



American Health Care Association

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September 29, 1995

skilled nursing home file

Mr. Chris Jennings
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Chris:

It was good to have a chance to come over to the White House on Wednesday to talk about where the President stands on Medicare and Medicaid and how the nursing facility industry can work with the Clinton Administration. This letter spells out in summary fashion the Medicare and Medicaid priorities of American Health Care Association (AHCA).

Enforcement

Our members have an immediate problem with the implementation of the nursing home enforcement regulations. As implemented, the new regulations have overnight redefined many good facilities as "out of compliance" or "substandard." (Please see the enclosed document describing "Implementation of HCFA's Final Survey, Certification, and Enforcement Rule.") This unfairly paints a bad picture of an industry that is working hard to do a very difficult job. The need to deal with this problem also distracts our members from focusing on, and becoming active on, the larger Medicare and Medicaid issues. We need a continuation of the current moratorium and a thorough reevaluation of the implementation of the enforcement regulations. We think the best solution would be a "deemed status" that would permit survey and certification by the Joint Commission on Accreditation of Hospital Organizations or other non-governmental entity.

Medicaid

We think the President's idea of \$54 billion in savings over seven years is a big improvement over \$182 billion. We can live with our share of that. We would like to see any Medicaid savings beyond \$54 billion come from permitting families to augment payment for the cost of care or from sources other than provider cuts. With the reductions in federal spending for Medicaid long term care should also come relief from

some aspects of the regulatory burden (e.g. requirements for pre-admission screening and annual resident review [PASARR]) that impose costs without corresponding benefits. Finally, we need some provision linking payment rates to quality. (Drafts of appropriate language regarding "Quality Standards/Reimbursement Methodology," and "Supplementation" of Medicaid reimbursement are enclosed.)

Medicare

We are eager to be part of the transition to a Medicare system with incentives for savings rather than the current incentives for greater and greater spending. Skilled nursing facilities (SNFs) can offer quality subacute care to a significant subset of Medicare beneficiaries at a much lower cost than hospital care. Medicare needs to take full advantage of this cost-savings potential -- and efforts to bring about Medicare savings must avoid shortsighted cuts that would cripple the capacity of SNFs to provide subacute care.

We propose:

- continuing the savings from the recent freeze in SNF routine cost limits (RCLs) (\$2.0 billion savings over seven years);
- implementing a prospective payment system (PPS) for skilled nursing facilities no later than October 1, 1998, with a statutory requirement for \$3.5 billion in savings;
- ending the differential between SNF routine cost limits between free-standing SNFs and hospital-based SNFs (\$4.1 billion savings over seven years);
- capping administrative overhead costs for ancillary services at the 90th percentile (\$3.1 billion savings over seven years);
- ending the current three-year exemption of new SNFs from routine cost limits (\$0.5 billion savings over seven years); and
- waiving the three-day prior hospital stay requirement for four specific Medicare diagnosis related groups (DRGs) (\$1.3 billion savings over seven years).

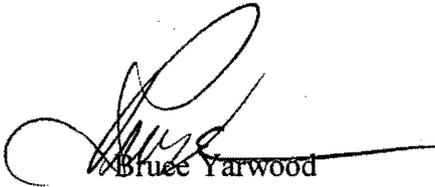
Please see the enclosed "Skilled Nursing Facilities, Cost Savings Options" for more detail. I have also enclosed a cost estimate by Muse & Associates regarding the potential savings from waiving the three-day prior hospital stay requirement for four DRGs, a summary of Abt & Associates research into the potential of SNF subacute care to bring about significant Medicare savings, and a letter I sent to Senator Roth regarding the Finance Committee mark on Medicare.

Long Term Care Insurance

We believe that private long term care insurance has real potential to ease the burden of long term care on the federal government and state governments. If Medicare and Medicaid spending is to be reduced, it becomes more important than ever that federal policy help Americans to help themselves via private long term care insurance. Therefore, we feel it is imperative that budget reconciliation legislation include provisions clarifying the federal tax status of private long term care insurance and establishing federal long term care insurance consumer protections.

Again, AHCA appreciates the opportunity to work with you on these key Medicaid and Medicare issues. We know that you are working hard to meet both policy and savings objectives and I hope that the measures outlined above help you do that. Let's be sure to continue our dialogue to make sure we reach our goals.

Sincerely,

A handwritten signature in black ink, appearing to read 'Bruce Yarwood', with a long horizontal flourish extending to the right.

Bruce Yarwood
Legislative Counsel

Enclosures

Enforcement Regs.

**Implementation of HCFA's Final Survey,
Certification and Enforcement Rule**

On November 10, 1995, the Health Care Financing Administration published the final nursing facility survey, certification and enforcement rule, dramatically changing the way nursing facilities are surveyed for compliance with federal requirements and the enforcement scheme applicable to noncompliant facilities. The rule was scheduled to become effective on July 1, 1995. In late June, 1995, HCFA announced adoption of a phased-in implementation plan for the enforcement portion of the final rule, under which remedies would be proposed against noncompliant facilities based on the scope (frequency) and severity (seriousness) of cited deficiencies, but no category 2 or 3 remedies [consisting of denial of payment for new admissions; denial of payment for all admissions; civil money penalties of up to \$10,000 per day; and temporary management] would actually be imposed for a period of 90 days or until October 1, 1995. It is important to note that during this 90-day period, all immediate jeopardy situations in poor performing facilities were, and continue to be subject to immediate remedies. According to HCFA officials, this 90-day testing period was designed to allow HCFA to conduct a "real-time" assessment of the final rule's enforcement provisions to ascertain their impact on the industry.

Prior to July 1, 1995, only segments of the survey portion of the final rule had been tested and no portion of the dramatic new enforcement system had been tested. During the 90-day period from July 1, 1995, HCFA has been gathering data from all states about the impact of the final rule on facilities and reviewing statements of deficiencies generated by states during facility surveys.

HCFA's 90-day testing period is scheduled to end on September 30, 1995, clearing the way for imposition of all available remedies on nursing facilities. **The American Health Care Association urges the Secretary of Health and Human Services, and HCFA officials, to continue the current ongoing monitoring and testing period of the enforcement portion of the final rule, for an indefinite period, for the following reasons:**

1. **HCFA's Data Reveals Significant Inconsistencies in Application of the Survey and Enforcement Process Across the Country:** The data HCFA has gathered on over 2,700 surveys from around the country reveals huge variations among states and HCFA regions in application of both the survey process and the resulting enforcement system. In the states of Utah and Nevada, for example, 100% of facilities surveyed have been found in substantial compliance with applicable requirements. By contrast, 99% of facilities in Michigan and 93% of facilities surveyed in Minnesota have been found out of compliance with applicable requirements and potentially subject to remedies. In HCFA region 10, 87% of facilities surveyed have been found out of compliance with requirements. HCFA region 5 follows closely with a noncompliance rate of 79%. By contrast 54% of facilities in region 9 and 64% of facilities in region 8 have been found out of compliance. More startling, the percentage of facilities identified as offering "substandard quality of care"--a designation which requires loss of the facility's nurse aide training program and notification to facility physicians and the state administrator's licensing board--is equally diverse across the country. In Kentucky and Michigan, for example, 57% and 61% respectively of all facilities surveyed have been labeled as offering substandard quality of care. By contrast, no facilities in either Colorado or Virginia have been labeled as substandard performers. Finally, the aggregate national data accumulated by HCFA reveals significant flaws in the system itself. According to HCFA's data, the revised survey and enforcement system has resulted in 73% of all facilities surveyed nationwide being found out of substantial compliance with minimum federal standards and 18% being labeled as substandard performers. Not only do these numbers not reflect the reality of the quality levels offered by nursing facilities in this country, but the huge variations across states and HCFA regions demonstrates that the rules as written and implemented are not being systematically and consistently applied. These significant variations cannot be explained by any factor other than inconsistency in the application of the survey and enforcement process itself. Although HCFA has promised to continue "monitoring" state survey actions, that alone will not remedy the inconsistency which now dominates this new system.

2. **The Data Being Gathered by HCFA to Evaluate This Dramatic New System is Incomplete and Inconsistent:** AHCA applauds HCFA's efforts to gather data from which it can assess the true impact of the final rule. During a recent meeting of HCFA's Impact Assessment Advisors, HCFA administrator Bruce Vladeck stated that the data-gathering efforts were implemented because "too much is at stake" to simply implement the rule fully as of July 1, 1995. AHCA agrees. However, HCFA's work is not completed. The data which HCFA is gathering, and upon which critical national decisions will be made, is incomplete, tentative and, in some cases, inconsistent. For example, HCFA has relied heavily in recent weeks upon the number of facilities which, after initially being found noncompliant, are back in compliance on a revisit. Yet, as of September 26, 1995 HCFA has data on only 201 revisits nationwide. Of those, about 15% remain out of compliance on the revisit. However, HCFA's data a week earlier indicated that only 8% were out of compliance on the revisit. Thus, this critical factor has nearly doubled in the span of one week as HCFA has gathered more data and even now the reported number of revisits is minuscule. Also, HCFA's data is largely self-reported data from the states. Several agency directors have indicated that the data reflected for their states on HCFA's reporting forms does not match data submitted by the state. And some agencies have reported confusion over how and what data to report. Given these issues, HCFA needs to continue its data-gathering efforts, ensure that all data is accurate, and withhold final assessment of the rule and imposition of remedies until it has a reliable database by which to measure the rule's impact.

3. **The Final Rule as Implemented Creates a Level of "Process" Which is Overwhelming State Survey Agencies :** The final rule as implemented creates a system of surveys, revisits and accompanying paperwork which is overwhelming state survey agencies. Many agency directors across the country have reported to HCFA and to AHCA that they cannot keep up with the work load. They have reported a lack of state funds to implement all available remedies and difficulty scheduling revisits of facilities found out of compliance. These problems have very real negative consequences for the industry as well. Under the rule and accompanying protocol, facilities found out of compliance must come back into compliance by a date established by the survey agency, either to avoid remedies altogether or to end remedies already in place. If survey agencies cannot respond to facility requests for timely revisits, facilities remain at risk for potentially crippling remedies, including heavy civil money penalties. The current financial climate in most states forecloses solving these problems by adding more survey agency staff.

4. **The Indiscriminate Impact of the Final Rule as Implemented on Good and Poor Providers Alike is Inciting Nursing Facility Provides Nationwide to View Pending Medigrant Proposals as a Preferable Alternative to Current Federal Oversight of Nursing Facilities:** Since its inception, the final rule has been touted as designed to identify and deal quickly with facilities which are chronic, serious and repeat offenders. AHCA has supported that effort. In practice, however, the final rule is resulting in high levels of noncompliance and potentially severe remedies for high quality and poor performers alike. During the initial 90 day monitoring period, many good facilities are being "nit-picked" with citations that do not affect resident's quality of care and which, because of HCFA directions and interpretations, often result in good facilities being labeled "substandard" because of an isolated incident or a series of minor incidents. This reality is creating a groundswell of support among providers for the pending Medigrant proposal and similar proposals which would wrest oversight of the industry from the federal government and return it to the states. This growing support for state control will be stemmed only if the industry is convinced that HCFA is dedicated to fair and consistent enforcement of applicable requirements before unleashing the full impact of this significant rule on the industry.

For all these reasons, the Secretary and HCFA should continue the ongoing monitoring and testing period of the final rule, with a suspension of penalties and a full and intense review to correct the problems with the enforcement system.

Payment & Quality

QUALITY STANDARDS/REIMBURSEMENT METHODOLOGY

Each state MediGrant Plan shall:

(1) provide for the establishment and maintenance of quality assurance and safety standards consistent with Section _____ of this Act for nursing facilities which furnish services under the Plan; and

(2) specify the methodology used by the state (or any of its contractors) to set reimbursement rates that are consistent with the quality assurance and safety standards established by the Plan for nursing facilities.

SUPPLEMENTATION

ATTACHMENT

Section 2135. RECOVERIES FROM BENEFICIARIES,
 RESPONSIBLE PARTIES, THIRD
 PARTIES, AND OTHERS.

(b) Beneficiary and Provider Protection. ---

(1) In General -- Each MediGrant plan shall provide that in the case of a provider or person furnishing services under the plan --

(A) the provider or person may seek to collect from the individual (or financially responsible relative) payment of an amount for services that: (i) are not included in the payment rate; and (ii) are needed or requested by the individual, the attending physician, or the financially responsible relative;

(B) the provider or person may seek to collect from the individual (or financially responsible relative) payment of the additional amounts attributable to furnishing deluxe or premium services where: (i) the payment rate only covers non-deluxe or non-premium delivery of such services; and (ii) the individual, the attending physician, or the financially responsible relative requests such deluxe or premium services; and

(C) the provider or person may seek to collect from the individual (or financially responsible relative) payment of certain amounts for services that are included in the payment rate to the extent that the payment rate does not cover the provider's or person's reasonable costs for such services; such collection shall not: (i) when added to the MediGrant rate (including cost-sharing) exceed the amount of the provider's reasonable costs for such services; or (ii) be construed to violate Section 1128B(d) of the Social Security Act (42 U.S.C. § 1320a-7b(d)).

Medicare SNF Svgs

SKILLED NURSING FACILITIES

COST SAVINGS OPTIONS

September 29, 1995

Episodic Prospective Payment System (PPS) and Data Collection **10/1/1998**

A new payment system for SNFs would be implemented to provide incentives for cost efficiencies and place the risk for an episode of care on the provider. SNFs would move to an episodic PPS on or before October 1, 1998 when the data necessary to implement such a system, with adjustments for case mix and higher acuity patients included, is ready. In the interim, all billings for services provided to beneficiaries in SNFs under Part A and Part B of Medicare would be consolidated and billed by the facilities. Routine and ancillary services would be defined in statute. After consolidated billing and the RUGS III Demonstration Project result in the appropriate data collection, **a single payment for all SNF services, including ancillary services, would be developed.** The Secretary would be required to work with industry to collect and maintain all data necessary, and in developing such a system. **Savings - \$3.5 billion in statute through 2002**

Payments for Routine Services **10/1/1996**

SNF Routine Cost Limits (RCLs) would lock in the institutional savings of the two year freeze on (RCLs) as proposed in the President's budget. **CBO Savings - \$2 billion through 2002.**

Payments for Ancillary Services **1/1/1996**

Ancillary services would be capped by limiting the loading factor for ancillary services at the 75th percentile, by region and by type of ancillary service. If a nursing facility has a load factor higher than the 75th percentile, then the amount above the percentile limit would not be allowed. The Secretary would also limit the allowable costs for such services to grow at no more than five percent (5%) annually unless the increase in excess of 5% is attributable to a nursing facilities case mix, increased admissions, increased length of stay, or other factors identified by the Secretary. **Estimated Savings - \$3.1 billion at 75% through 2002.**

Limits on Therapy Payments **1/1/1996**

Payments to contract occupational and speech therapists would also be limited to amounts paid if they were employed by a facility. **Estimated Savings - \$1 billion through 2002.**

Reduce the New Provider Exemption from the RCLs **10/1/1996**

New skilled nursing facilities are exempt from routine cost limits for a three year period. This exemption would be eliminated. **Estimated Savings - \$500 million through 2002.**

Equalize RCLs of All Skilled-Nursing Facilities **1/1/1996**

Studies show there is no longer a justification for an RCL differential between free standing and hospital-based SNFs. Equalizing the RCLs at 112% of the mean for all SNFs is justified. **Estimated Savings - \$4.1 billion through 2002.**

Partial Repeal Of The 3-Day Hospital Stay **1/1/1996**

Abt Associates, Inc. estimates that waiving the mandatory 3-day hospital stay for certain DRGs could save Medicare up to **\$500 million per year.** A proposal to require the Secretary to waive the 3-day stay for only 4 DRGs identified as not having any potential for increased utilization would result in significant savings. **Estimated Savings - \$1.3 billion through 2002 (beneficiaries would save \$625 in reduced hospital copayments over the period).**

20% Copayment for SNF Services

1/1/1996

AHCA supports the concept that beneficiaries be exposed to first-dollar costs to heighten their awareness of medical costs. AHCA also believes that copayments for post-acute care services should be applied equally. SNF services currently have a copayment after the 21st day equal to approximately 83% of average routine costs. AHCA supports the imposition of a 20% copayment per average SNF day on post acute care. **Estimated savings - \$4.4 billion through 2002.**

3-Day Stay

Memorandum

Date: September 27, 1995
To: Bruce Yarwood
From: Don Muse
Re: Savings From Elimination of the 3 Day Stay Requirement for Selected DRGs

The purpose of this memorandum is to detail the savings estimate for the proposal AHCA is considering which eliminates the three day hospitalization requirement in the Medicare program for Skilled Nursing Facility (SNF) services for selected Diagnostic Related Groups (DRGs). We estimate that the proposal would save the Medicare program \$1.3 billion and Medicare beneficiaries \$625 million over the seven year Congressional scoring window.

Current Law

Medicare currently requires that beneficiaries be hospitalized for three days prior to admission to a skilled nursing facility. This requirement was repealed during the Medicare Catastrophic Program, but was subsequently reinstated.

Proposal

Allow physicians to admit Medicare beneficiaries directly into a SNF for subacute services for the following DRG's:

- DRG 410 Chemotherapy w/o acute leukemia as secondary diagnosis
- DRG 271 Skin ulcers
- DRG 254 Fx sprain & disl of uparm lowleg ex foot age >17 w/o cc
- DRG 238 Osteomyelitis

These DRG's were selected for two reasons. First, a panel of physicians and other medical experts concluded that patients with the conditions specified by these DRG's were medically safe to admit

directly to a SNF.¹ Secondly, these DRG's are for conditions that are clearly medically verifiable and not subject to the possibility of "induced demand." That is, as a consequence of Medicare allowing direct admission to a SNF, it is extremely unlikely that the number of Medicare beneficiaries needing, for example, chemotherapy, will increase.

Payment under the proposal will be a capitated payment at 80 percent of current Medicare reimbursement for the DRG. This payment methodology avoids increasing in Medicare spending that might occur as a consequence of a SNF increasing the number of days that a beneficiary would stay and also takes into account the hospital deductible, since reimbursement levels are net of deductibles. The beneficiary would also benefit since they would avoid the hospital deductible. This proposal excludes intra-institution transfers of patients.

Cost Estimate

Detailed data on the four DRGs was available from the Abt study (Copy attached). Medicare data from 1991 showed 176,939 admissions to hospitals for these DRGs at an average reimbursement of \$7,168. Data from 1994 showed that these had increased to 186,117 and \$8,062 respectively. Assuming that 50 percent of these admissions were shifted to SNFs, the savings to Medicare in 1994 for the proposed policy would have been \$1,612 per admission or \$155 million dollars. Using Congressional Budget Office baseline assumptions, this would lead to savings of \$1.3 billion dollars over the 1996-1997. In addition, beneficiaries would save \$625 million in avoided hospital copayments over the 1996-1997 period.

Please call me if you have any questions.

AHCA/3day

¹ Subacute Care in Freestanding Skilled Nursing Facilities: Estimate of Savings to Medicare, May 1994, Abt Associates Inc., Cambridge, Ma.

Subacute Care SVgs



Abt Associates Inc.

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Subacute Care at Freestanding Skilled Nursing Facilities: A Source of Quality Care for Medicare Patients

26 September 1995

Prepared for
American Health Care Association
1201 L Street, N.W.
Washington, D.C. 20005-4014

Prepared by
Daniel Sherman, Ph.D.
Abt Associates Inc.

Subacute Care at Freestanding Skilled Nursing Facilities: A Source of Quality Care for Medicare Patients

In the search for cost-effective approaches to providing health care, attention has centered on identifying ways to care for hospital inpatients in alternative settings without sacrificing quality of care. Two recent research reports conducted by economists at Abt Associates have shown that freestanding skilled nursing facilities (SNFs) can provide certain patients currently treated in hospitals with quality subacute care at a substantially lower cost than can hospitals.

The first study focused primarily on identifying Medicare hospital inpatients who could receive subacute care at freestanding SNFs.¹ The study found that freestanding SNFs could have provided subacute care to up to 2.9 million Medicare patients in 1991. These patients would have spent 19.6 million fewer days in hospitals. As a result, Medicare could have saved as much as \$9 billion per year by treating patients in less-expensive subacute skilled nursing facilities rather than hospitals.

The estimates in this report were developed in consultation with clinicians who identified the share of patient in 62 diagnosis related groups (DRGs) who could be treated as subacute care patients in freestanding SNFs. Most of these patients would require at least some hospitalization before transfer to a SNF. The clinicians felt, however, that at some point of the time that is currently spent in a hospital, most of these patients could be transferred to a SNF for subacute care without sacrificing the quality of care. These included patients in DRGs with the largest number of patients, including DRG 127 (heart failure and shock) DRG 89 (simple pneumonia and pleurisy), and DRG 14 (cerebrovascular disorders). They also included medically complex patients such as those dependent on ventilators.

Based on analysis of the cost of treating patients in the two settings, the report found that Medicare could have saved an average of \$455 for each day that subacute care at freestanding SNFs was substituted for hospital-based care. For Medicare to realize these savings, however, Medicare would need to allocate the current hospital DRG payment for a subacute patient between hospitals and SNFs based on the cost of providing care, with the excess reverting to the Medicare program in the form of program savings. In order to gain the maximum program savings, Medicare would also have to eliminate, for selected DRGs, the requirement that patients stay at least three days in a hospital before becoming eligible for Medicare coverage in a SNF.

The second study specifically examined the issue of quality of care in alternative settings by focusing on the outcomes of rehabilitation patients.² The study compared changes in patients'

¹ The study, Subacute Care in Freestanding Skilled Nursing Facilities: An Estimate of Savings to Medicare, was prepared by Abt Associates for the American Health Care Association in 1994.

² This study, Rehabilitation Outcomes by Site of Service: A Comparison of Hospitals to Subacute Care Units of Freestanding Skilled Nursing Facilities, was prepared by Abt Associates for the American Health Care Association in 1995 and is currently under review.

functional status from admission to discharge to a rehabilitation program as measured by the Functional Independence Measure (FIM) instrument. The FIM instrument is widely used and has been extensively validated as a means for clinicians to assess rehabilitation patients' independence in performing different tasks (e.g., bathing, locomotion, communication).

The Abt study used recent (1994-95) information on over 22,000 rehabilitation patients. The data included both patients treated at hospitals and at the subacute units of freestanding skilled nursing facilities. The analysis covered patients from across the nation with all types of impairments, including stroke and orthopedic patients who represent the majority of rehabilitation patients.

The primary finding of the study was that although rehabilitation patients treated at SNFs were somewhat older and more debilitated than patients at hospitals, they experienced the same level of improvement in functional status on average as did patients treated in hospitals. The results of the study indicate that outcomes of rehabilitation patients treated at subacute SNFs were greater than they are for the most debilitated patients (i.e., patients whose functional status is in the lowest fifth of all patients). For most other patients, there were no significant differences in outcomes between the hospitals and subacute setting. The exception was among the least debilitated patients where patients treated at hospitals experienced larger gains in functional status than those treated in freestanding SNFs.

Data from the Abt study indicate that rehabilitation patients at subacute SNFs were treated at a substantially lower charge than are patients in hospitals. The average daily charge at hospitals for treating rehabilitation patients was \$1,127 compared to \$621 per day at subacute SNFs. On a per-case basis, average total charges at subacute SNFs (\$16,170) were 70.3 percent of those at hospitals (\$22,895). In combination with the finding that outcomes are comparable across settings, these results provide evidence that subacute SNFs are a cost-effective alternative to hospitals in treating rehabilitation patients.

Ltr. to Sen. Roth



American Health Care Association

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September 27, 1995

Senator William V. Roth Jr.
SH-104 Hart Building
Washington, D.C. 20510

Dear Senator Roth:

On behalf of the American Health Care Association, a federation of 51 affiliated associations that represent more than 11,000 non-profit and for profit assisted living, nursing facility, and subacute care providers nationwide, I am writing to express our strong opposition to the unfair and unwise treatment of skilled nursing facilities in the Medicare portions of your Committee's draft mark. Coupled with Medicaid spending reductions of as much as \$67 billion over the next seven years (a figure with which we also strongly disagree), a fact that was virtually ignored in putting together the proposal, the Medicare reductions will cripple the provision of skilled nursing facility (SNF) services that offer tremendous opportunity to save Medicare as much as \$9 billion per year.

This letter is to strongly object to most of the Medicare proposals included in your mark and to urge you to again review our alternatives. Most importantly, we disagree with the concept that we have a "fair share" to come up with to meet budget targets. We have been told to offer up \$10 to \$13 billion; irrespective of the fact we are a lower cost, highly economic alternative in today's market. This shortsightedness is not reflective of our industry - one that is controlled by a Routine Cost Limit (RCL) that is frozen with 79% of SNF facilities over the limit, not a DRG that has continued growth built in each year.

We do agree that changes are necessary to control ancillary costs and put us on a prospective system. In fact we have been pushing for such a system for years. Our concept however, is to encourage the industry to compete on a level playing field, not to penalize us for being efficient. Consequently, we have a very simple approach to obtain savings by enhancing competition while moving to curtail costs. In short, we suggest:

- ◆ Accept the Presidents budget proposal on capturing RCL savings from OBRA'93 **\$ 2.0 billion**
- ◆ Eliminate exemptions from RCLs for new providers **\$.5 billion**
- ◆ Eliminate arbitrary 50% RCL add-on for hospital-based SNFs **\$ 4.1 billion**
- ◆ Cap ancillary service overhead factors at the 90th percentile **\$ 3.1 billion**
- ◆ Require SNFs to move to a PPS by 2000 with mandatory savings in statute **\$ 1.0 billion**
- TOTAL \$10.6 billion**

It is important to note that we would increase the PPS savings required to meet any necessary adjustment in the cost savings required should scoring difficulties arise.

Let me say a word about the proposals put on the table by the Finance staff. In general they seem to disregard our need to maintain a competitive edge in the emerging subacute field. Rather, they constrict our ability to be a lower cost alternative in the Medicare market. Here are a few of our objections:

¹ Subacute Care in Freestanding Skilled Nursing Facilities, An Estimate of Savings to Medicare, Abt Associates, Inc., June 1994.

The proposal to curtail price and volume in ancillary services will discourage SNFs from offering services to patients of higher acuity, thus greatly diminishing the ability of SNFs to substitute for hospital stays that are 30% to 60% more costly² per day and save up to \$9 billion per year. The proposal will drive SNF providers with high acuity patients out of the market and push more patients back into high cost hospital system.

- ◆ The staff proposal wrongly claims there are no limits on SNF capital reimbursement, when in fact SNFs have been under strict capital limits since 1984, requiring recapture of depreciation and allowing no step-up in basis on sale. In addition, SNFs lost return on equity payments just two years ago. SNFs require capital to compete in the managed care marketplace.
- ◆ The proposal to limit "atypical exceptions" which allow SNFs to be reimbursed for taking higher acuity heavy care patients, allowing them to be treated away from more expensive hospital settings. This creates a disincentive for use to offer a lower cost alternative to expensive hospitalization. The staff driven imposition of artificial price controls ignores business practices in managed care and the private market place where SNFs are being used to significantly reduce costs. One need only look at managed care companies use of SNFs to buttress our assertion that we are treating sicker patients.
- ◆ Staff has proposed to limit ancillary services on a per case basis, when in fact no system exists or will there be data to develop such a system to determine episodic SNF beneficiary experiences until RUGs III Demonstration data and at least one year of consolidated billing data are available. In the rush to attack the provision of higher acute services in SNFs, staff has developed a proposal that will harm patient care and cannot be implemented properly, ignoring industry proposals that could be implemented immediately.
- ◆ Staff has rejected industry proposals to remove costly and unnecessary advantages given to hospital-based SNFs, including cost limits that are set at a rate 50% higher than the difference between freestanding and hospital-based SNF costs. A study to be released this week by Abt Associates, Inc. found that according to standard Functional Independence Measurement instruments, rehabilitation patients in freestanding SNFs have a more severe level of impairment upon admission than those treated in hospitals. Other studies have found little difference in patient acuity between the different SNF settings. Yet, care in hospital-based SNFs costs an average of \$435 per day vs. only \$275 and hospital-based SNFs are growing at almost 10 times the rate of freestanding SNFs.³
- ◆ Our proposal to begin with an episodic case-mix adjusted prospective payment system by 1999 while guaranteeing as much as \$3.5 billion in savings, has fallen on deaf ears. Statutory language can be written to guarantee this substantial offer.

Attached for your review and perusal, is a draft of our original proposal submitted to your staff as well as a just completed analysis of the similarities between hospital-based and freestanding SNFs. We believe that you could reach your reconciliation target goals by equalizing payment for SNFs regardless of setting, by moving to prospective payment and controlling the growth in ancillary services. This can be done without creating disincentives for us and causing us to try to compete in an unfair marketplace.

² HCFA Administrator Bruce Vladeck, Testimony before the House Ways and Means Committee, July 20, 1995.

³ Over the last 8 years, hospital-based SNFs grew at 200% vs. 29% for freestanding SNFs, ProPAC analysis of SNF services, September 1995.

Senator William V. Roth, Jr.
Page Three
September 27, 1995

Without substantial changes to your Medicare proposals, we must oppose them strongly and feel that industry proposals should have been given better opportunity for fair review.

Sincerely,

COPY

Bruce Yarwood
Legislative Counsel

Enclosure

Medicare Survey Certification File



OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS



FACSIMILE COVER SHEET

TO: Chris Jennings DATE: 3/15/96

Telephone: _____ Fax No. _____

FROM: John T. Hammarlund
200 Independence Ave SW, Room 341-H
Washington, DC 20201
Telephone: (202) 690-5512; Fax: (202) 690-8168

Number of pages (without cover sheet): 1

*Nancy Ann -
Here's the whole
package -*

*Thanks
[Signature]*

COMPARISON OF REP. LINCOLN BILL WITH HCFA RECOMMENDED CHANGES

1. *Universe of Providers for whom deemed status is possible.*

Lincoln's bill expands the provider types to include all Medicare providers, suppliers, managed care plans, and Medicaid as well as Medicare nursing homes. HCFA's changes exclude deemed authority for DME suppliers, Medicare managed care plans, and Medicare and Medicaid nursing homes.

2. *Degree of Secretarial flexibility in making deeming decisions.*

A. Under current law, the Secretary makes two decisions: (1) can a private accrediting body provide adequate assurance that it understands Medicare standards, can survey against them, and enforce them? and (2) should the Secretary allow a particular provider type to have deemed status (that is, to be surveyed by an accrediting body rather than by States acting on behalf of HCFA)? The Secretary may treat, to the extent he or she deems it appropriate, providers as having met Medicare standards if the provider has been accredited by a HCFA-accepted national accrediting body. Lincoln's bill would require ("shall") the Secretary to deem providers if a provider has been accredited by an accepted accrediting body. This constrains decision (2) above. The HCFA recommendations, in a compromise, adopt the "shall" language (that Rep. Lincoln advocates) but retain the modifier "to the extent he or she deems appropriate" (so that the Secretary retains flexible authority over both decisions (1) and (2)).

B. Current law has no time limit for Secretarial decision-making about deeming. Lincoln bill would impose a 120-day decision-making period, with a 30-day Federal register notice period included within this 120 days. In a major concession, the HCFA changes would adopt a statutory time line, but would extend 120 days to "180 days" and have the Federal register notice and public comment period outside the 180-day window.

C. Lincoln bill does not specify factors the Secretary may use in making a deeming decision. The HCFA recommendations include factors (lifted from HCFA regulations) that would ensure (1) high quality care and (2) that the accrediting body can fully perform the survey and enforcement functions.

3. *Potential for Deeming Nursing Homes.* Lincoln bill's expansive language opens the door for deeming of Medicaid providers, particularly nursing homes. The House Appropriations version of the Lincoln's proposal explicitly states that if a provider is treated as meeting the Medicare conditions, the Secretary must treat the entity as meeting the Medicaid requirements as well. This removes States' flexibility in determining Medicaid participation and ties the Secretary's hands. The HCFA recommendations make it clear that deemed status for Medicare has no bearing on participation in Medicaid (to preserve State flexibility) and removes any deeming potential for Medicare and Medicaid nursing homes.

4. *Partial Deeming.*

Lincoln bill could be construed to allow partial deeming, which is unacceptable to HCFA. HCFA recommendations make it clear that the Secretary must have reasonable assurance from an accrediting body that all conditions of participation are met or exceeded.

5. *Validation of accreditation bodies' surveys and enforcement through look-behind surveys.*

Lincoln's bill could be interpreted to remove responsibility from States to conduct validation surveys or beneficiary complaint surveys. The HCFA changes delete this "Recognition of Surveys of National Accreditation Bodies" section and instead make clear that the States may conduct validation surveys at the request of the Secretary.

URGENT

Chris

NOTE TO: Jerry Klepner
Jack Ebeler
John Callahan

MAR 15 1996

FRT

FROM: Debbie Chang

We will need
your help in clearing

URGENT RESPONSE REQUIRED!!!!

We have been asked, by Chris Jennings, to provide technical assistance to Rep. Blanch Lambert Lincoln (D-Ak) on a provision that may be attached to the CR. Bruce Vladeck met with Rep. Lincoln Wednesday evening, and she requested comments on her bill by Friday morning.

w/OMB

Rep. Lincoln's bill does two things: (1) allows a longer survey cycle for HHAs, and (2) expands deeming. We have no problems with the first provision (survey cycle for HHAs) as it is one of our proposals. We do, however, have serious concerns about the expansion of deeming.

because
Lincoln

The Secretary currently has authority to deem providers as meeting the Medicare conditions of participation on the basis of a survey from an approved accreditation organizations. While HCFA does not have any philosophical disagreement with an expanded partnership between the Federal government and private accrediting organizations to achieve quality oversight of providers, we are concerned that the bill diminishes Secretarial flexibility. In addition, the bill would allow deeming of Medicaid nursing homes. If the facility meets the Medicare standards, the State would be required to deem it as meeting the Medicaid standards, even if the Medicaid standards are different. It would also add managed care organizations and Medicare suppliers to the universe of entities that accrediting organizations can survey. Finally, it may allow "partial" deeming. Currently, we have taken the position that all conditions of participation may be met for providers to enter and remain in the program.

wants

by noon

Friday

3/15

WE ARE SEEKING YOUR CLEARANCE ON THE MARK-UP OF LEGISLATIVE LANGUAGE ATTACHED. We will be providing this language today to Rep. Lincoln at her request. We have also attached for your information current law, and talking points that we prepared for Bruce Vladeck on this topic. We are NOT seeking your clearance on these talking points at this time.

Handwritten signature

Debbie

DUE TO THE TIGHT TIME FRAME, WE ARE SEEKING YOUR COMMENTS NO LATER THAN 10:00 THIS MORNING. PLEASE PROVIDE COMMENTS TO JOHN HAMMARLUND (690-5512) OR SHARON ARNOLD (690-5705) AS SOON AS POSSIBLE. THANK YOU.

Handwritten scribble

104TH CONGRESS
2D SESSION

H. R. 3004

IN THE HOUSE OF REPRESENTATIVES

Mrs. LINCOLN (for herself and Mr. TAUZIN) introduced the following bill;
which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to extend the maximum period permitted between standard surveys of home health agencies and to expand the scope of "deemed status" and permit recognition of surveys by national accreditation bodies for providers under the medicare program.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. CHANGE IN INTERVALS BETWEEN STANDARD
 2 SURVEYS FOR HOME HEALTH AGENCIES
 3 UNDER THE MEDICARE PROGRAM.

4 Section 1891(c)(2)(A) of the Social Security Act (42
 5 U.S.C. 1395bbb(c)(2)(A)) is amended—

6 (1) by striking “15 months” and inserting “36
 7 months”, and

8 (2) by amending the second sentence to read as
 9 follows: “The Secretary shall establish statewide av-
 10 erage intervals between standard surveys that are
 11 consistent with the previous sentence and the need
 12 to assure the delivery of quality home health serv-
 13 ices.”.

14 SEC. 2. EXPANSION OF “DEEMED STATUS” AND RECOGNI-
 15 TION OF SURVEYS BY NATIONAL ACCREDITA-
 16 TION BODIES FOR PROVIDERS UNDER THE
 17 MEDICARE PROGRAM.

18 (a) “DEEMED STATUS”.—

19 (1) IN GENERAL.—Section 1865(a) of the So-
 20 cial Security Act (42 U.S.C. 1395bb(a)) is amend-
 21 ed—

22 (A) in the third sentence—

23 (i) by striking “of section
 24 1832(a)(2)(F)(i)” and all that follows
 25 through “deems it appropriate” and insert-

Replace
with
attached
re-wording

1 ing "or requirements of this title are met,
2 the Secretary shall", and

3 (ii) by striking "the condition or con-
4 ditions" and inserting "any condition or
5 requirement"; and

6 (B) by inserting after the third sentence
7 the following: "The Secretary shall approve or
8 deny a written request for such a finding (and
9 publish notice of such approval or denial) not
10 later than 120 days after the date such a re-
11 quest (with any documentation necessary to
12 make a determination on the request) is re-
13 ceived. The Secretary shall provide notice and a
14 period of at least 30 days (during such 120
15 days) for public comment on such a written re-
16 quest."

17 ~~(2) CONFORMING AMENDMENT.—Section~~
18 ~~1834(j)(1)(E) of such Act (42 U.S.C.~~
19 ~~1395m(j)(1)(E)) is amended by inserting "or as au-~~
20 ~~thorized under section 1864(a) or the third sentence~~
21 ~~of section 1865(a)" after "section 1842".~~

22 ~~(b) RECOGNITION OF SURVEYS OF NATIONAL AC-~~
23 ~~CREDITATION BODIES.—Section 1864 of such Act (42~~
24 ~~U.S.C. 1395aa) is amended by adding at the end the fol-~~
25 ~~lowing new subsection:~~

← delete

← delete

1 “(f)(1) The Secretary shall treat an entity referred
2 to in subsection (a) as meeting the applicable require-
3 ments or standards described in such subsection if the en-
4 tity has been determined to meet such requirements or
5 standards by a national accreditation body that deter-
6 mines compliance with such requirements or standards in
7 a manner that the Secretary finds is comparable to the
8 manner in which a State agency would otherwise deter-
9 mine compliance with such requirements or standards
10 under an agreement under this section.

11 “(2) The Secretary shall approve or disapprove a
12 written request for such a finding (and publish notice of
13 such approval or denial) not later than 120 days after the
14 date such a request (with any documentation necessary
15 to make the determination on the request) is received. The
16 Secretary shall provide notice and a period of at least 30
17 days (during such 120 days) for public comment on the
18 request.”

← delete

SEC. 2. EXPANSION OF "DEEMED STATUS" AND RECOGNITION OF SURVEYS
BY NATIONAL ACCREDITATION BODIES FOR PROVIDERS
UNDER THE MEDICARE PROGRAM.

(a) "DEEMED STATUS". --

(1) IN GENERAL.-- Section 1865(a) of the Social Security Act (42 U.S.C. 1395bb(a)) is amended--

(A) in the third sentence --

(i) by inserting, after "accreditation of an entity" the following: "(other than providers of services that meet the conditions of section 1861(j), entities described in section 1876, and suppliers described in section 1861(n))"

(ii) by striking "any or"

(iii) by inserting, after "all of the conditions", the following: "or quality outcomes, required under this title or as specified by the Secretary in regulation, are met or exceeded"

(iv) by striking "of section 1832(a)(2)(F)(i)" and all that follows through "deems it appropriate" "he may" and inserting "or requirements of this title are met, the Secretary shall", and

(v) by striking "the condition or conditions" and inserting "any all conditions or requirements quality outcomes,"

(B) by inserting between the third and fourth sentences the following:

"In making such a finding, the Secretary shall consider, among other factors, the national accreditation

body's accreditation requirements, survey procedures, ability to provide adequate resources for conducting required surveys and enforcement activities, monitoring procedures for entities found out of compliance with the conditions or quality outcomes, and ability to provide the Secretary with necessary data for validation. The Secretary shall approve or deny an application a written request for such a finding ~~(and publish notice of such approval or denial)~~ not later than ~~120~~ 180 days after receiving a completed application the date such a request (with all documentation deemed necessary by the Secretary to make a determination on the request) is received. The Secretary shall provide publish notice of any such approval or denial and shall provide a period of at least 30 days ~~(during such 120 days)~~ for public comment on an application during the ~~120 day period~~ any such approval or denial. Within 30 days after the close of such comment period, the Secretary shall publish final notice of such finding".

(b) AUTHORITY FOR VALIDATION SURVEYS.--

(1) Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended by adding the following new subsection:

" (c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in section 1864(a) of this title will survey, on a selective basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the

existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), entities that, pursuant to the third sentence of subsection (a), are treated as meeting the conditions or quality outcomes of this title and as specified by the Secretary in regulation. The Secretary shall pay for such services in the manner prescribed in section 1864(b)."

(2) Section 1864(c) of the Social Security Act (42 U.S.C. 1395aa(c)) is repealed.

(c) NO MANDATED APPLICATION TO TITLE XIX.--Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended by adding the following new subsection:

"(d) That an entity is treated, pursuant to subsection (a), as meeting all of the conditions or quality outcomes, required under this title or as specified by the Secretary in regulation, shall not require that the entity be treated as meeting the conditions, quality outcomes, or requirements, of title XIX."

To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1819(a). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1865 with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1865, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of

performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).

(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e) and section 1819(g) and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies).

(e) Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title (other than any fee relating to section 353 of the Public Health Service Act)⁴⁹⁷.

EFFECT OF ACCREDITATION

SEC. 1865. [42 U.S.C. 1395bb] (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2)(A) such institution authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),

(B) such Commission releases such a copy and any such information to the Secretary, then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

⁴⁹⁷P.L. 103-432, §160(a)(1)(A), struck out "title" and substituted "title (other than any fee relating to section 353 of the Public Health Service Act)", effective October 31, 1994.

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1832(a)(2)(F)(i),⁴⁹⁸ 1861(e), 1861(f), 1861(j), 1861(o), 1861(p)(4)(A) or (B), paragraphs (15) and (16) of section 1861(s), section 1861(aa)(2), 1861(cc)(2), 1861(dd)(2), or 1861(mm)(1), as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding. The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(b) Notwithstanding any other provision of this title, if the Secretary finds that a hospital has significant deficiencies (as defined in regulations pertaining to health and safety), the hospital shall, after the date of notice of such finding to the hospital and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1861(e).

AGREEMENTS WITH PROVIDERS OF SERVICES⁴⁹⁹

SEC. 1866. [42 U.S.C. 1395cc] (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)),

⁴⁹⁸P.L. 103-432, §145(c)(4), struck out "1834(c)(3)," applicable with respect to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act apply to such mammography conducted by such facility.

⁴⁹⁹See Vol. II, P.L. 97-248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance

“EXPANDED DEEMING” PROPOSAL

Summary of Proposal:

- (1) Would make deeming decisions less permissive and impose a short time frame for Secretarial decision-making.
- (2) Would remove State discretion on meeting Medicaid participation requirements; in effect, this would permit deeming for Medicaid nursing homes.
- (3) Would require that HCFA recognize results of approved private surveys for Medicare certification, which could remove State survey agencies from any survey and certification activities, including look-back surveys.
- (4) May allow partial deeming.
- (5) Appears to add Medicare managed care organizations to the universe of entities that accrediting organizations can survey.
- (6) Adds suppliers and ESRD facilities to the universe of entities that accrediting organizations can survey.

General Concerns About the Proposal:

1. The proposal would impose fundamental changes on the current process for Medicare deeming. It has long-term implications for beneficiary quality and would result in a draw on the Medicare Trust Funds. It is inappropriate to consider this proposal in the context of a temporary appropriations bill. Instead, it should be considered as part of a budget reconciliation bill.

A. A fundamental change to current procedure -- with long term consequences for quality of care. The proposal makes fundamental changes to the current law process -- a process that has worked well and that allows HCFA to thoughtfully consider two fundamental questions: (1) Is it appropriate to allow a particular provider category to be surveyed by private organizations rather than by States? (2) Can a private accrediting body provide HCFA with assurance that it fully understands the Medicare conditions of participation and requirements, and survey successfully against them so that quality of care is maintained at the highest possible level? The pros and cons of changing current law should involve a debate among HCFA, industry providers, national accrediting organizations, State survey agencies, and beneficiary representatives, and fact-finding by the Congressional authorizing committees. This debate cannot occur in the context of a temporary appropriations bill.

B. Draw on the Medicare Trust Funds. Under Medicare reimbursement law, the fees paid to national accrediting bodies for surveys are treated as patient care related costs and are therefore reimbursable according to the percentage of the facility volume that represents Medicare beneficiaries. Initial survey fees constitute start-up costs and are reimbursable over a 5-year period; recertification survey fees are reimbursable during the year incurred. This proposal would thus impose a draw on the Medicare Trust Funds. HCFA estimates that the draw could be anywhere from \$160 to \$200 million in FY 97 and at least that

much for each subsequent year.

2. The proposal places restrictions on HCFA in the deeming decision-making process and pushes HCFA to make rushed decisions.

- A. *Ties HCFA's hands when the current process works well.*** The proposal states that HCFA **must** allow deeming if it finds that an accrediting body can give reasonable assurance that a provider meets Medicare standards. Further, it **forces** HCFA to make decisions about the adequacy of the accrediting organization's assurances in an unrealistically tight time frame. Meanwhile, the current, more permissive, authority works well. HCFA has never denied an application from a national accrediting body. HCFA has demonstrated a willingness to deem where appropriate; HCFA gave CHAP and JCAHO permission to survey HHAs on its behalf. Soon, HCFA will make its final decision to allow the AAAHC to survey ASCs. HCFA does not have private groups clamoring to do surveys and has considered applications in a timely manner as they come in.
- B. *Potential effect is to shift "burden of persuasion."*** The potential effect of the proposal is to shift the burden of persuasion from the industry to the government, such that HCFA must affirmatively find that an accrediting organization is ill-equipped to do surveys, or that deeming is not appropriate for a particular provider type. If HCFA does not make a strong finding, it would have to accept the accrediting organization's application or risk litigation.
- C. *Inadequate decision-making time frame restricts HCFA's flexibility.*** The proposal's 120-day limit on Secretarial decision-making restricts HCFA's flexibility to determine the appropriate time frame to allow deeming of certain provider types by certain accrediting organizations.
- D. *Forces HCFA to rush through the decision-making process which could result in adverse long-term consequences.*** The practical consequence of allowing a private organization to perform Medicare surveys is that appropriations for the Federal survey and certification budget may be reduced commensurately. While HCFA would always retain its oversight role, the practical consequence of this decrease in appropriations is HCFA would be limited in its oversight role and thus could have to continue to allow deemed status even in the fact of quality concerns. A thoughtful, careful decision-making approach is critical for ensuring that quality care for beneficiaries is assured.

3. Proposal creates new, potentially damaging, consequences.

- A. *Allows deeming of Medicaid nursing homes.*** The proposal would allow deeming of Medicaid nursing homes because it states that where a provider has met Medicare conditions or requirements, it will be deemed to also meet Medicaid requirements. HCFA strongly believes that private accreditation bodies do not have adequate experience with the OBRA-87 requirements and enforcement procedures to adequately survey against them and enforce quality standards. Further, many States use restrictive Medicaid

certification as one way to control expenditures. For these States, this proposal could translate into a substantial increase in Medicaid expenditures.

- B. *Allows deeming of Medicare managed care plans.*** Under current law, there is no deeming authority for managed care plans. (In the Administration's balanced budget bill, we would allow for deeming for internal quality assurance programs, but retain external quality review by PROs.) This proposal, by expanding deeming to entities that meet "conditions or requirements under (title XVIII)," would allow deeming for Medicare managed care plans and reduce the external quality assurance role of PROs. HCFA strongly believes that quality care is best assured when the oversight responsibility falls on external, completely disinterested organizations such as PROs.
- C. *Decreases States' flexibility.*** By requiring the Secretary to recognize the results of surveys conducted by accrediting organizations for purposes of Medicare certification, the proposal could reduce State's important quality assurance role by allowing private accrediting bodies to completely take over responsibility for initial and subsequent surveys.
- D. *Could remove important information about provider quality from public access.*** By law, HCFA cannot compel private accrediting organizations to provide their survey results to the public. However, State survey results can be made public. To the extent that this proposal replaces the State role with private accrediting organizations, it removes information about provider quality from public access.
- E. *May allow "partial deeming."*** Under current law, all conditions or participation must be met by a provider before that provider can be Medicare certified. HCFA applies this rule regardless of whether a provider is surveyed by a State agency or a private accrediting organization. HCFA will not allow partial deeming. That is, HCFA will not allow a hospital, for example, to perform all hospital activities, but not nursing, if it finds that the nursing conditions were not met. With the proposed subtle change in wording, one could argue that partial deeming is permissible. HCFA believes the language should be clarified so that this interpretation is not possible.

4. Expanded deeming will not provide immediate relief to the immediate problem -- the backlog of initial surveys -- and will be costly in the long run. (See earlier point about draw on Trust Funds.)

- A. *Provides no immediate relief.*** HCFA needs adequate time to make the difficult decisions about whether private organizations can give us assurance that they understand our standards and can survey against them. This process involves a dialogue among HCFA, the provider industry, and the accrediting body. These are important decisions and they must be given adequate time. Under the proposal's time frames, or under more realistic ones, the proposal would not immediately help the backlog on initial surveys.
- B. *Increases Federal administrative costs.*** The short-time frame with which HCFA must

make its "findings" would require it to devote more resources to the decision-making process and less time to finding greater economies in the State survey process. Also, wherever HCFA grants deeming authority, it must then design and implement a process by which it evaluates the quality of the deeming organization's standards and survey procedures. This evaluation is costly to the Federal government and involves the employment of State agencies to perform look-back surveys.

- C. *No long-term savings to the survey and certification budget.*** Under current funding levels, HCFA can perform recertification surveys on 15 percent of the Medicare providers (excluding HHAs and SNFs) each year. Recertification surveys are so infrequent that very little program management money is saved by transferring the task from States to private organizations.

TD: Chris Jennings

FYI.

**HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS****MEMORANDUM**Survey & Cert File

TO: Jerry Klepner
Jack Ebeler
John Callahan

FROM: Debbie Chang *Sharon Clarken*
for

DATE: March 29, 1996

RE: Clearance of Talking Points for Hill Staff on Medicare Nursing Home
"Deeming"

As you are aware, the Omnibus CR will contain an amendment to the current deeming law that would place more guidelines on the Secretary in making deemed status decisions. The Department, after negotiations with an industry coalition and majority and minority Hill staff, agreed to support the amendment. Among other things, the proposal would retain current law with respect to deemed status for SNFs -- that is, the Secretary would retain permission to deem SNFs but not be mandated to do so. Also, HCFA would be required to study the appropriateness of granting deemed status to SNFs and Medicaid NFs sometime in the future. The proposal reflects our view that the Secretary should not be forced to grant deemed status to SNFs at this time.

Nursing home industry representatives (namely AHCA) are criticizing the expanded deeming amendment. They argue that it unfairly singles out Medicare SNFs.

We submit to you for clearance the attached talking points for our use with Hill staff in countering the arguments of the nursing home industry. **Please respond to John Hammarlund, 690-5512, with your comments and/or concurrence by no later than 4:00 p.m. today. Thank you.**

cc: Bruce Vladeck
Kathy King
Annette Coates
Tom Gustafson
Karen Pollitz
Sharon Clarken
Christy Schmidt
Ashley Files

ISSUE: Nursing home industry representatives are claiming that the expanded deeming legislation would *unfairly* single out Medicare SNFs from deemed status.

RESPONSE: This is untrue for the reasons stated below.

The legislation would not prohibit deemed status for Medicare SNFs.

Instead, it retains current law which permits the Secretary to consider deemed status for SNFs.

It also commits HCFA to study the appropriateness of deeming nursing homes sometime in the future and to report to Congress on a nursing home deeming process, if appropriate.

The legislation does not "single out" SNFs.

Under the legislation, DME suppliers, ESRD facilities, and managed care plans are excluded from deemed status completely. Thus, there are a number of entities for which the expanded deeming proposal does not apply.

To ensure high quality care, the Secretary must take a deliberate, measured approach to deeming for all provider types (SNFs are no different than other providers in this regard), and the study mandated by this legislation facilitate this approach for SNFs.

Why are hospitals and HHAs currently granted deemed status, but not SNFs?

The law specifically mandates the Secretary to give deemed status to hospitals -- there is no discretion in the matter. HCFA and the JCAHO have worked hard over many years to improve the process by which the JCAHO surveys hospitals and ensures high quality care.

With respect to HHAs, the law gives permissive authority to consider deemed status -- just like with SNFs. HHAs have been complying with Medicare conditions that have been in place, with little modification, since 1973. The industry knows Medicare's standards well and accrediting bodies (JCAHO and CHAP) have had much time to develop an expertise with surveying against the standards. The situation is very different with SNFs since they are operating under new requirements (effective 1990) and survey and enforcement procedures (effective 1995).

There are important quality assurance reasons why the Secretary should not be mandated to allow deeming of SNFs at this time.

The enforcement system for assuring that nursing homes correct detected deficiencies was implemented July 1, 1995. It will take a few years' experience with these enforcement procedures to assess the impact of this system on improving care in nursing homes. It is not

reasonable for HCFA to hand over quality oversight to accrediting bodies before a thorough assessment of the new enforcement system is complete.

A major emphasis of nursing home reform is improving quality of life through an effective survey and enforcement system. Development of protocols and training for State surveyors has been a time consuming effort. Most accreditation agency surveyors have not focused on quality of life issues when inspecting other provider types. Therefore, accreditation at this time could jeopardize the accomplishments made to date on improving the quality of life of patients in nursing homes.

There is bipartisan agreement that deeming for nursing homes should not be forced at this time.

The legislation reflects bipartisan agreement that deeming for SNFs (and NFs) should not be forced upon the Secretary at this time.

Citizens' groups and others in the private sector agree that deeming for nursing homes should not be forced at this time.

AARP and the National Citizens' Coalition for Nursing Home Reform do not support deemed status for nursing homes.

The legislation, reflecting permissive deemed status for SNFs and a study on possible future deeming, has the endorsement of a coalition of national accreditation organizations and provider groups, including the JCAHO, American Association for Ambulatory Health Care, American Hospital Association, Federation of American Health Systems, and the National Association for Home Care.

Summary/Cert File**Summary of Survey and Certification Language in Omnibus CR****Expand deeming law**

- **Current law:** the Secretary may "deem" a category of providers as meeting Medicare participation standards if the Secretary has received assurance by a national accrediting body (such as the Joint Commission on the Accreditation of Healthcare Organizations) that the private accreditation process is an adequate proxy for Medicare certification by a State survey agency.
 - By statute, the Secretary must grant deemed status to a hospital if the hospital has been accredited by the JCAHO or the American Osteopathic Association.
 - The Secretary is not authorized to grant Medicare deemed status to DME suppliers, renal dialysis facilities, and managed care plans.
 - By regulation, HCFA has established an application process (and time frame) by which it accepts or denies an application from a national accrediting body.
 - HCFA has granted deemed status to home health agencies and is considering an application for ambulatory surgical centers.
- **The proposal:** The Secretary would be mandated to grant Medicare deemed status to any category of providers (except SNFs, DME suppliers, renal dialysis facilities, and managed care plans) if the Secretary has received assurance by a national accrediting body that its accreditation process is an adequate proxy for Medicare certification by a State survey agency.
 - The Secretary must make a decision regarding deemed status within a 210-day time frame after receiving a completed application from a national accrediting body.
 - The proposal retains current law deeming for SNFs -- that is, the Secretary may grant deemed status but is not mandated to do so.
 - Current law is retained under which DME suppliers, renal dialysis facilities, and managed care plans are not eligible for deemed status.
 - The proposal mandates HCFA to prepare studies on the appropriateness of deeming nursing homes (Medicare and Medicaid) and renal dialysis facilities sometime in the future. Reports are due to Congress by July 1, 1997.
 - + The Secretary would report on the effectiveness and appropriateness of the current mechanism for surveying and certifying nursing homes and renal dialysis facilities and suggest a framework for implementing a process, where appropriate, for deeming nursing homes and renal dialysis facilities.

Issues of controversy and how they were resolved:

There were two areas of controversy which involved negotiations. The Administration can claim victories on both counts.

(1) Forced deeming of nursing homes, managed care plans, DME suppliers, and ESRD facilities.

The proposal, as originally drafted, would have forced the Secretary to grant deemed status to Medicare SNFs, managed care plans, DME suppliers, and renal dialysis facilities if the Secretary had assurance from accrediting bodies that Medicare conditions were met through accreditation. Furthermore, it stated that where a provider category has been deemed by the Secretary to meet Medicare requirements, it shall also be deemed to meet Medicaid requirements. In this way, deeming of Medicare nursing homes would have resulted in deeming of Medicaid nursing homes, thereby making Medicaid standards (which may be more stringent than Medicare) completely irrelevant.

The Department objected to these provisions and they were removed from the legislation. The end result is: (1) deemed status is not allowed for managed care plans, DME suppliers, and renal dialysis facilities, (2) deemed status for Medicare SNFs is permitted but not mandated (this is current law); (3) HCFA will study the appropriateness of deeming nursing homes and renal dialysis facilities sometime in the future; and (4) deemed status for Medicare will not result in deemed status for Medicaid.

(2) Time frame for Secretarial decision-making about deemed status.

The proposal, as originally drafted, would have given the Secretary only 120 days (after receipt of an application from a national accrediting body) to make a deeming decision for a provider type. This period included a 30-day period for notice and public comment.

The Department argued that this time frame was too short -- that it did not allow the Secretary sufficient time to make decisions with important quality implications. The end result is a 210-day time frame for decisions, including a 60-day period for public notice and comment. The Department also insisted that the language make clear that the Secretary need not consider an application until it is deemed by her to be complete. HCFA believes that 210 days is adequate for deeming decisions.

Summary of Survey and Certification Language in Omnibus CR

Expand interval between re-certification surveys of home health agencies

- **Current law:** HHAs must be surveyed at a Statewide average frequency of 12 months, with 15 months as the maximum interval between surveys.
- **The proposal:** would extend the maximum interval to 36 months and allow the Secretary to establish a survey frequency within this 36-month interval "commensurate with the need to assure the delivery of quality services."
 - Would save about \$8.8 million each year (which could be used to finance more initial surveys for would-be Medicare providers).
 - Would give the Secretary greater flexibility -- allowing HCFA to focus more resources on deficient providers.
- **Issues of controversy and how they were resolved:** No issues of controversy surrounding this proposal. A similar proposal was offered by the President in his FY 1996 budget. This proposal was also included in the Conference balanced budget bill (H.R. 2491).



Missouri Medicaid File

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SUSAN HARRIS
DIRECTOR

January 22, 1997

MEMO

TO: Chris Jennings

FROM: Susan Harris

RE: Request for Meeting

Chris:

Today during his State of the State address, Governor Carnahan will propose for Missouri a major initiative to expand Medicaid coverage for children. Knowing that the Administration is in the process of developing its Medicaid proposal, Governor Carnahan will be calling Erskine Bowles tomorrow to discuss Missouri's Medicaid situation and our common goal of expanding coverage for kids.

Prior to the Governor placing the call, I would like to chat with you a few minutes about this issue. Gary Stangler, Missouri's Director of Social Services, and Andrea Routh, Governor Carnahan's Policy Director, would also like to be in on the call.

Please let me know if you would be available for ten minutes this afternoon or tomorrow morning. I can be reached at 202-624-7720. Thank you.

Page 2 - AHA Statement

We are pleased that the Administration has decided to include in its budget two important provisions: allowing Provider Sponsored Organizations (PSOs) which meet federal standards to contract directly with Medicare; and taking adjustments for clinical education and disproportionate share out of the Adjusted Average Per Capita Costs (AAPCC) payments made to managed care plans. These improvements in the Medicare program are critical as we try to give beneficiaries more choice while protecting the important mission of teaching hospitals and hospitals that serve large numbers of the poor.

At the same time, the news about changes in outpatient payments is mixed. While the Administration is proposing an outpatient prospective payment system, it is also seeking a short-term quick budget fix that would undermine its own goal. A new outpatient payment system, simple to administer with a clear, attainable savings goal, is all that's needed.

We look forward to working with the Administration and the Congress as the debate over a balanced budget moves forward. We appreciate the efforts of the Administration for holding the line on Medicare reductions for hospitals, and commend them for including some very important program improvements.

EXPANDED COVERAGE FOR CHILDREN AND WELFARE REFORM SUPPORT

Missouri's 1115 Waiver

- Missouri's Medicaid managed care program, MC+, is demonstrating that managed care significantly increases access to health care for the Medicaid population while containing costs. It also has demonstrated the need for more flexibility in program design that under today's law only an 1115 demonstration waiver can afford. We believe it is time to take what we have learned in MC+ and apply it statewide in a cohesive and efficient program by amending our pending 1115 waiver request to reflect today's needs. This amendment would give us greater administrative flexibility than our current waiver program while allowing us to focus on serving three new populations:
 - Uninsured children up to 200%-225% of the Federal poverty level.
 - Supporting uninsured dependents and their parents in transitioning to and remaining in the workforce through our welfare reform efforts by providing stable health care coverage.
 - Developing a fee scale system to allow low income families to participate in the program who would otherwise not be eligible, thus strengthening their ability to remain in the workforce.
- Such a waiver expansion would be a positive step forward for the State in support of the Clinton Administration's efforts to expand health care coverage for children and in efforts to reform welfare by successfully moving families into the work force. At the same time, this waiver will allow Missouri to continue operating one of the most effective and lowest per capita cost Medicaid programs in the nation.
- In order to expand coverage, it is imperative that Missouri be able to guarantee its current funding base, consisting of the traditional Medicaid funds and disproportionate share Moines funded in part by the provider tax program. With this guarantee we will be able to move into the 21st century with the confidence that we can assist our most vulnerable citizens in securing and maintaining health care coverage while remaining employed.

MISSOURI'S DISPROPORTIONATE SHARE OPTIONS

- The objective of coverage for uninsured children is a positive move for health care, but the cutting of disproportionate share funding to support this is wasteful and inefficient. A more effective way to allow states to expand coverage is to allow them to retain their disproportionate share money in return for a guarantee of covering uninsured children. If a state does not want to participate in this program, then cut their disproportionate share.

- Use current Medicaid funding for all states as the base and reduce everyone at an equitable “flat” rate. Any formulary for cuts in state funding should be equitable and result in the smallest of cuts for each state.
- Use the most recent year as the base year for determining any base amount.
- If disproportionate share funding is eliminated or reduced without a per capita cap, then Missouri should be given an increase in its match rate in order to level the playing field. This would eliminate the debate about disproportionate share funding being handled differently while holding state Medicaid funding level.
- There should be agreement that Missouri’s waivers implement cost effective programs even when disproportionate funds are considered. Therefore, we believe Missouri’s funding base, including disproportionate share funds, should be protected by our waiver requests, and we believe these waivers should be approved clearly giving this protection statewide as we expand our waiver programs.

MISSOURI’S PER CAPITA CAP OPTIONS

- Per capita caps can be implemented to meet the needs of cost containment while protecting individual entitlement, but they **MUST** be coupled with significant state flexibility in program design, benefit packages and administration. Along with a change to per capita caps, we believe it is time to relax the rich benefit package Medicaid currently requires. Efforts to bring coverage more in line with “standard” packages in the private sector would enhance states’ abilities to operate an efficient, cost-effective program. It is also essential to eliminate the Boren Amendment which holds states hostage to providers.
- Any move to per capita cap must recognize the significant cost differences between some groups, such as the elderly, disable, and children and families. There should be a separate per capita rate for each defined group. In determining the amounts paid to states over time, changes in the numbers of individuals within these groups in a state must be recognized so that changing demographics do not devastate some states while giving others a windfall.
- If using per capita caps, the base should be **ALL** money included in a state’s Medicaid program. This base **MUST** include state’s disproportionate share funds. These are real dollars serving real people. The base must be for the most recent year, 1996.
- If the Medicaid program is changed to per capita caps, it is imperative that funding be grandfathered in at current levels. Savings should come from reduced growth and management improvements, not by cutting current state programs in an inequitable manner across the nation.