Supporting Statement for Skilled Nursing Facility (SNF)
Prospective Payment System and Consolidated Billing for FY 2012: Change of Therapy (COT) OMRA (Other Medicare required Assessment) as proposed in CMS-1351-P

A. Background

We are requesting approval of a Change of Therapy OMRA for Skilled Nursing Facilities (SNFs). As described in CMS-1351-P, we are proposing that effective October 1, 2011, SNFs would be required to submit this assessment. A COT OMRA is comprised of a subset of resident assessment information developed for use by SNFs to satisfy this new Medicare payment requirement. The burden associated with this is the SNF staff time required to complete the COT OMRA, SNF staff time to encode the data, and SNF staff time spent in transmitting the data.

The COT OMRA would be required when intensity of therapy (i.e., the total count of Reimbursable Therapy Minutes (RTM)) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment. The COT OMRA would be a new type of required PPS assessment which will use the same item set as the current End Of Therapy (EOT) OMRA, with the addition (a new value for the type of assessment).

B. Justification

1. Need and Legal Basis

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA). However, this new COT OMRA is outside the scope of OBRA 1987 and requires a Paperwork Reduction Act submission.

In order to operate the Medicare program in an efficient and economic manner, the COT OMRA is needed to more accurately pay for SNF-PPS therapy services.

2. Information Users

CMS uses the MDS 3.0 data to reimburse skilled nursing facilities for SNF-level care furnished to Medicare beneficiaries.

3. Improved Information Technology

CMS has developed customized software that allows skilled nursing facilities to encode, store and transmit MDS 3.0 data. The software is available free of

charge, and CMS provides customer support for software and transmission problems encountered by the providers.

A Change of Therapy OMRA is required when a change in therapy levels results in a change to the therapy Resource Utilization Group (RUG). To accommodate this new type of assessment, a new value is being added to the OMRA type of assessment item (A0310C and X0600C). A new value of 4 indicates a Change of Therapy assessment. The item subset for a Change of Therapy OMRA is the same as for an End of Therapy OMRA (the NO subset for nursing homes and the SO subset for swing beds). The Change of Therapy OMRA cannot be combined with either a Start of Therapy (SOT) OMRA or an End of Therapy (EOT) OMRA. The Change of Therapy OMRA can be combined with an OBRA comprehensive, quarterly, or discharge assessment or with a scheduled PPS assessment.

4. Duplication of Similar Information

The data required for reimbursement are not currently available from any other source.

5. Small Entities

As part of our PRA analysis for this approval, we considered whether the change impacts a significant number of small entities. In this filing we utilized the instructions that pertain to the paperwork Reduction Act Submission Worksheet, Part II to determine the number of small entities. Specifically, a small entity can be defined as a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field. In the proposed rule CMS-1351-P, CMS 25% of the total SNF number are non-profit. This equates to 3,597 non-profit SNFs.

We estimate the average number of COT OMRAs to be completed will equal 67 per year per facility and will be the same across all respondents based on guidance provided in CMS-1351-P.

6. Collection Frequency

We need to collect this information when there is a change in the RTM as calculated over a seven-day span based on the Assessment Reference Date (ARD). We predict this will occur once over an average 30 day stay for changes resulting in a decrease in therapy. We estimate that this will occur approximately 10 times per year per facility for changes that result in an increase therapy.

7. Special Circumstances

The information may be required to be collected at periodic intervals throughout a skilled nursing facility stay, and is used to calculate the skilled nursing facility's payment rate.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for this approval of the COT OMRA published as part of the proposed rule (CMS-1351-P) that published on May 6, 2011, (76 FR 26364).

9. Payment/Gift To Respondent

There were no gifts and no payment to respondents.

10. Confidentiality

To address concerns about confidentiality of resident data, we provide that a facility and a State may not release resident-identifiable information to the public, and may not release the information to an agent or contractor without certain safeguards (42 CFR 483.20(f)(5) and 483.315(j)).

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimate (Total Hours & Wages)

As required under Section 1888(e)(7) of the Act, skilled nursing facilities must be reimbursed under the SNF PPS. We have **increased** the MDS burden on skilled nursing facilities by requiring the completion of the COT OMRA when there is a significant change in the RTM provided, and the therapy delivered over a 7 day period no longer reflects the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.

a. COT OMRA Preparation, Encoding and Transmission Time

According to the On-Line Survey and Certification System (OSCAR) there were approximately 14,266 skilled nursing facilities certified to participate in the Medicare program during the FY 2011 year- to-date projections. We anticipate the average number of COT OMRAs requiring completion due to an increase in therapy to be one for average 30-day SNF stays. For CY 2009 there were approximately 5.7M million claims, 90 percent having a RUG-IV group containing rehabilitation. The number of stays for CY 2009 was 2.26M.

In our FY 2011 year-to-date projection from the first quarter of data, approximately 40 percent of the claims resulted in a higher than projected rehab RUG. Using this as a way to estimate the maximum number of times that a therapy decrease could result in the need for a COT OMRA, 40 percent or 813,074 stays could be affected. The total number of estimated stays per SNF for FY 2011would be 57. (2,258,539 stays * 0.90 rehab)/14,266 SNFs = 57 stays with a decrease in therapy per SNF.

Although the estimate cited above represents situations where a COT will be used to report decreases in therapy, we anticipate this will be an overestimate in total payment impact as providers will likely react by supplying therapy needed to maintain the reported RUG level.

In addition, the COT OMRA can be used when providers increase the amount of therapy provided. The Start of Therapy (SOT) OMRA represents situations where therapy has increased to a level significant enough to change the RUG. We provide estimates for the possible number of times that a COT would be required due to an increase in therapy based on the number of SOT OMRAs as a proxy. Using the first quarter of FY 2011 projected for the entire year, we estimate the number of SOT OMRAs to be approximately 10 per facility. Therefore, we believe the estimate of 57 stays per SNF needing a COT OMRA for decreased therapy levels and 10 COTs per facility per year for increased therapy levels to be reasonable.

As stated above, the FY 2011 year-to-date projection from the first quarter of data, indicates that approximately 40 percent of the claims resulted in a higher than projected rehab RUG. The case-mix for the ultra-high and very high rehab categories was much higher than expected and the case-mix utilization for the high and medium rehab categories were lower than expected. Using this information, we calculated an estimated dollar impact in cases where a COT would be required due to a decrease in therapy. We used a resource utilization shift from RUC ($634.27) to RHC ($487.76) for urban providers as a reasonable estimate to determine payment differences after a required COT due to a decrease in therapy. The payment difference between RUC and RHC is $146.51 per day. With over 79% of stays being 30 days or less, and assuming that half of the 30-day stay (15 days) represented a decrease in therapy levels, there would be a $2,198 difference in payment after billing at the new COT RUG level. With approximately 813,074 stays per year involving a COT with decreased therapy, this results in a possible savings of $1,786,582,164.

For those COTs completed for an increase in therapy, we estimated possible increases in expenditures based on a case-mix utilization shift from RMC ($434.73) to RVC ($551.51). Our projected utilization anticipated 70 percent of all days to be in the RM, RH or RV rehabilitation categories. Therefore, we believe an estimate based on a shift from the lowest to highest rehabilitation category in this range is reasonable. The payment difference per day for a shift

from RMC to RVC is $116.78 per day. Again, half of a 30-day stay would result in an increase payment of $1,751.70 per stay. With an average of 10 stays for 14,266 facilities, the increase in expenditures for all facilities for one year is estimated to be $249,897,522.

Combining the anticipated savings from the COTs involving decreased therapy ($1,786,852,164), with the COTs involving increased therapy ($249,897,522), the net savings is approximately $1,536,954,642.

The average completion time of the COT OMRA is 50 minutes. We have also estimated coding time at 10 minutes per assessment. In addition, we estimate that skilled nursing facility staff will require 2 minutes per COT OMRA transmission.

The total estimated hours for COT OMRA preparation for both decreased and increased therapy hours, coding and transmission are 987,560 (677, 535+ 135,539+ 27, 075) + (118,879 + 23,781 + 4,751). The break-out is shown below.

COT Preparation: Increased and Decreased Therapy

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*813,074 (# of RUG-IV stays subject to COT for **decreased therapy**)]
57 Per Respondent/year	0.8333 hrs	677,535 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*142,660 (# of RUG-IV stays subject to COT for **increased therapy**)]
10 Per Respondent/year	0.8333 hrs	118,879 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
10 Per Respondent/year	0.8333 hrs	796,414 hours/year

COT Coding: Increased and Decreased Therapy

Average No. of Assessments Reporting	Completion Time/COT	Total Completion Time [Hours per

		response*813,074 (# of RUG-IV stays subject to COT **for decreased therapy**)]
57 per Respondent/year	0.1667 hrs	135,539 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*142,660 (# of RUG-IV stays subject to COT for **increased therapy**)]
10 Per Respondent/year	0.1667 hrs	23,781 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
10 Per Respondent/year	0.1667 hrs	159,320 hours/year

COT Transmission: Increased and Decreased Therapy

Average No. of Assessments Reporting	Completion Time/MDS	Total Completion Time [Hours per response*813,074 (# of RUG-IV stays subject to COT for **decreased therapy**)]
57 per Respondent/year	0.0333 hrs	27,075 hrs/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*142,660 (# of RUG-IV stays subject to COT for **increased therapy**)]
10 Per Respondent/year	0.0333 hrs	4,751 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
10 Per Respondent/year	0.0333 hrs	31,826 hours/year

b. Estimated Costs Associated with the COT-OMRA

To calculate burden, we obtained hourly wage rates for Registered Nurses (RNs) and data operators from the Bureau of Labor Statistics. MDS preparation costs were estimated using RN hourly wage rates of $56,060 per year, $0.45/minute without consideration of employee benefit cost and $0.58/minute after application of a 30 percent increase to account for employee benefit compensation cost. For coding functions we used a blended rate of $41,090; this was the average for RNs ($56,060/yr) and data operators ($26,120/year). The blended rate calculates to $0.33 per minute without consideration of employee benefit cost and $0.43 after application of a 30 percent increase to account for employee benefit compensation cost. The blended rate of RN and data operator wages reflects the fact that SNF providers have historically used both RN and support staff for the data entry function. For transmission personnel, we used data operator wages of $26,120 per year, or $0.21 per minute without consideration of employee benefit cost and $0.27 after application of a 30 percent increase to account for employee benefit compensation cost (See accompanying Excel Spreadsheet, Tab 1)

MDS Function	Total Minutes Per Respondent	Per Minute Loaded $ Rate	Estimated Cost Per Respondent per COT	Annual Cost Burden [(Annual Hour Burden in Minutes * 60)* minute rate)]
COT Preparation	50	$0.58	$29.00	$27,715,207
COT Coding	10	$0.43	$4.30	$4,110,456
COT Transmission	2	$0.27	$0.54	$515,581
TOTAL	62	$1.28	$33.84	$32,341,244

There were 14,266 skilled nursing facilities which sought reimbursement under the year-to-date projected SNF PPS during FY 2011. The cost per facility would be $2,267.02 ($32,342,039/14,266 facilities), assuming 57 stays involving 1 COT of decreasing therapy per stay per year per facility, and, 10 COTs involving increasing therapy per facility per year.

Basic Requirements for all claims

In evaluating the impact of billing changes in the HCFA-1500 common claim form, approved under OMB number 0938-0008, our long-standing policy is to focus on changes in billing volume. Under the SNF PPS, the COT OMRA will dovetail with normal billing operations and there will be no change in billing volume for skilled nursing facilities.

13. Capital Costs (Maintenance of Capital Costs)

Facilities are currently required to collect, compile, and transmit MDS data. Therefore, there are no capital costs. Any other cost can be considered a cost of doing business.

14. Cost to Federal Government

There are no additional costs to the Federal Government.

15. Program Changes

There are no program changes because this is the first year applicable to this request.

16. Publication and Tabulation Dates

The proposed regulation will be published.

17. Expiration Date

With respect to the OMB approval, CMS does not object to the displaying of the expiration date.

18. Certification Statement

There are no exceptions.

C. Collection of Information Employing Statistical Methods

This section is not applicable