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 finalized in CMS-1351-F

A. Background

We are requesting approval of a Change of Therapy OMRA for Skilled Nursing Facilities (SNFs). As described in CMS-1351-F, we are finalizing 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.

SNFs will be required to complete a COT OMRA only when the intensity of therapy (i.e., the total count of Reimbursable Therapy Minutes (RTM)) actually being furnished 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 will 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 of 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 final rule CMS-1351-F, 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 62 per year per facility and will be the same across all respondents based on guidance provided in CMS-1351-F.

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). Because providers currently are not required to report the RTM that occur outside the observation window of a given PPS assessment, we do not have the relevant data to predict with certainty the number of COT OMRAs that may be required per year. However, we have attempted to use the administrative data

currently available as a reasonable proxy to determine estimates of provider burden.

The number of stays for 2009 was approximately 2.26 million. Based on a 30-day average length of stay for RUG-IV, we believe the average number of times that a COT OMRA would need to be completed due to a decrease in therapy is once per stay. Based on our review of the first eight months of FY 2011 data, we found that approximately 40 percent of the claims resulted in assignment to a higher-than-projected Rehabilitation RUG. A possible reason for the difference between projected and actual FY 2011 RUG-IV case-mix utilization could involve instances where the intensity of therapy actually being furnished changed (that is, decreased) within the payment period to such a degree that it no longer reflected the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment. As discussed, previously, if such changes or decreases in therapy utilization occur outside the observation window of a given PPS assessment, and the provider would continue to be reimbursed under a higher-paying Rehabilitation RUG until the next PPS assessment.

For FY 2012, providers will be required to complete a COT OMRA in these situations. Although we believe that only some of the 40 percent difference is likely attributable to these instances, the 450 percent would provide a quantifiable maximum burden estimate for these cases. At this time, we are unable to determine other quantifiable estimates for decreases in therapy utilization necessitating a COT OMRA. Using the percentage of claims resulting in a higher-than-projected Rehabilitation RUG 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 of 2.26 million, or 813,074 stays, could be affected. The total number of estimated COT OMRAs per SNF for FY 2011 would be 57.

In addition, the COT OMRA can be used when providers increase the amount of therapy provided. As stated above, providers currently are not required to report RTM that occur outside the observation window of a given PPS assessment; therefore, we do not have the relevant data to predict with certainty the number of COT OMRAs that may be required per year due to an increase in therapy. We have used the historical data available at this time to quantify situations where an increase in therapy occurs. The Start-Of-Therapy (SOT) OMRA represents situations where therapy has increased to a level significant enough to change the RUG to a therapy RUG. The estimate for the possible number of times that a CT OMRA would be required due to an increase in therapy uses the number of SOT OMRAs as a proxy. Using the number of SOT OMRAs completed in the first eight months of FY 2011, projected for the entire year, we estimate that the total COT OMRAs required due to an increase in therapy would be 71, 330, or 5 times per facility per year.

Therefore, the estimated total number of COT OMRAs per facility per year is 62.

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 seven 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 5.7 million claims, 90 percent having a RUG-IV group containing

rehabilitation. The number of stays for CY 2009 was roughly 2.26 million (2,258,539).

Therefore, 2,032,685 stays (2,258,539 stays * .90) are estimated to be classified into a rehabilitation category. In our FY 2011 year-to-date projection from the first eight months 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 annual estimated stays per SNF for FY 2011would be 57. (813,074)/14,266 SNFs = 57 stays per facility with a decrease in therapy per SNF per year.)

Although the estimate cited above represents a proxy for times 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 eight months of FY 2011 projected for the entire year, we estimate the number of SOT OMRAs to be approximately 5 per facility. Therefore, we believe the estimate of 57 stays per SNF needing a COT OMRA for decreased therapy levels and 5 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 eight months 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 based on the FY 2011 SNF PPS rates in cases where a COT would be required due to a decrease in therapy. We used a resource utilization shift from an ultra-high level of rehab, RUC ($634.27), to a high level of rehab, 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 percent of stays being 30 days or less, and assuming that half of the 30-day stay (15 days) represented a decrease in therapy levels (essentially one of the two assessments during this time), there would be a $2,197.65 ($146.51 * 15) difference per stay 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 $1,786,852,164.

For those COTs completed for an increase in therapy, we estimated possible increases in expenditures based on a case-mix utilization shift from rehab medium utilization, RMC ($434.73), to rehab very high utilization, 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 ($116.78*15) per stay. With an average of 5 stays for 14,266 facilities needing a COT OMRA for increases in therapy, the increase in expenditures for all facilities for one year is estimated to be $124,948,761.

Combining the anticipated savings from the COTs involving decreased therapy ($1,786,852,164), with the COTs involving increased therapy ($124,948,761), the net savings is approximately $1,661,903,403.

We note that the estimate cited above generates savings from situations where a COT will be used to report decreases in therapy. We anticipate this will be a significant overestimate in total payment impact as providers will likely react by supplying therapy needed to maintain the reported RUG level.

We estimate that, based on average burden associated with the End-Of-Therapy (EOT) OMRA, which uses the same basic item set as the COT OMRA, it will take 50 minutes (0.8333 hours) to collect the information necessary for coding a COT OMRA, 10 minutes (0.1667 hours) to code the responses, and 2 minutes (0.0333 hours) to transmit the results, or a total of 62 minutes (1.0333 hours) to complete a single COT OMRA.

The total estimated hours for COT OMRA preparation for both decreased and increased therapy hours, coding and transmission are 913,884 (677, 562+ 135,512+ 27, 102) + (59,442 + 11,888 + 2,378). 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	677,552 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*71,330 (# of RUG-IV stays subject

		to COT for **increased therapy**)]
5 Per Respondent/year	0.8333 hrs	59,442 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
62 Per Respondent/year	0.8333 hrs	737,003 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	135,512 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*71,330 (# of RUG-IV stays subject to COT for **increased therapy**)]
5 Per Respondent/year	0.1667 hrs	11,888 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
62 Per Respondent/year	0.1667 hrs	147,401 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	27,102 hrs/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Hours per response*71,330

		(# of RUG-IV stays subject to COT for **increased therapy**)]
5 Per Respondent/year	0.0333 hrs	2,378 hours/year

Average No. of Assessments Reporting	Completion Time/COT	Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]
62 Per Respondent/year	0.0333 hrs	29,480 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

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	$25,647,717
COT Coding	10	$0.43	$4.30	$3,802,937
COT Transmission	2	$0.27	$0.54	$477,578
TOTAL	62	$1.28	$33.84	$29,928,233

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 $2,097.87 ($29,928,233/14,266 facilities), assuming 57 stays involving 1 COT of decreasing therapy per stay per year per facility, and, 5 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