulnerable in our system. These patients include those with multiple diagnoses - they could be our parents and grandparents, as well as cancer and AIDS patients that require multiple treatment plans. The problem is Medicare reimbursing at too low a level for non-therapy ancillary services.

Non-Therapy Ancillaries

What are they?

Drugs, IVs, oxygen, medical supplies, lab work, x-ray and respiratory therapy which are critical to SNFs serving medically complex, high cost/high care patients.

Whom do they benefit?

High cost, high care patient conditions, such as ventilator care, head trauma, chemotherapy, and AIDS.

How Did HCFA Determine Rates for Non-Therapies?

Average cost

HCFA apparently divided spending by the number of patient days to arrive at an average $47 to include in the rate for "nursing component."

Indexed

When this $47 rate is adjusted by the nursing index for case-mix and the wage index for geographical differentials, a range of $111 - $27 is possible.

Why is this Bad Policy?

Not based on actual cost data and clinical variations

The "average cost" is based on insufficient and inadequate data: The RUG III criteria (the basis for HCFAs data) is based on Medicaid patients and does not correctly incorporate non-therapy ancillary costs. RUG III also does not recognize high cost patients within a case-mix category (for example, a stroke patient with advanced stage pressure ulcers).

Overpays for light care at the expense of heavy care

Pro/Con Arguments

Pro: HCFA would contend that the costs will average out under PPS, imposing a type of "rough justice" on all forms of SNFs.
Con: This would be true if the numbers were accurate. They are not.

Pro: HCFA argues that computers are already being programmed for changes.
Con: Our proposed changes would not affect computer programming.

What was Congress' Intent?

HCFA did **not** do what Congress directed for high cost/high care patients

BBA -> "The Secretary shall provide for an appropriate adjustment to account for case mix...that accounts for the relative resource utilization of different patient types...based on...data that the Secretary considers appropriate" (new SSA §1888(e)(4)(G)(i) created by BBA §4432).

Conferees -> "The Conferees note that under the proposed SNF prospective payment system, services and supplies provided to residents will be included in pre-determined per diem payment rates. To ensure that the frail elderly residing in SNFs receive needed and appropriate medication therapy, the Secretary should consider the results of studies conducted by independent organizations including those which examine appropriate payment mechanisms and payment rates for medication therapy under a prospective payment system for SNFs. It is the intent of the Conferees that the Secretary develop case mix adjusters that reflect the needs of such patients." (p. 758 of H.Rept. 105-217)

HCFA has not collected data to adjust rates for non-therapy ancillary costs among patient case-mix categories (also, there are no known relevant "studies conducted by independent organizations"). Furthermore, HCFA has not developed a method to handle high cost patients within a case-mix category.

Solution

The best solution would be to delay folding-in non-therapy ancillaries for one year to develop an adequate database of costs and valid case-mix adjustor.

In addition, to address HCFA concerns about its computer mess, the following is a fair, realistic approach:

For a SNF's first year under PPS, the fiscal intermediary will review their cost report and, within 30 days of submission, perform a lookback of actual reasonable costs for non-therapy ancillaries to recover 100% of an overpayment and pay 99% of an underpayment.

Why Does This Proposed Change Make Good Policy?

It's mindful of Congress' intent

It's budget neutral

It doesn't require computer adjustments

It provides needed data

Consequences for Inaction

High cost, high care patients will suffer

Costs will increase as spending will shift to more expensive Long Term Care hospitals and other settings

RUG III AND NON-THERAPY ANCILLARY MISMATCHES

The Problem

The Medicare Prospective Payment System (PPS) for skilled nursing facilities (SNFs), scheduled for implementation beginning July 1, 1998, utilizes the RUG III categories originally developed for the case-mix demonstration project. While many feel that the current 44 RUG III categories are insufficient from a nursing perspective (e.g., the therapy categories do not have provisions for handling medical complexities and co-morbidities), there is no pretense that the current RUG III categories adequately handle non-therapy ancillaries. In fact, the demonstration specifically excluded consideration of non-therapy ancillary services in the design of the RUG III case-mix categories.

Further, the case mix demonstration project did not include non-therapy ancillaries at all in its prospective payments. Instead, these costs were reimbursed on a cost basis (i.e., passed through) throughout the term of the demonstration. It should be clear then why the industry objects to the arbitrary distribution of non-therapy ancillaries among the RUG III patient classifications for the recently implemented PPS. The current case-mix categories are inadequate to account for the full range of non-therapy ancillary costs experienced by SNF patients.

It is not a question of whether the non-therapy ancillary costs are included in the cost base or not, because, except for procedures recently introduced into the SNF category that vary, the ancillary costs of all procedures have been included in the base and spread out among the RUG III categories. The fact that these costs have been included in the base, however, is of little consolation to the provider which admits a patient who requires a level of non-therapy ancillary service utilization that is not adequately accounted for by the RUG III classification into which the patient falls.

Ultimately, what is needed is a careful examination of each RUG III category in order to identify patients that utilize high levels of non-therapy ancillaries, so that adequate provisions can be made to recognize the service needs of these patients. Once patient categories are established which recognize these needs, proper payment rates can be established. It should be pointed out that this process will be budget neutral, since all the non-therapy ancillary costs are already in the base. They are merely misallocated by the existing RUG III categories.

The Solution

The necessary, in depth research projects are currently underway (the Morrison contract funded jointly by NSCA and AHCA, a study of pharmacy utilization by Vince Mor of Brown University funded by HCFA, and the Abt study also funded by HCFA) to identify these patients. The problem is that these projects will not be completed in time for the

first PPS year, and it is even uncertain whether they will be completed in time to utilize their findings for the second PPS year. **Accordingly, the best solution would be to delay folding-in non-therapy ancillaries for one year to develop an adequate database of costs and a valid case-mix adjustor. In addition, for a SNF's first year under PPS, the fiscal intermediary could review the SNF's cost report and, within 30 days of submission, perform a lookback of actual reasonable costs for non-therapy ancillaries to recover 100% of an overpayment and pay 99% of an underpayment.**

This temporary treatment of non-therapy ancillary costs is justifiable in that no one knows at present how to handle non-therapy ancillaries. The multi-state, multi-year case-mix and quality demonstration project never addressed the issue and continued throughout its life to pass these costs through, rather than include them in the prospective payments. Further, HCFA attempted to identify the "best" method of handling these costs prospectively, given Congress' mandate, but none of the options available to HCFA are even marginally adequate. HCFA ultimately found some correlation between these costs and nursing costs in the aggregate, so it folded non-therapy ancillaries into nursing costs and adjusted both with the nursing case-mix index. But this produces many serious payment anomalies which threaten the access to needed services on behalf of a wide variety of Medicare patients.

There is reason to believe that there are many patients for whom the PPS payment applies who will be harmed because of the inadequacy of the RUG III categories in handling non-therapy ancillaries. For these patients, access to Medicare SNF services may become problematic unless a solution is provided that allows sufficient time to take corrective action to rectify the shortcomings of the RUG III patient classification system.

The Evidence

Case Studies - A few selected examples of medically complex patients who are systematically denied adequate consideration under the current RUG III classification system serve to illustrate the nature and extent of the problem the industry and its patients face if the proposed treatment of non-therapy ancillary services is allowed to continue. Attached are eight specific case studies of the kinds of patients that are not handled adequately by the RUG III patient classification and payment system. These case studies exemplify the types of rehabilitative therapy patients, clinically complex patients, and extensive care patients who require non-therapy ancillary services (principally pharmacy and respiratory therapy) of a magnitude that will not be compensated for under the PPS.

In almost all of these case studies, the cost of the required non-therapy ancillaries are greater than the payment from the total nursing component (about half of the nursing component has been allocated to cover non-therapy ancillaries). In fact, five of the eight case studies show that the non-therapy ancillary costs alone will be greater than the total PPS payments and the other three have non-therapy ancillary costs that approach the total

PPS payments. In these instances, there is literally no payments remaining to cover any of the other costs of care. Sadly, these case studies do not represent rare instances. In fact, medically complex patients from which these case studies were drawn represent about 27 per cent of all admissions.

Pharmacy - The method of payment provided for pharmacy in the proposed PPS is particularly egregious because the utilization of pharmaceutical services is so weakly correlated with the case-mix index for nursing services. Table A illustrates the problem by tracking several fairly common conditions that were found for 439 patients (8.5 percent) among 5,165 patients in mid-western skilled nursing facilities, describing the pharmaceutical needs associated with each of these conditions, and contrasting the costs of these pharmaceuticals with the payments provided under the PPS.

Table A

Condition	Number of Patients	Required Drugs	RUG III Classes	Daily Drug Cost	Payment: Total & (Nursing)
Decubitis Ulcers and Wounds	132 (2.6%)	Vancomycin, Gentamycin, Fortaz, Cipro, PPN, Timentin, Claforan, Rocephin, Ampicillin, Zosya, E-Mycin, Ampicillin, Pipercillin	Extensive Services; Special Care; Clinically Complex	$226.30	$175-$252 ($108-$186)
Pneumonia URI	99 (1.9%)	Gentomycin, Monocet, Rocephin, Cipro, Timemtin, Zosyn, Claforan, Levaquin, Flagyl, Lasix	Special Care; Clinically Complex	$151.25	$175-$189 ($108-$123)
Urinary Tract Infection	51 (1.0%)	Vancomycin, Gentamycin, Hydration, Timentin, Rocephin, Zosyn, Azactam, Tobramycin, Flagyl	All Categories	$165.50	$117-$384 ($92-$148)
Malnutrition, Nausea, Vomiting	50 (1.0%)	PPN, TPN	Extensive Care; Special Care	$527.40-$548.50	$177-$252 ($111-$186)
Dehydration	78 (1.5%)	Hydration	Special Care	$142.30	$177 ($111)
Bowel Obstruction	16 (0.3%)	TPN, Hydration	Extensive Services	$548.50	$252 ($186)
Septicemia	2 (0.04%)	Vancomycin, Gentamycin, Flagyl	Extensive Services; Special Care	$258.50	$177-$252 ($111-$186)
CHF	5 (0.1%)	Hydration, Lasix	Clinically Complex	$119.50	$149-$189 ($82-$123)
Pain	6 (0.1%)	Morphine	Special Care	$66.25	$177-$191 ($111-$124)

It is clear from Table A that, considering pharmaceutical expenses alone, the payment rates provided by the newly implemented PPS are inadequate for a substantial portion of the Medicare patients commonly treated in skilled nursing facilities. It is clear that the nursing component payments (which are intended to cover both nursing costs and non-

therapy ancillary costs) are almost never adequate to cover pharmacy alone. It is also clear that even the total PPS rates are often insufficient to pay just the pharmaceutical expenses, much less all non-therapy ancillaries or all facility costs for these types of patients.

High Cost Non-Therapy Ancillary Patients - A large, national multi-facility organization examined its patient records during FY 1997 to identify those patients with non-therapy ancillary needs that would be disadvantaged by the treatment of non-therapy ancillary costs by the PPS. All patients were examined who incurred non-therapy ancillary costs of more than $200 per day. A total of 8,205 patient records were examined and 802 patients (or 10 per cent of the total) were identified as meeting this criterion. Table B displays the findings for 759 (or 9.25 per cent) of these patients as categorized in the 15 case types into which these patients could be classified.

Table B shows that, of the 15 patient categories, 11 had pharmaceutical costs alone which were in excess of the total PPS nursing component payment and all 15 patient categories had total non-therapy ancillary costs that were well in excess of the proposed nursing component payments (recall that the non-therapy ancillaries are programmed to be covered by less than half of the nursing component of the PPS). In fact, one-third of the patient categories have total non-therapy costs alone which exceed the total payments that can be expected from the PPS. Clearly, the present allocation of non-therapy ancillary payments by the RUG III classification system leaves a lot to be desired, and attempts to include these payments in the RUG III based PPS is inappropriate unless and until research is completed on the correlation of these costs with patient conditions.

Table B

Case Types	Patients: Number (Percent)	RUG III Classes	Daily Drug Cost	Non-Therapy Cost	Payment: Total & (Nursing)
Ventilator Care	126 (1.5%)	Rehab Therapy; Extensive Services	$191.34	$515.97	$218-$346 ($104-$186)
Tracheostomy Care	76 (0.9%)	Rehab Therapy; Extensive Services	$118.80	$409.92	$218-$346 ($104-$186)
Pressure Ulcers, Advanced Stage	202 (2.5%)	Rehab Therapy; Extensive Services; Special Services; Clinically Complex	$163.16	$365.47	$149-$384 ($82-$186)
Stroke	44 (0.5%)	Rehabilitation Therapy	$179.72	$314.14	$229-$384 ($85-$142)
Non-Vent, Non-Trach Pneumonia	55 (0.7%)	Rehab Therapy; Extensive Services; Special Services;	$123.51	$301.47	$159-$384 ($89-$142)

		Clinically Complex			
Dialysis	10 (0.1%)	Rehab Therapy; Extensive Services; Special care; Clinically Complex	$178.60	$282.68	$149-$346 ($82-$152)
Infusion Therapy - (MRSA)	16 (0.2%)	Rehab Therapy; Extensive Services; Clinically Complex	$234.41	$339.27	$149-$384 ($82-$152)
TPN	28 (0.3%)	Rehab Therapy; Extensive Services; Clinically Complex	$408.91	$446.34	$149-$384 ($82-$186)
Other Major Infections	91 (1.1%)	Rehab Therapy; Extensive Services; Special Services; Clinically Complex; Impaired Cognition	$219.57	$319.25	$125-$384 ($58-$142)
Hip Fracture	8 (0.1%)	Rehabilitation Therapy	$173.58	$254.12	$250-$346 ($104-$116)
Deep Vein Thrombosis	2 (0.02%)	Rehab Therapy; Clinically Complex	$738.74	$742.09	$150-$327 ($82-$85)
Congestive Heart Failure	8 (0.1%)	Rehab Therapy; Extensive Services; Clinically Complex	$100.16	$274.41	$159-$346 ($85-$152)
COPD	60 (0.7%)	Rehab Therapy; Special Services; Clinically Complex; Reduced Physical Function	$151.68	$299.54	$149-$384 ($55-$119)
Diabetes	12 (0.15%)	Rehab Therapy; Special services	$235.61	$309.07	$181-$345 ($85-$124)
Cancer	12 (0.15%)	All Categories	$270.36	$366.55	$117-$327 ($50-$152)

Appendix A

Case Studies of Medically Complex SNF Patients

Case Study #1

Admitting Diagnosis: Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Shoulder Fracture, Rib Fractures, Hypothyroidism, Depression, Peripheral Vascular Disease, Sepsis, Pneumonia.

Clinical History: Patient admitted from local hospital for sub acute nursing. Upon admission patient was ventilator dependent with the goal of ventilator weaning. Patient was receiving nutrition through a G-feeding tube. Patient required trachea care daily as well as Accu-Checks for the unstable Insulin Diabetes. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, Rehabilitation
Altered Nutrition	Nursing, Dietary
Self Care Deficit	Nursing, Occupational Therapy
Impaired Gas Exchange	Nursing, Respiratory Therapy
Impaired Physical Mobility	Nursing, Physical Therapy
Inability to Sustain Spontaneous ventilation	Nursing, Respiratory Therapy
Knowledge Deficit	Nursing, Therapies, Social Work
Pain	Nursing, Physical Therapy
Risk for Aspiration	Nursing, Speech Therapy
Risk for Pneumonia	Nursing, Respiratory Therapy
Risk for Infection	All Disciplines
Impaired Skin Integrity	All Disciplines
Risk for Suffocation	All Disciplines
Risk for Fluid Volume Deficit	Nursing, Dietary
Feeding Self Care Deficit	Nursing, Speech Therapy, Dietary
Fear, Hopelessness	Nursing, Recreation Therapy, Social Work, MD

Medications: Patient was concurrently on the following medications:

Ascorbic Acid	Certagen	Coumadin	Colace
Lasix	K-Dur	Reglan	Miacalcin Nasal
Prednisone	Synthyroid	Zinc Sulfate Zoloft	
Insulin	Albuterol	Cromolyn	

Special Services: Patient required extensive nursing care hours for tube feedings, ventilator weaning, suctioning, tracheostomy care, medication delivery, monitoring of vital signs, pulsed oximetry for oxygenation levels, I&O monitoring, and total physical care secondary to the extremely high level of physical dependency. Patient also required the services of Occupational Therapy for the severe ADL (activities of daily living) deficits. Physical Therapy Services were required for the highly impacting activity intolerance level. Speech Therapy was required for the dysphasia to accomplish weaning from the G-Tube feedings. Social work involvement included assisting the patient and family members through the recovery process, and in discharge planning. Recreation Therapy played a significant role in the isolation and depression component of the patient's medical history. Dietitians monitored the caloric and fluid intake to nutritionally stabilize this patient through the treatment of the dysphasia.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	74.35
Pharmacy	170.34
Rental-Ventilator	22.06
Labs	6.71
Total:	**$273.46**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RHC** which provides a national average Federal payment rate of approximately $272.00 per patient day, and an average nursing component payment of only $138.00.

In this example, an urban SNF would be paid on average $59.22 for non-therapy ancillaries under this RUG, resulting in a loss of $214.24 per day.

Case Study #2

Admitting Diagnosis: Coronary Artery Disease, Sciatica, Arrhythmia, Renal Insufficiency, Lumbar Fracture

Clinical History: Patient admitted from local hospital for sub acute nursing and rehabilitation care. Upon admission, patient was dependent with mobility skills and required more extensive rehabilitation to enable discharge to home. Care planning goals of the interdisciplinary treatment plan were centered on:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, Rehabilitation
Altered Health Maintenance	Nursing, Dietary, Rehabilitation
Self Care Deficit	Nursing, Occupational Therapy
Anxiety	Nursing, Recreation Therapy, Social Work
Impaired Home Maintenance Management	Nursing, Rehabilitation
Impaired Physical Mobility	Nursing, Rehabilitation
Impaired Skin Integrity	Nursing, Dietary
Knowledge Deficit	All disciplines
Pain	Nursing, Rehabilitation
Risk for Injury	All Disciplines
Risk for Disuse Syndrome	Rehabilitation
Toileting Self Care Deficit	Nursing, Rehabilitation

Medications: Patient was concurrently on the following medications:

Dyazide	Zestril	Digoxin	Coumadin
Curdorone	Zinacef	Granulex	

Special Services: Patient required nursing care hours to monitor for the potential medical complications which include infections, Pneumonia, Thrombophlebitis, Embolism and Vascular Compromise. Patient was also receiving oxygen and nursing time was spent to ensure adequate oxygenation with activity tolerances. Patient also required a special air mattress and special skin care procedures for impaired skin integrity of bilateral heels. Occupational Therapy was required for the patient's ADL deficits. Physical Therapy was required to assess the patient's level of confusion to safely plan for discharge to the most appropriate setting. Social Work was actively involved in pre-discharge planning with the patient and family members, to provide for the continuum of care that would be required after discharge from the center. Recreation Therapy assisted in care planning of the patient's isolation and associated depression. Dietary provided for nutritional needs and addressed the concerns associated with renal insufficiency.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Pharmacy	100.79
Labs	4.02
Total:	**$104.81**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RHB** which provides a national average Federal payment rate of approximately $250.00 per patient day and an average nursing component of only $116.00.

In this example, an urban SNF would be paid on average $49.82 for non-therapy ancillaries for this RUG, resulting in a loss of $54.99 per day.

Case Study #3

Admitting Diagnosis: Respiratory Failure, Congestive Heart Failure, Hypertension, Renal Failure, Arteriosclerotic Cardiovascular Disease, Glucose Intolerance, Osteoarthritis, Dementia.

Clinical History: This 58 year old patient was admitted for follow-up care after hospitalization for respiratory failure and hypoxemia. Upon admission, the patient was alert, oriented only to self, and could follow simple commands. Patient required physical therapy to improve strength, range of motion and endurance; needed assistance with bed mobility, transfers, ambulation and ADL's; received respiratory therapy for pulse oximetry, nebulizer treatments, 3 times day and chest physiotherapy to promote recovery from pulmonary infection; and required speech therapy for dysphagia (swallowing). Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Psychiatric Mood Deficit	Activities, Nursing, Social Services
Sensory Deficit	Nursing, Activities, Social Services
Self-Care Deficit	Nursing, PT, OT
Alteration in Bowel and Bladder	Nursing
Impaired Skin Integrity	Nursing, Dietary, PT
Behavioral Meds	Nursing, Pharmacy
Impaired Physical Mobility	Nursing, PT
Alteration in Nutritional Status	Nursing, Dietary
Risk for Aspiration	Nursing, Speech Therapy
Feeding Self Care Deficit	Nursing, Speech Therapy, OT

Medications: Patient was concurrently on the following medications:

Lasix	Cardizem	Xalation eye drops
Prednisone	Nitropaste	Tylenol
Axid	Digoxin	Insulin

Special Services: Patient required nursing care for medication delivery, monitoring vital signs, assistance with ADL's, I & O monitoring, pulse oximetry, mobilization, ambulation. Patient had high level of physical dependency due to dementia and decreased strength. Required PT/OT for ADL's/strengthening. Speech Therapy was required for dysphagia which had a high impact on her nutritional status. Respiratory Therapy was needed for Chest Physiotherapy and recovery from pulmonary infection. Social Service worked with family and patient to promote transition. Dietitians monitored caloric intake throughout the treatment for dysphagia.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	173.15
Pharmacy	32.83
Labs	6.96
Rental	1.07
X ray	15.59
Total:	**$229.60**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RLB** which provides a national average Federal payment rate of approximately $213.00 per patient day and an average nursing component payment of only $122.00.

In this example, an urban SNF would be paid on average $52.17 for non-therapy ancillaries for this RUG, resulting in a loss of $177.43 per day.

Case Study #4

Admitting Diagnosis: Severe exacerbation COPD, Pneumonia, osteoporosis, Dementia, Pericardial Effusion, Asthma.

Clinical History: Patient admitted from hospital for severe exacerbation of COPD and pneumonia. Patient has a history of pulmonary problems. Upon admission, the patient had greatly diminished breath sounds, mildly labored breathing with use of accessory muscles. Mobility and ADL's were diminished. Patient also had a left ankle sprain which significantly affected mobility. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, PT
Self-Care Deficit	Nursing
Impaired gas exchange	Nursing, Respiratory
Impaired Skin Integrity	Nursing, Dietary, PT
Impaired Physical Mobility	Nursing, PT
Pain	Nursing, PT
Risk for Infection	Nursing, Physician, Respiratory

Medications: Patient was concurrently on the following medications:

Prednisone
Flovent MDI

Special Services: Patient required extensive respiratory therapy to relieve dyspnea and increase oxygenation, nebulizer treatment three times a day, seven days a week, chest physiotherapy and instruction in breathing patterns. Patient also required PT to improve severely decreased functional abilities, ADL's and mobility. Left ankle sprain contributed to difficulty in regaining strength and mobility. Social Services worked with family and patient to promote transition.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	204.12
Pharmacy	27.10
Rental	6.46
X-ray	15.59
Total:	**$253.27**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RMB** which provides a national average Federal payment rate of approximately $239.00 per patient day and an average nursing component payment of only $119.00.

In this example, an urban SNF would be paid on average $51.23 for non-therapy ancillaries for this RUG, resulting in a loss of $202.04 per day.

Case Study #5

Admitting Diagnosis: Cancer of breast with Bone Metastasis, Diabetes, Rheumatoid Arthritis

Clinical History: Patient admitted from local hospital for sub acute nursing. Upon admission patient was alert and oriented x3, and was undergoing radiation therapy five times a week. Patient was debilitated with significant functional deficits secondary to clinical condition, and had a port-a-cath which required care. Patient was very depressed over medical condition and situation. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing
Impaired Mobility	Nursing
Self Care Deficit	Nursing
Pain	Nursing
Alteration in Mood	Nursing, Medical

Medications: Patient was concurrently on the following medications:

Decadron	Paxil	Vancomycin
Coumadin	Xanax	Insulin
Pepcid	PeriColace	Percocet
Restoril	Talwin	Flonase
Compazine	Zafron	

Special Services: Patient required nursing services at a moderate care level for assistance with all care and ADL's due to patient's weakness and debilitation due to medical condition. Patient required monitoring of Diabetes including Accuchecks twice a day with insulin coverage. Patient received radiation therapy five times a week. Patient received blood work daily to monitor and regulate Coumadin.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Pharmacy	109.32
Medical Supplies	0.37
Labs	18.28
Total:	**$127.97**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Category **CB1** which provides a national average Federal payment rate of approximately $159.00 per patient day and an average nursing component of only $92.00.

In this example, an urban SNF would be paid on average $39.48 for non-therapy ancillaries for this RUG, resulting in a loss of $88.49 per day.

Case Study #6

Admitting Diagnosis: End stage Cardiac Disease, CHF, COPD, Lymphoma, Severe Anemia, Pneumonia, Sepsis, Depression, MRSA in port-a-cath and sputum, Hypertension, Cardiomyopathy, pacemaker.

Clinical History: Patient admitted from local hospital for sub acute nursing and rehab. Upon admission, patient was severely debilitated due to medical condition. Patient was placed in isolation due to MRSA. Patient's clinical condition was very unstable. Patient was severely depressed with suicidal ideation. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, Rehab
Self Care Deficit	Nursing
Alteration in Mood	Nursing, Medical, SS
Impaired Mobility	Nursing, Rehab

Medications: Patient was concurrently on the following medications:

Coumadin	Digoxin	Indur
Lasix	Zerolyxin	Tylenol
Potassium	Cipro	Claforon
Prinivil	Prozac	

Special Services: Patient required extensive nursing care to monitor his condition due to the severity and progressing nature of his medical status. This included vital signs, intake and output, O_2 therapy, port-a-cath care, frequent observation and high level physical care due to patient's debilitating state. Patient required multiple EKGs, Chest X-Rays and lab work to monitor clinical course. Physical Therapy was provided to increase ability to ambulate, transfer, maintain balance and improve gait. Occupational Therapy was provided to increase ability to perform ADLs increase mobility, muscle strength and endurance. Patient was in Isolation due to MRSA/port-a-cath and sputum. Social Services was involved, along with psychiatric consultation to manage depression and suicide ideation. Social Services provided daily visits and multiple family meetings in regards to this problem. Activities provided one-on-one interaction and stimulation in patient's room to decrease feeling of isolation and manage depression and confusion.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Pharmacy	84.43
Medical Supplies	0.95
Labs	2.05
X Ray	31.83
Total:	**$119.26**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Category CC2 which provides a national average Federal payment rate of approximately $189.00 per patient day and an average nursing component payment of $123.00.

In this example, an urban SNF would be paid on average $52.64 for non-therapy ancillaries for this RUG, resulting in a loss of $66.22 per day.

Case Study #7

Admitting Diagnosis: Aspiration Pneumonia, CHF, Dysphagia, Lung Cancer with CNS Metastasis, Hypertension, COPD, Septic, VRE.

Clinical History: Patient admitted from local hospital for sub acute care and rehab. Upon admission, patient was totally dependent, bed bound and required total care due to clinical condition; had a PEG tube in place for feeding; and was S/P Ventilator Therapy for her severe pulmonary condition. Patient was alert and oriented X3, and was also incontinent of both bowel and bladder. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, Rehab
Altered Nutrition	Nursing, Dietary
Feeding Self Care Deficit	Nursing, Speech Therapy
Self Care Deficit	Nursing
Impaired Gas Exchange	Respiratory Therapy
Impaired Physical Mobility	Nursing, Rehab
Risk for Aspiration	Nursing, Rehab
Risk for Impaired Skin Integrity	Nursing, Rehab, Dietary
Alteration in Patterns of Elimination	Nursing

Medications: Patient was concurrently on the following medications:

Nitro Glycerin	Docusate
Enalapril	Notrtiptyline
Aspirin	Digoxin

Special Services: Patient required extensive nursing care for monitoring her condition and providing care due to patient's total dependence. Monitoring included Vital Signs, Intake and Output, Pulse Oximetry. Patient had continuous IV and O_2 therapy. Physical care included ADL's, bed mobility, incontinence care, prevention of alteration in skin integrity, including the use of a special surface. Occupational therapy was provided for ADL training, lower extremity strengthening and endurance, improving functional bed mobility, transfer and balance. Speech therapy was provided due to Dysphagia and to teach therapeutic feeding and caregiver education. Respiratory Therapy was provided several times a day to improve oxygenation.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	168.75
Pharmacy	26.55
Medical Supplies	15.17
Labs	39.37
X-Ray	38.24
Total:	**$288.08**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Category **SE2** which provides a national average Federal payment rate of approximately $219.00 per patient day and an average nursing component of $152.00.

In this example, an urban SNF would be paid on average $65.33 for non-therapy ancillaries for this RUG, resulting in a loss of $222.75 per day.

Case Study #8

Admitting Diagnosis: CHF, Pneumonia, GERD, S/P fall at home; hx of A Fib; Bronchitis, Pernicious Anemia, Expressive Aphasia.

Clinical History: Patient admitted from a local hospital for sub acute nursing and rehab. Upon admission, patient was alert, aphasic with significant cardiac and respiratory instability. Patient was not confused, but did have short term memory loss. Functional status was severely compromised due to decreased strength from cardiac/pulmonary conditions. Case planning goals of the interdisciplinary treatment plan were centered on the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing, Rehab
Self Care Deficit	Nursing
Impaired Gas Exchange	Nursing, Respiratory Therapy
Impaired Physical Mobility	Nursing, Physical Therapy
Feeding self-care deficit	Nursing, OT
Communication Deficit	Nursing, Speech Therapy

Medications: Patient was concurrently on the following medications:

Lasix	Coumadin
Zithromax	Lopressor
Amoxicillin	

Special Services: Patient required extensive nursing care for monitoring of condition including vital signs, pulse oximetry, I/O and a high level of physical care due to patients unstable cardiac condition, continuous monitoring of condition also included multiple blood draws, EKGs, Chest X-Rays and medical re-evaluation with order and medication changes. Patient required respiratory therapy three times a day to promote pulmonary recovery. Physical therapy was required five days a week for functional training, transfer instruction, ambulation and therapeutic exercise. Occupational therapy was required five days a week for ADL retraining, strengthening, bed mobility, transferring and balance. Speech therapy was required five days a week for training to overcome communication problems of aphasia. Social work involvement included discharge planning and setting up "Lifeline" so patient could return to independent living in the community.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	295.84
Pharmacy	38.97
Medical Supplies	3.88
Labs	31.01
X Ray	39.91
Total:	**$409.61**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category **RVB** which provides a national average Federal payment rate of approximately $286.00 per patient day and an average nursing component payment of $114.00.

In this example, an urban SNF would be paid on average $48.88 for non-therapy ancillaries for this RUG, resulting in a loss of $360.73 per day.

Bedsores: $1 billion burden

N.Y. peer review organization tries education to stop a preventable problem

By J. Duncan Moore Jr.

People who suffer strokes enter the hospital with their skin intact. Whether they leave that way depends on how hard the staff works to make sure that an immobile or unconscious patient doesn't develop a pressure ulcer.

Pressure ulcers, or bedsores, cost the U.S. healthcare system about $1.3 billion every year. People develop bedsores in the hospital or nursing home; they don't normally arrive with them. With proper care, bed-bound or wheelchair-bound patients shouldn't be vulnerable to bedsores at all. Thus, it's the ultimate preventable affliction.

IPRO, the Medicare peer review organization in New York state, wants to educate healthcare workers to prevent bedsores. It has created a "tool kit" to pass around to hospitals and is holding conferences for nurses, all part of a comprehensive educational program. Funding comes from HCFA.

"Our nation's $1 billion bedsore burden is created in a clinical setting and can be prevented in a clinical setting," says Mary Hibberd, M.D., IPRO's senior medical director.

To get the project started, IPRO sent letters to hospitals in New York inviting them to participate. Sixty-seven hospitals enlisted. IPRO then analyzed Medicare Part A data from 1994 to construct a baseline. It examined 1,253 patient records of admissions with cerebral bleeds, or strokes.

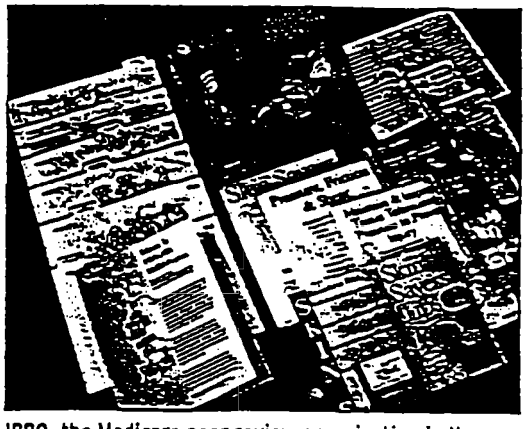
Certain patients have higher risk of developing bedsores than others, and stroke victims top the list. People who have suffered strokes may be paralyzed on one side of the body and unable to roll over or walk or sit up. They may be incontinent as well.

And they come into the hospital without bedsores, yielding the "cleanest baseline" for statistics, Hibberd says.

The baseline showed that risk assessments were carried out in just 56% of cases, when 88% of cases were at risk. Of those who did receive an initial risk assessment, 38% got a reassessment. Every at-risk patient should have had a follow-up assessment. Caregivers intervened with pressure relief in 27% of cases.

A severe bedsore extends the patient's time in the hospital and requires "an incredible amount of staff time" before it heals, Hibberd says. An ulcer that goes all the way to the bone takes four to six months to heal. Total costs can easily be upward of $50,000.

Hibberd used to work with a skilled nursing facility. "We would get patients back from the hospital all the time (with ulcers). Patients go into the hospital without a pressure ulcer and come back with a pressure ulcer," she says. The financial obligation to treat it falls on the nursing home.



IPRO, the Medicare peer review organization in New York, is offering a kit to teach bedsore prevention.

IPRO's tool kit includes self tests, diagrams on prevention and treatment, posters and a slide show for teaching. Plus, it includes guidelines from the Agency for Health Care Policy and Research, part of the Public Health Service, on how to prevent and predict pressure ulcers.

IPRO asks participating hospitals to draw up quality improvement plans based on their weaknesses shown in the initial assessment. "Some may be poor at repositioning; some may be poor at skin care," Hibberd says. "We look it over. We give them suggestions."

Hibberd

IPRO will give the hospitals and nursing homes six to 12 months to change their practices; then it will do a second measurement. Those are scheduled for the end of this year.

IPRO, based in Lake Success on Long Island, found a willing collaborator in Winthrop-University Hospital, in nearby Mineola. Barbara Scharf, a registered nurse, runs Winthrop's home health agency. Winthrop conducted an ulcer-prevalence study with Hill-Rom, a maker of durable medical equipment.

"We used the AHCPR guidelines to develop pressure-ulcer treatment protocols specific to our agency," Scharf says. "When it came time to present and educate the staff about protocols and wound-care practices, we used the kit—the teaching materials, posters and slide show."

On June 17 about 75 nurses and other caregivers visited the home-care agency for a pressure-ulcer education day. The IPRO tool kit was "wonderful," Scharf says. "We could focus our attention on getting the message to the nurses rather than go back to square one and research the best practices."

The survey Scharf did with Hill-Rom covered 420 agency patients, 31 of whom had bedsores. That's a baseline rate of 7.4%. Hill-Rom's national bedsore rate was 7.3%, she says.

Nurses loved the program, especially the self-learning format, she says. Also invited were 15 wound-care and moisture-control vendors, which demonstrated their products.

"This was the first step in the education," she says. "Now we have to do some more group teaching, then get more field visits and chart reviews to make sure the nurses are absorbing the new information."

The Winthrop agency intends to repeat the survey in a year or two to gauge improvement. At the HCFA regional office in Boston, which oversees the New York PRO, there's considerable excitement about this project, especially the way it fosters continuous quality improvement in the hospital.

"It's not just the tool kit," says Doris West, branch chief in the division of clinical standards and quality. "Also they're having periodic phone calls among the hospitals so they can share things. The PRO (staff are) making themselves available."

She and medical officer Diana Ordin, M.D., say they are especially pleased that so many hospitals are collaborating on the bedsore study. It's unusual to get so many participants in a statewide project, they say, and that will provide more credibility.

If the remeasurement later this year shows the kind of results they're hoping for, the project design would be a good candidate for dissemination to other states, West and Ordin say. ❑