Crosswalk of Changes to Reinstatement/ Revised Collection of CMS #10387: Prospective Payment and Consolidated Billing for Skilled Nursing Facilities-Change of Therapy Other Medicare Required Assessment OMB Control #0938:1140

Section	Original	Change	Rationale
A. Background	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.	SNFs are required to complete a COT OMRA when a SNF resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) 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.	Revised to match clarified instructions in MDS3.0 RAI Manual.
B.5. Small Entities	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.	In the proposed rule CMS-1622-P, CMS identified 25% of the total SNF number are non-profit. This equates to 3,678 non-profit SNFs.	Updated to reflect most recent data.
B.5. Small Entities	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.	Based on our analysis of assessments completed during FY 2014, we estimate the average number of COT OMRAs to be completed will equal 44 per year per facility	Updated to reflect most recent data.
B.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	Based on our analysis of assessments completed during FY 2014, we estimate the average number of COT OMRAs to be completed will equal 44 per year per facility. The number of stays for FY2014 FY 2014 was approximately 2.63 million.	When estimates were originally made, we did not have the relevant data to predict the amount of COTs which would be done yearly. We were also unsure about how COTs would be completed when therapy was increased versus decreased. We now have that data and have determined that we do not need to separate the data on COTs completed when

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	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.		therapy is increased versus decreased.

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	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.		
B.12. Burden Estimate (Total Hour and Wages)	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.	Initially, when the COT was introduced, we **increased** the MDS burden on skilled nursing facilities by requiring the completion of the COT OMRA when a SNF resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of	We decreased the burden estimate based on the current and updated data that was not available when this was originally proposed.

<table>
<tr><th>Section</th><th>Original</th><th>Change</th><th>Rationale</th></tr>
<tr><td></td><td></td><td>therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) 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. However, with this current reinstatement of the COT OMRA and updated data for the current reporting period, we have decreased the burden estimates to complete this assessment.</td><td></td></tr>
<tr><td>B.12.a. COT OMRA Preparation, Encoding and Transmission Time</td><td>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.)</td><td>According to the On-Line Survey and Certification System (OSCAR), there were approximately 15, 421 skilled nursing facilities in FY 2014. Based on our analysis of assessments completed during FY 2014, we anticipate the average number of COT OMRAs requiring completion per facility per year to be 44.

We estimate that 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, coding and transmission are 701,119 hours/year (565,414 + 113,110 + 22,595). The break-out for each component of this estimate is shown below.

COT Preparation:

<table>
<tr><td>Average No. of</td><td>Completion</td><td>Total Annual</td></tr>
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</td><td>Time Burden decreased based on actual and current data used as opposed to predicted data.</td></tr>
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<tr><th>Section</th><th>Original</th><th>Change</th><th>Rationale</th></tr>
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<td>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</td>
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<table>
<tr><td>Assessments Reporting</td><td>Time/COT</td><td>Hour Burden</td></tr>
<tr><td>44 Per Respondent/year</td><td>0.8333 hrs</td><td>565,414 hours/year</td></tr>
</table>
COT Coding:
<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Annual Hour Burden</td></tr>
<tr><td>44 Per Respondent/year</td><td>0.1667 hrs</td><td>113,110 hours/year</td></tr>
</table>
COT Transmission:
<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Annual Hour Burden</td></tr>
<tr><td>44 Per Respondent/year</td><td>0.0333 hrs</td><td>22,595 hours/year</td></tr>
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	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.		

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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.

<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Annual Hour Burden [Hours per response*813,074 (# of RUG-IV stays subject to COT for <u>decreased</u></td></tr>
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Section	Original	Change	Rationale

		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

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COT Coding: Increased and Decreased Therapy

<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Completion Time [Hours per response*813,074 (# of RUG-IV stays subject to COT <u>for decreased therapy</u>)]</td></tr>
<tr><td>57 per Respondent/year</td><td>0.1667 hrs</td><td>135,512 hours/year</td></tr>
</table>

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

<table>
<tr><td>Average No. of Assessments</td><td>Completion Time/COT</td><td>Total Annual Hour Burden</td></tr>
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<tr><th>Section</th><th>Original</th><th>Change</th><th>Rationale</th></tr>
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<table>
<tr><td>Reporting</td><td></td><td>[Stays subject to COT for <u>increased and decreased therapy</u>)]</td></tr>
<tr><td>62 Per Respondent/year</td><td>0.1667 hrs</td><td>147,401 hours/year</td></tr>
</table>
COT Transmission: Increased and Decreased Therapy
<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/MDS</td><td>Total Completion Time [Hours per response*813,074 (# of RUG-IV stays subject to COT for <u>decreased therapy</u>)]</td></tr>
<tr><td>57 per Respondent/year</td><td>0.0333 hrs</td><td>27,102 hrs/year</td></tr>
</table>
<table>
<tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Annual Hour Burden [Hours per response*71,330</td></tr>
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Section	Original	Change	Rationale
	<table><tr><td></td><td></td><td>(# of RUG-IV stays subject to COT for **increased therapy**)]</td></tr><tr><td>5 Per Respondent/year</td><td>0.0333 hrs</td><td>2,378 hours/year</td></tr></table> <table><tr><td>Average No. of Assessments Reporting</td><td>Completion Time/COT</td><td>Total Annual Hour Burden [Stays subject to COT for **increased and decreased therapy**)]</td></tr><tr><td>62 Per Respondent/year</td><td>0.0333 hrs</td><td>29,480 hours/year</td></tr></table>		
B. 12. B. Estimated Costs Associated with 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	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 $62,440 per year, $0.50/minute without consideration of employee benefit cost and $0.65/minute after application of a 30 percent increase to account for employee benefit compensation cost. For coding	Updated to account for latest salary data from the Bureau of Labor and Statistics.

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<td>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
<table>
<tr><th>MDS Function</th><th>Total Minutes Per Respondent</th><th>Per Loaded $ Rate</th><th>Estimated Cost Per Respondent Per COT</th><th>Annual Cost Burden [(Annual Hour Burden in Minutes* 60) * minute rate)]</th></tr>
<tr><td>COT Preparation</td><td>50</td><td>$0.58</td><td>$29.00</td><td>$25,647,717</td></tr>
<tr><td>COT Coding</td><td>10</td><td>$0.43</td><td>$4.30</td><td>$3,802,937</td></tr>
<tr><td>Cot Transmission</td><td>2</td><td>$0.27</td><td>$0.54</td><td>$477,578</td></tr>
<tr><td>Total</td><td>62</td><td>$1.28</td><td>$33.84</td><td>$29,928,233</td></tr>
</table>
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.</td>
<td>functions we used a blended rate of $48,275; this was the average for RNs ($62,440/yr) and data operators ($34,110/year). The blended rate calculates to $0.39 per minute without consideration of employee benefit cost and $0.51 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 $34,110 per year, or $0.27 per minute without consideration of employee benefit cost and $0.35 after application of a 30 percent increase to account for employee benefit compensation cost
<table>
<tr><th>MDS Function</th><th>Total Minutes Per Respondent</th><th>Per Loaded $ Rate</th><th>Estimated Cost Per Respondent Per COT</th><th>Annual Cost Burden [(Annual Hour Burden in Minutes* 60) * minute rate)]</th></tr>
<tr><td>COT Preparation</td><td>50</td><td>$0.65</td><td>$32.50</td><td>$22,052,030</td></tr>
<tr><td>COT Coding</td><td>10</td><td>$0.51</td><td>$5.10</td><td>$3,460,47</td></tr>
<tr><td>Cot Transmission</td><td>2</td><td>$0.35</td><td>$0.70</td><td>$74,967</td></tr>
<tr><td>Total</td><td>62</td><td>$1.51</td><td>$38.30</td><td>$25,987,469</td></tr>
</table>
There were 15,421 skilled nursing facilities which sought reimbursement under the year-to-date projected SNF PPS during FY 2014 The cost per facility would be $1,685.20 ($25,987,469/15,421</td>
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		facilities), assuming 44 COTs per facility per year.	