

December 16, 2016

Mr. Donald J. Trump
1800 F St NW
Washington, DC 20006

Dear President-Elect Trump,

Congratulations on your victory last month. The American public has spoken and we look forward to working with you. Part of the public's message was asking for less Washington influence, less regulation, and more empowerment to the free market that has made our country the greatest in the world. We embrace that message and look forward to working with you to improve the lives of the residents in our facilities.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is by far the largest trade association in the country representing skilled nursing facilities (SNFs) and assisted living communities. We represent more than 13,000 providers, employing over one million people honored to take care of millions of citizens each year.

It truly is a privilege to care for our country's elderly and frail citizens. Many of these individuals are what is left of the Greatest Generation. The residents we care for are, on average, 82 years old. Not only are these great people elderly, most are infirmed and in need of assistance to make it in and out of bed, to the restroom, with eating, taking medication and all the other activities of daily life. Due to families being dispersed across the country and other factors, family caregivers are increasingly unavailable to aid our nation's elders. This makes the care provided by our skilled nursing centers all the more important.

In our centers, we care for two distinct populations. The first is the group of people that have come to our centers to spend the last few years of their lives, called long term residents. Approximately, one million Americans reside in a SNF as their home. Long term residents are generally frail, with nearly two-thirds suffering from dementia. On average, these residents need assistance with four out of the five basic activities of daily living (bathing, toileting, walking, feeding, and transferring). Sadly, the overwhelming majority of them have run out of personal funds and both the state and federal government pay for their stays through Medicaid. Nearly two-

thirds (62.5%) of all residents in a center are covered by Medicaid. Almost all long term residents are dependent on the program at some point in their stay. Unfortunately, few private long term care financing options are available, making Medicaid a critical resource for the nation's frail elderly. Virtually all private long term care insurers ceased issuing new policies in recent years.

The second population group we serve is short term residents, those who come to our centers for rehabilitation. Nearly four million Americans are admitted to SNFs each year, half of which are Medicare beneficiaries. Medicare covers this service for beneficiaries who spend at least three days in a hospital and who need rehabilitation prior to going back to their homes. Fifteen to twenty years ago, most of these residents received rehabilitation in the hospital, which was comparatively very expensive and strained the Medicare program. Over the years, society began to recognize that skilled nursing facilities are a more appropriate setting for rehabilitation, and also less costly. Many SNFs are specifically designed to conduct rehabilitation and are more efficient and significantly cheaper than a hospital setting. Most importantly, the outcomes for the residents in SNFs have been terrific. Rehabilitation in our setting works. Millions have received therapy, with two-thirds (65%) of those short-term residents returning to their homes in great shape, saving the federal government billions of dollars.

Indeed, skilled nursing and assisted living providers have a renewed commitment to quality. We are delivering results and improving in our care and services. On nearly every metric, the quality of care Americans receive in skilled nursing centers has improved in recent years. Over a four-year period, the national averages have improved for 17 of the 18 quality measures CMS collects and reports on Nursing Home Compare. In addition, staffing levels have been steadily increasing. AHCA's Quality Initiative began five years ago and has resulted in a 32.9% reduction in antipsychotic prescription use. Our members also have reduced rehospitalizations by 8%, which translates into approximately 80,000 fewer rehospitalizations and a savings of \$828 million in hospitalization costs.

Despite these successes, the pivotal role we play in taking care of this important population, and the growing need for our services as our nation ages, there is a sad reality. The long term care profession is on the brink of failure. That is not an overstatement. The profession is on the brink of failure.

This is true for two reasons. The first is reimbursement. Medicaid woefully underpays for the care and services providers render. An independent national analysis of state by state Medicaid reimbursement concluded in 2015 that nursing centers, on average, were reimbursed only 89 cents for every dollar of allowable

costs they incurred. Nationally, this resulted in a shortfall of nearly \$7 billion for skilled nursing centers. This is consistent with The Medicare Payment Advisory Commission’s (MedPAC) findings that indicate when Medicare reimbursement is excluded, the overall margin for our facilities is negative two percent.

The only way providers survive as a business is through Medicare reimbursement. Medicare margins are positive, but only enough to get us slightly above breakeven. MedPAC is required to issue an “all in” margin each year. This year, MedPAC reported that the “all in” margin for SNFs is 1.6%. A margin of 1.6% means that any additional cuts, regulatory burdens, onslaught of lawsuits, or any other hiccup results in a negative margin. This creates the risk of skilled nursing centers closing just as we approach an era of unprecedented demand for long term care.

We have arrived at this point for a variety of reasons, but the biggest is a myriad of reimbursement cuts that have taken place over the last eight years. When Congress looked for funds to pay for health care reform, the doc fix, or just about anything and everything else, it looked to skilled nursing providers and our residents. The table below and Attachment A both provide a list of the cuts our profession has sustained over the last eight years.

Policy Resulting in Cut	Reduction Total Through 2024
Health Care Reform Productivity Adjustment	\$3.8 Billion
Sequestration	\$2.4 Billion
Bad Debt	\$739 Billion
Therapy MPPR Cuts	\$1.58 Billion
Regulatory Changes (Forecast Error Cut)	\$3.0 Billion
Total To-Date	\$27.35 Billion
Medicaid Under Funding	\$26.6 Billion
SNF Rehospitalization Withhold (2019-2024)	\$2 Billion
Grand Total	\$55.95 Billion

The second reason we are on the brink of failure is that we are being inundated with rules and regulations. We are already the most regulated profession in the country. Additional regulations have become extremely burdensome. In addition, a punitive approach by survey teams across the country has put even the best operators on the brink of failure. Attachment B provides an overview of the tremendous regulatory burden imposed upon us in recent years.

We also represent assisted living providers, which are regulated at the state level. This sector of long term care has thrived and met consumer demand, in part because state regulation enables innovation and people to receive care in the right setting at the right time. We urge a continuation of this successful model where

assisted living is regulated at the state level. We also request support for assisted living's continued status as a Medicaid home and community-based provider.

We are committed to taking care of the Greatest Generation and beyond, but we need help. Fortunately, there are some quick and relatively easy fixes that would provide us the breathing room to focus on our passion. We respectfully request that you consider the following requests.

Most of the relief we seek can take place quickly at the Centers for Medicare and Medicaid Services (CMS).

Every fiscal year CMS issues a payment rule for skilled nursing providers. The 2018 payment rule offers the opportunity to stop a potential threat and reverse a prior rule change. Both would fundamentally help the long term care profession and neither would cost the federal government anything.

The potential threat we face is a completely new Medicare payment system that career government staff have been developing. This payment system would shift SNFs into a characteristic-based payment system. Such a system is not inherently bad, but as currently conceived would be harmful to our residents. In addition, it would be particularly difficult for smaller operators and operators in rural areas to implement. It is overly complex and would make managing spending for the government and care for people needlessly complicated. This payment proposal completely changes payment philosophy and further erodes razor-thin SNF margins. We ask that you put this work on hold until the new administration can evaluate the system. We fear that without direction to the contrary, CMS is likely to propose this new system on May 1, 2017.

We also ask you to reverse the rule relating to the delivery of therapy. Prior to 2011, most therapy services in SNFs were delivered based upon the professional therapist's and attending physician's judgment. In addition to individual one-on-one therapy, there were some situations where concurrent therapy (a therapist working with two residents) or even group therapy (a therapist working with four residents) was effectively delivered. Research shows that in some situations, residents prefer the socialization of a group and it is very effective. Unfortunately, in the 2011 and 2012 payment rules, CMS dictated how therapy should be delivered, making it virtually impossible to provide group and concurrent therapy. The net result is that nearly all therapy is now one-on-one. Not only is this costly—in some markets it has also created shortages of therapists.

We recognize there are concerns with therapy utilization. We welcome the opportunity to work with a more transparent CMS on a solution that addresses

concerns but also ensures needed rehabilitation services and workforces. We ask that you restore the pre-2011 rules relating to reimbursement for skilled nursing facility rehabilitation. This would allow concurrent and group therapies where they are clinically appropriate and restore prior protections on its use, assuring that most therapy would still be one-on-one. This move would immediately reduce unneeded cost and solve therapist shortage issues where they exist.

We also believe that CMS can solve a barrier to access for Medicare beneficiaries: the observation stay problem. In order for a Medicare beneficiary to receive their skilled nursing facility benefit, Medicare requires a three-day hospital stay. Most people believe that any three-day stay in a hospital will qualify but unfortunately, this is not correct. If the hospital codes the stay as “observation,” or outpatient, then these stays do not qualify toward the three-day requirement. This unfairly burdens patients with huge bills that should be covered by Medicare. It is obvious in looking at the intent of the Medicare statute that any three-day stay should qualify a Medicare beneficiary for needed SNF care. There are tens of thousands of Medicare beneficiaries who get tangled in this each year. They think they have a SNF benefit, only to learn that because of a classification glitch they have nothing to do with, they receive no rehabilitation.

It is clear that CMS can solve this. In Attachment C, you will find a legal opinion that indicates that CMS has this authority. We tried multiple times to convince the prior administration that it could fix this challenging problem, but it continued to maintain that it did not have the ability under their specific legal interpretation. We disagree and ask you to direct CMS to issue a new rule fixing this problem.

We are also one of the most highly regulated and penalized professions. We acknowledge that the government should regulate our sector; however, the regulation should be a collaborative effort between the federal government and providers to furnish the best care possible. Currently, this is not taking place. The survey process is punitive, subjective, and fails to improve resident care. The best evidence that it is not working is that even the very best providers, those with the Five Star rankings from the CMS rating system and histories of great service, have been tangled in the downward spiral of punitive regulations, retroactive civil monetary penalties, and threats of building closures.

The good news is that it is entirely possible to create a collaborative approach to the regulation. Some agencies, like the Federal Aviation Agency, have a highly collaborative approach with their industries and, working together, they have created a remarkable safety record. We can do the same thing. As a result, we will

be coming to the new Administration with models that create collaboration and incentives for both regulators and operators to work together.

In the meantime, we need some specific relief. Career surveyors, some of whom believe they are not accountable to the CMS central office, let alone elected officials, use their discretion to damage the profession. They have specifically stated that their job is to catch providers doing something wrong, not trying to help providers meet the regulations to achieve better outcomes for the residents. Our specific requests get into the minutia, but it is critical that we have relief.

In short, sub-regulatory guidance issued in July 2016, changed how CMS issued civil monetary penalties (CMP) fines, denial of admissions and denial of payments, along with other penalties. The same guidance removed any discretion the State Survey Agency and the Regional Office had in the past. We request that this memo (SC 16-31-NH) be repealed and that CMPs and other remedies be halted from being applied retrospectively. Furthermore, the imposition of these fines and remedies revokes our certified nurse aide (CNA) training programs for two years, creating a chilling effect on our workforce. For many SNFs, particularly those in rural areas, the CNA training program is the only way to get enough staff to care for residents. We ask that CMS change the overly strict criteria and allow for time to return to compliance before revoking the CNA training program.

We also ask that the Regional Office staff working for the Survey and Certification Division be moved under that group at the CMS central office. The Regional Office staff currently report to a different division within CMS and therefore are not accountable CMS's Survey and Certification Division in the central office. We can follow-up with a more detailed accounting given the detailed nature of our regulations and enforcement regulations.

These problems with over-regulation also affect our staffing. The recently implemented Payroll Based Journal (PBJ) contains numerous problems that, if left unaddressed, put undue burden on providers and misrepresent true staffing patterns. We understand the critical the role that staffing plays in the delivery of quality care, this is why we have asked our members to focus on increasing staff stability in their organizations. Since the implementation of the PBJ, we have encouraged and supported members in submitting their staffing data to the system. Until the significant problems in the program are fixed, however, we request that further data submissions to the system be delayed so that consumers and beneficiaries can obtain reliable and accurate information.

To support the administration and CMS in implementing solutions, we are willing to help recruit providers to serve on an advisory group. These providers should

represent a broad cross-section of providers, from large multi-facility organizations to independent single facilities using several different payroll and time and attendance systems to work out the issues needing revisions to the system. The fixes to PBJ should also focus on creating efficiencies in the data collection such that there is no undue burden on providers. This will permit staff to spend their time providing care instead of completing data entry.

We also request that the administration issue a “stop” order on a rule proposed by the previous administration that has not yet taken effect. On December 14, 2016, CMS sent the Advancing Care Coordination through Episode Payment Models final rule to OMB, which is the final step before it becomes law. This final rule would implement a mandatory demonstration of three new payment models, two cardiac and one orthoscopic, in dozens of markets—93 for one model specifically—across the country. As proposed, the rule would run for almost five years, from 2017-2021.

This is yet another example of third parties coming in between patients and caregivers. The varied effect on markets and mandatory nature of this demonstration will leave providers and beneficiaries little time to adapt. The confusion it creates may even be more damaging than the problems it seeks to solve. Many of these mandatory demonstrations across a wide swath of markets have already adversely affected the way in which our members provide care. Prior incoming administrations have instructed staff to halt rules and we believe this is an action your administration can immediately take to ease the burden on elderly Americans and their caretakers alike.

One incredibly important population our members care for is our nation’s veterans and we ask that your administration work with the Department of Veterans Affairs to help better provide for these heroes. AHCA is committed to ensuring veterans have access to quality care in our centers through VA Provider Agreements. It is long-standing policy that Medicare and Medicaid providers are not considered to be federal contractors. If a provider currently has VA patients through a VA contract, however, they are considered to be a federal contractor. As employers and Medicare and Medicaid providers, SNFs are already required to comply with a variety of regulations. Treating SNFs as federal contractors and adding additional regulations on top of the existing Medicare and Medicaid regulations is inefficient, redundant, and reduces the time staff can spend caring for our veterans. Congress already waived federal contracting requirements for eligible providers furnishing services to veterans in one instance, through the *Veterans Access, Choice and Accountability Act of 2014*, and we believe our providers should be treated no differently.

Skilled nursing centers want to ensure that those that have served our nation so bravely have adequate options to access services closer to their homes, families, and friends. Once providers can enter into provider agreements, the number of centers serving veterans will increase in most markets, expanding the options among veterans for nursing center care. We ask the administration to work with Department of Veterans Affairs on VA provider agreements to not consider skilled nursing care providers with VA contracts a federal contractor.

In addition to the requests we have of your administration, we also have some areas we think would be beneficial to work on with the incoming Congress where long term care providers and our residents can really benefit.

Ignoring stakeholder input, the prior administration issued a 184-page rule with hundreds of new requirements for every SNF in the country. Failure to comply with this behemoth rule makes SNFs ineligible to participate in Medicare or Medicaid programs and would effectively shut them down. Within the rule there are some well-meaning changes to our regulations, but the theme is micromanagement and costly burdens. It is a classic example of Washington regulators imposing rules about how to run a business without understanding the practical, real-world implications.

The real-world implications are significant. CMS's own projection is that the total projected cost of this final rule will be about \$831 million in the first year and \$736 million per year for subsequent years. For an average SNF to implement this new rule, CMS estimates it will cost about \$62,900 in the first year and \$55,000 per year for subsequent years. Our members, who have to implement this rule, believe it will cost, on average, closer to \$150,000 to implement, given the requirements to hire new staff with specific training requirements to meet all the documentation, program development and administration requirements. Considering MedPAC's assessment of 1.6% margins, the average SNF is netting about \$100,000 a year, some more and some less. The cost to implement this new regulation entirely eliminates that margin.

Though the rule cannot be repealed immediately through executive action, it falls within the 60-legislative day window for Congressional Review Act (CRA) eligibility. We ask that Congress use the CRA to repeal the regulation. The new Administration can then work with CMS to decide what within it is absolutely essential and move forward with those changes.

As part of our commitment to bring solutions to lawmakers, AHCA has developed a new Medicare payment model that we are advancing with Congressional leadership.

It moves SNF payments away from fee-for-service and towards an outcome-based payment system which will improve care and save Medicare dollars. This new payment model would focus on improved outcomes for patients and measurable quality care while placing risk on providers. We believe it will save the Medicare system billions of dollars over the ten-year scoring window and improve the lives of residents. We appreciate the support we have already received from Congressional leadership on this work and encourage you to work with Congress as we work toward passage of this model in 2017.

In light of these requests, we are prepared to continue providing amazing care and building on our past success. Our commitment to you is that we will continue our quality efforts on an unprecedented scale. During the prior administration, we worked with CMS to agree to establish a set of quality objectives and we agreed to strive for specific metrics. Our focus was on reduction of unnecessary rehospitalizations and the use of off label anti-psychotic medications. As I mentioned earlier in this letter, the results were remarkable; in both areas we achieved and exceeded our goals.

We make the same commitment to your new administration. Work with us on reimbursement and regulation, and we will make you and the country proud. We will collaborate together to insure that we take care of the greatest generation and the millions of Americans who will need our services in the future.

We are the solution when it comes to taking care of this important frail and elderly population. Whether caring for long stay residents or providing therapy for short-stay resident, SNFs are the lowest cost, highest quality setting. We can continue to deliver this solution, but we need relief. We need breathing room on reimbursement, and we need the federal government to work with us on the regulatory side. Give us both, and together we will create the greatest long term care system in the world.

Sincerely



Mark Parkinson
President and CEO

CC: Andrew Bremberg
Paula Stannard
Josh Pitcock

Attachment

A



MEDICARE CUTS

	2010	2011	2012	2013	2014	2015	TOTAL
Affordable Care Act Productivity Adjustment			\$419 million	\$746 million	\$1.030 billion	\$1.637 billion	\$3.832 billion
Sequestration				\$600 million	\$855 million	\$957 million	\$2.412 billion
Bad Debt				\$230 million	\$245 million	\$264 million	\$739 million
Therapy MPPR Cuts		\$228 million	\$229 million	\$489 million	\$634 million		\$1.580 billion
Regulatory Changes* Forecast Error Cut		\$261 million	\$250 million	\$261 million	\$519 million	\$1.743 billion	\$3.034 billion
Regulatory Changes* Payment Formula Changes	\$2.244 billion	\$2.615 billion	\$2.507 billion	\$2.613 billion	\$2.780 billion	\$2.995 billion	\$15.754 billion

* 2006 Non-Therapy Ancillary Case Mix Index Refinement; 2006 Elimination of Add-On; 2010 Recalibration of Case Mix Indexes





TOTAL: \$27.351 billion





Medicaid Underfunding	\$6 billion	\$7 billion	\$7 billion	\$7.7 billion			\$26.6 billion
SNF Rehospitalization Withhold	2019 \$300 million	2020 \$300 million	2021 \$300 million	2022 \$400 million	2023 \$400 million	2024 \$400 million	2019-2024 \$2 billion

GRAND TOTAL: \$55.951 billion

Attachment B

Summary of Current and Future Changes with Key Dates

Current and Future Changes 	Key Highlights 	Key Dates (estimated) 
 Regulations		
<ul style="list-style-type: none"> • Focused Surveys 		
<ul style="list-style-type: none"> • MDS focused surveys 	<ul style="list-style-type: none"> • Focus on MDS accuracy and frequency; • Posting and archiving of daily staffing 	Feb 2015
<ul style="list-style-type: none"> • Dementia focused surveys 	<ul style="list-style-type: none"> • Staffing training and demonstrated competency in dementia care 	Early 2016
<ul style="list-style-type: none"> • Adverse events focused surveys 	<ul style="list-style-type: none"> • Focus on medication errors, • How SNF investigated adverse events 	Early 2016
<ul style="list-style-type: none"> • Requirements of Participation 	Proposed extensive changes; last done in 1991.	Final rule expected Summer 2016
<ul style="list-style-type: none"> • New Life Safety Codes 	Updates life safety codes to national 2012 life safety codes; <ul style="list-style-type: none"> • Increases inspection, testing and maintenance requirements • Additional sprinklering requirements 	Final rule at OMB for clearance; early 2016
<ul style="list-style-type: none"> • New Emergency Preparedness requirements for all provider types 	Extensive rewrite with all hazard approach; with cost implications to comply, need to have <ul style="list-style-type: none"> • plan and tested plan for different types of emergencies and must meet the needs of the type of residents served • test generator on load 1x yr for 4 hours • Training upon hire and annually 	Final rule at OMB for clearance; expect issued in 2016
<ul style="list-style-type: none"> • Discharge planning for hospitals & HH 	Proposed rule issued Nov 2016; impacts SNFs <ul style="list-style-type: none"> • Requires hospitals to give patients info on <ul style="list-style-type: none"> ■ SNF quality prior to discharge and advice on SNF selection ■ SNFs in Managed Care network 	Final rule expected Summer 2016
<ul style="list-style-type: none"> • OSHA electronic reporting of illnesses/injuries 	Database of electronic reporting info will be available to the public	Final rule at OMB for clearance; expect issued in Dec 2015

Current and Future Changes 	Key Highlights 	Key Dates (estimated) 
<ul style="list-style-type: none"> Department of Labor Rules on exempt and non-exempt employment 	<p>Defining and Delimiting The Exemption for Executive, Administrative, Professional, Outside Sales, and Computer Employees (RIN 1235-AA11) with key proposed changes:</p> <ul style="list-style-type: none"> Setting minimum salary levels and hourly rates and overtime requirements and annual inflator Changes criteria about exempt compensated employees 	<p>Expect in early 2016</p>
 Quality Measure & Reporting		
<ul style="list-style-type: none"> IMPACT Act 		
<ul style="list-style-type: none"> Changes to MDS 	<p>2016 SNF PPS rule add new section GG to MDS and changes to MDS discharge assessment; need to complete when discharged from Part A coverage</p>	<p>Oct 2016</p>
<ul style="list-style-type: none"> Three measures finalized (PU, Falls, Function) 	<p>2016 SNF PPS rule finalized three measures</p>	<p>Oct 2016 start to collect data</p>
<ul style="list-style-type: none"> Four new measures 	<p>CMS issued for comment prior to putting in SNF PPS proposed rule</p> <ul style="list-style-type: none"> Potentially preventable rehospitalizations during and 30 days after SNF discharge Discharge to community Drug regimen review Average cost per beneficiary during and after SNF discharge 	<ul style="list-style-type: none"> NQF MAP review Dec 2015 & Jan 2016 Expect in SNF PPS rule Apr 2016 Oct 2017 start to collect data
<ul style="list-style-type: none"> Changes to Five Star 		
<ul style="list-style-type: none"> Add new measures 	<ul style="list-style-type: none"> Adding rehospitalization, DC to community, mobility in room; hypnotics, change in ADL from admission 	<p>May-June 2016</p>
<ul style="list-style-type: none"> Rebase ratings 	<ul style="list-style-type: none"> Rebase the QM thresholds to achieve each Star level 	
<ul style="list-style-type: none"> Payroll Based Journal (staffing) 	<ul style="list-style-type: none"> Requires quarterly submission of staffing from payroll and all contract and agency use collected and reported by employee name. 	<p>Voluntary Oct 2015 Mandatory Jul 2016</p>

Current and Future Changes 	Key Highlights 	Key Dates (estimated) 
 HHS Quality Initiatives		
<ul style="list-style-type: none"> • CDC healthcare Acquired Infections 	<ul style="list-style-type: none"> • Focus on C. Diff and UTI treatment and all antibiotic prescribing • Encourages SNFs to use of infection reporting to CDC NHSN website 	Nov 2015 into 2016
<ul style="list-style-type: none"> • Dementia care 	<ul style="list-style-type: none"> • Focus on antipsychotics and use of medications 	ongoing
 Payment to SNFs		
<ul style="list-style-type: none"> • SNF VBP (2% with-hold linked to rehospitalizations) 	Will reduce SNF Part A payments 2% based on SNFs rehospitalization rates	<ul style="list-style-type: none"> • Performance will be based beginning July 2016 to July 2017 • Adding First Payment Adjustment: Oct 1, 2018
<ul style="list-style-type: none"> • SNF PPS 2017 rule 	It is possible, but not probable, that CMS would make payment methodology changes in the FY17 rule. AHCA has a robust research effort underway to support the Association's ongoing dialogue with CMS on the SNF PPS	April 2016
<ul style="list-style-type: none"> • IMPACT Act failure to report penalty 	Beginning in 2016 for finalized the three finalized measures, IMPACT Act measures, SNFs that fail to report on quality measures and resource use and other measures will be subject to a two percentage point reduction in market basket prices in effect under the existing payment methodology in the Social Security Act.	

Current and Future Changes



Key Highlights



Key Dates (estimated)



Hospital and Physician Payment Incentive Changes Which will Impact SNF Referral Patterns and Possibly Volume

- Hospital VBP – 25% of hospital payments now tied to some form of VBP. Three are of note to SNFS:
 - Hospital Medicare Spending Per Beneficiary (MSPB) Measure
 - Rehospitalization
 - Hospital Acquired Conditions

- Medicare Spending Per Beneficiary (MSBP) is part of Hospital Value Based Purchasing but separately mandated by statute. Referred to as “efficiency” measure. First mandated episode of care measure—3 days before hospitalization and 30 days post-discharge. All Part A and B spending included. Model for resource use measures in other payment systems. Regular reporting to hospitals of their episode cost history—will see exact SNF cost
- Hospitals 3% cut part A payments if high 30 day rehospitalizations
- Hospital payments are adjusted based on infection rates, particularly antibiotic resistant infections so hospitals screening SNF admissions for these types of infections (MRSA, VRE, etc).

Began last year but hospitals likely will begin in earnest this year now that hospitals have SNF spending data by facility

- Physician Payments

- **Merit Based Incentive Payment System (MIPS)** will be core payment for physicians who don't qualify for APM bonus and exemption from this system. Begins to impact physician payment in 2019 but physicians will begin to assess downstream care costs and outcomes, now, to prepare for 2019. Physicians who meet certain performance criteria will have the opportunity to be exempt from MIPS and participate in an alternative payment method with more opportunity for gainsharing. Again, will result in more physician focus on care transitions, coding and downstream costs than the past.
- Increased attention to codes & valuation, bundling more codes, and creating codes for coordination of care.

Physician behavioral changes likely to begin, now, to prepare for 2019.

Current and Future Changes 	Key Highlights 	Key Dates (estimated) 
<ul style="list-style-type: none"> •CJR (Hips and Knees) 	<ul style="list-style-type: none"> • Holds hospitals in 67 MSAs accountable for 90 day post-hospital discharge costs for hip and knee replacements including SNF costs; • Opportunity for SNFs to serve as collaborators with hospitals and share in risk-bearing; • Waives 3 day stay for SNFs rated 3 Stars or better. 	<p>Jan 2015</p>
<ul style="list-style-type: none"> •Bundle Payment models BIPA 	<p>Creates incentive to decrease SNF utilization and SNF LOS.</p>	<p>Ongoing demonstration</p>
<ul style="list-style-type: none"> •ACOs 	<p>Creates financial incentives for hospitals and other to lower rehospitalizations, improve outcomes, and lower SNF utilization and create post-acute care networks. The most recent iteration of ACO's are now active and carry double sided risk. This could be an opportunity to engage in risk-sharing. For a snapshot of final rule changes click here</p>	<p>Demonstration ongoing</p>
 OIG Upcoming Reports		
<ul style="list-style-type: none"> •Adverse Events in IRFs and LTCHs OEI; 06-14-00110 	<p>Report on the estimate of the national incidence of adverse and temporary harm events for those in IRFs. The report will identify factors contributing to these events, determine the extent to which these events are preventable and the associated cost.</p>	<p>FY 2016</p>
<ul style="list-style-type: none"> •National Background Check Program for Long Term Care Employees OEI; 07-10-00420; 	<p>Report on the implementation status and early results for the National Background Check Program for long term care employees from the first 4 years of the program. Required by Section 6201 if ACA.</p>	<p>FY 2016</p>
<ul style="list-style-type: none"> •Skilled Nursing Facility PPS Requirements OAS; W-00-15-35744 	<p>Review compliance with various aspects of the SNF PPS, including the documentation requirement in support of the claims paid by Medicare.</p>	<p>FY 2016</p>

Attachment C

CMS HAS AUTHORITY UNDER EXISTING LAW TO DEFINE INPATIENT CARE

Under a 2008 decision of the Second Circuit Court of Appeals, the Secretary of HHS has authority under the Medicare statute to include a hospital patient’s time in observation as part of inpatient time in the hospital for purposes of determining whether the patient qualifies for Part A coverage of a subsequent stay in a skilled nursing facility (SNF). *Estate of Landers v. Leavitt*, 545 F.3d 98 (2nd Cir. 2008). The Court recognized that neither the statute nor regulations define the word “inpatient” and that the Secretary defined inpatient in the Medicare Benefit Policy Manual as occurring after a formal physician order for admission. Although the Court upheld the Secretary’s position in litigation – that only time in formal inpatient status may be counted toward satisfying the qualifying three-day inpatient requirement – it acknowledged that the Secretary had authority to *change* his interpretation of inpatient to include time spent in observation. The Court wrote:

[W]e note that the Medicare statute does not unambiguously require the construction we have adopted. If CMS were to promulgate a different definition of inpatient in the exercise of its authority to make rules carrying the force of law, that definition would be eligible for *Chevron* deference notwithstanding our holding today.

545 F.3d at 112.

In fact, the Centers for Medicare & Medicaid Services (CMS) has recognized its authority to change the definition of inpatient. In May 2005, CMS asked for public comment on whether time in observation should be counted towards satisfying the three-day inpatient requirement for Medicare Part A SNF coverage. 70 Fed. Reg. 29069, 29098-29100 (May 19, 2005). In August 2005, CMS acknowledged that most commenters “expressed support for the idea that hospital time spent in observation status immediately preceding a formal inpatient admission should count toward satisfying the SNF benefit’s statutory qualifying three-day hospital stay requirement.” 70 Fed. Reg. 45025, 45050 (Aug. 4, 2005). CMS reported that “some advocated eliminating the statutory requirement altogether.” *Id.*

CMS analyzed the two suggestions separately. With respect to repealing the three-day requirement entirely, CMS wrote, “we note that such an action would require legislation by the Congress to amend the law itself and, thus, is beyond the scope of this final rule.” *Id.* With respect to *counting* time in observation towards the qualifying inpatient stay, CMS wrote, “we note that we are continuing to review this issue, but are not yet ready to make a final determination at this time.” *Id.*

CMS correctly understood that it could not repeal the three-day statutory requirement by regulation but that it *could* count the time in outpatient status, if it chose. Its only stated reason for not counting observation time, despite widespread support of such a change from commenters, was that it wanted to continue reviewing the issue.

Finally, CMS allows certain hospital stays to count in qualifying a patient for Part A-covered SNF care even when the hospital care is different from Part A-covered hospital care.

In the context of hospice services, CMS has recognized that “general inpatient care” in a hospital, although “not equivalent to a hospital level of care under the Medicare hospital benefit,” nevertheless qualifies a hospice beneficiary for Part A-covered SNF services. Medicare Benefit Policy Manual, Chapter 9, §40.1.5, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf>.

Similarly, a three-day stay in a foreign hospital may qualify a beneficiary for Part A SNF coverage if the foreign hospital is qualified as an “emergency hospital.” Medicare Benefit Policy Manual, Chapter 8, §20.1.1, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>.

The argument for counting observation or outpatient time for purposes of calculating eligibility for the Part A SNF benefit is, of course, far stronger than either of the prior examples since the consensus is that care in the hospital is indistinguishable whether the patient is formally admitted as an inpatient or called an outpatient.

Most recently, in describing why a beneficiary continues to be eligible for Part A SNF coverage after the hospital withdraws its Part A claim and submits Part B claims for the patient’s care instead (the hospital rebilling option), CMS writes, “the 3-day inpatient hospital stay which qualifies a beneficiary for ‘posthospital’ SNF benefits need not actually be Medicare-covered, as long as it is medically necessary.” 78 Fed. Reg. 50495, 50921 (Aug. 19, 2013). CMS confirms that a hospital’s decision to withdraw its claim for Part A reimbursement and to seek Part B reimbursement instead does not negate the fact that the patient received medically necessary inpatient care, for purposes of Part A SNF coverage. CMS continues:

In addition, the status of the beneficiaries themselves does not change from inpatient to outpatient under the Part B inpatient billing policy. Therefore, even if the admission itself is determined to be not medically necessary under this policy, the beneficiary would still be considered a hospital inpatient for the duration of the stay – which, if it occurs for the appropriate duration, would comprise a “qualifying” hospital stay for SNF benefit purposes so long as the care provided during the stay meets the broad definition of medical necessity described above.

Id. A patient’s receiving “medically necessary” care in the hospital, not the classification of the care as “inpatient,” is the key factor for determining the patient’s eligibility for Part A SNF coverage.

Conclusion

As the Court in *Landers* held and CMS itself recognized in 2005, CMS has authority under the Medicare statute to redefine inpatient status to count all time in the hospital. In Manual provisions, CMS recognizes that time in a hospital that is different from Medicare-covered hospital time can count for purposes of Part A SNF coverage. In the hospital rebilling option, CMS recognizes that receiving medically necessary care in the hospital is the key factor in determining Part A SNF coverage. CMS should confirm that time spent in observation or

outpatient status qualifies a patient for Medicare Part A SNF coverage so long as the time in the hospital was medically necessary.

The **Background** statement attached to this memorandum shows CMS's ongoing consideration of this issue, CMS's repeated expressions of concern about the impact of extended observation stays on Medicare beneficiaries, and the findings of independent research on observation.

Background

CMS's concern about observation and outpatient status

In the nine years since it declined commenters' recommendations to include observation time as inpatient time, CMS has received considerable input from the public and repeatedly expressed its own concern about the significant impact of observation on Medicare beneficiaries.

In July 2010, CMS sent letters to the national hospital associations asking why they used observation status for extended periods.

In August 2010, CMS held a Listening Session about observation status. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/94244031HospitalObservationBedsListeningSession082410.pdf>. Commenters opposed use of observation status to deprive beneficiaries of Part A coverage of their subsequent medically necessary SNF stay.

In 2012, in proposed and final rules for the outpatient prospective payment system, CMS expressed concern about the increasing amount of time that patients spend in the hospital under observation. 77 Fed. Reg. 45155-157 (July 30, 2012) (proposed rules); 77 Fed. Reg. 68426-433 (Nov. 15, 2012) (final rules).

In 2012, CMS asked for public comment on possible changes to observation status, 77 Fed. Reg. 45061, 45155 (July 30, 2012), but again declined to make any changes, 77 Fed. Reg. 68209, 68433 (Nov. 15, 2012) ("[w]e will take all of the public comments that we received into consideration as we consider future actions that we could potentially undertake to provide more clarity and consensus regarding patient status for purposes of Medicare payment.")

In proposed rules on the Part A-B hospital rebilling option, CMS repeated its concerns. 78 Fed. Reg. 16632, 16634 (March 18, 2013).

In proposed rules the inpatient prospective payment system, published May 10, 2013, 78 Fed. Reg. 27486, 27644-649, CMS once again commented on the increased use of observation status by hospitals and the consequences for Medicare beneficiaries.

In 2013, CMS established a hospital rebilling program and time-based definitions of inpatient care (the two-midnight rule), 78 Fed. Reg. 50495, 50906-931, 50938-954, respectively (Aug. 19,

2013). CMS expressed the hope and expectation that these changes would address concerns about extended observation and outpatient stays. 78 Fed. Reg. at 50922.

Research and studies

In the nine years since CMS first asked for public comment on observation time, a considerable amount of research and analysis has shown the increasing use of observation and outpatient status, the declining use of inpatient status, and the financial consequences for beneficiaries of the changed descriptions of their status in the hospital.

In 2012, Brown University reviewed 100% of Medicare claims data for 2007-2009. Researchers found that the number of observation stays increased 34% and inpatient admissions decreased, suggesting “a substitution of outpatient observation services for inpatient admissions.” Zhanlian Feng, et al, “Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences,” *Health Affairs* 31, No. 6 (2012). They also found that the average length of stay in observation increased by more than 7% and that more than 10% of patients were on observation for more than 48 hours. The Brown researchers identified the Recovery Audit Contractor program (as the Recovery Audit program was then known) and Condition Code 44 as the primary causes of hospitals’ increased use of observation status.

In 2013, the HHS Office of Inspector General described observation stays, long outpatient stays, and short inpatient stays. The Inspector General found that in 2012, 1.5 million hospital stays were classified as observation and 1.4 million hospital stays were classified as long outpatient stays (that is, the hospital described the patient as an outpatient but did not bill for observation hours). Moreover, more than 600,000 hospital stays were for three or more midnights, but did not include three *inpatient* midnights. The Inspector General recommended that CMS consider how to ensure that Medicare beneficiaries with similar post-acute care needs have the same access to, and cost-sharing requirements for, SNF care. *Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02—12-00040 (July 29, 2013), <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

Research at the University of Wisconsin Hospital and Clinics between July 1, 2010 and December 31, 2011 found

- 4,578 of the total 43,853 hospital stays (10.4%) were observation stays; and
- 756 observation stays (16.5%) exceeded 48 hours; 1,791 observation stays (39.1%) were 24-48 hours; 2,031 observation stays (44.4%) were less than 24 hours.

More than one quarter of patients in observation had longer lengths of stay and were more likely than inpatients to be discharged to a SNF, to have more acute/unscheduled admissions, to have more "avoidable days" (days not accounted for by medical need), and to have more "repeat encounters." The researchers concluded, "observation care in clinical practice is very different than what CMS initially envisioned and creates insurance loopholes that adversely affect patients, health care providers, and hospitals." Ann M. Sheehy, MD, MS, et al., "Hospitalized but Not Admitted: Characteristics of Patients With 'Observation Status' at an Academic Medical

Center," *JAMA Intern Med.* 2013; ():-. doi:10.1001/jamainternmed.2013.7306. (abstract published online July 8, 2013), <http://archinte.jamanetwork.com/article.aspx?articleid=1710122>.

In an invited commentary on the Wisconsin study, Robert M. Wachter, MD, Department of Medicine University of California, San Francisco, described "Observation Status" as having "morphed into madness" and wrote, "[I]n fact, if one was charged with coming up with a policy whose purpose was to confuse and enrage physicians and nearly everyone else, one could hardly have done better than Observation Status." "Observation Status for Hospitalized Patients," *JAMA Intern Med* (published online July 8, 2013), <http://archinte.jamanetwork.com/article.aspx?articleid=1710118>.

CMS's new two-midnight rule has not changed the situation. A retrospective application of the two-midnight rule at the University of Wisconsin Hospital and Clinics for the period January 1, 2012 – February 23, 2013 found

- Patients arriving at the hospital after 4:00 p.m. were admitted to inpatient status 31.2% of the time; if they arrived at the hospital before 8:00 a.m., they were admitted to inpatient status 13.6% of the time.
- There was little overlap in diagnosis codes for short-stay inpatients and observation patients.
- Most diagnosis codes in observation were the same, regardless of the patient's length of stay in the hospital.

Ann Sheehy, M.D., University of Wisconsin, "Observation and Inpatient Status: Clinical Impact of the 2-Midnight Rule," *Journal of Hospital Medicine* (2014).

Conclusion

In the nine years since CMS first expressed concern about observation status, the use of outpatient status and observation status for hospitalized patients has dramatically increased. There is widespread support for counting all time in the hospital in determining Medicare patients' entitlement to Part A coverage of a SNF stay.

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