CMS Response to Public Comments on the Post Acute Care Payment Reform Demonstration: Cost and Resource Use Forms

The Centers for Medicare & Medicaid Services (CMS) received one comment from the American Medical Rehabilitation Providers Association (AMRPA).

Concerns and comments are addressed in the sections below. CMS appreciates greatly the efforts of individuals and organizations that contributed comments, and believe that the revisions made in response to comments have resulted in an improved instrument.

1. Comments on analysis plans and how data will be used.

Comment: The majority of comments expressed concerns regarding the analyses that would be performed under the demonstrations and the possible nature of the payment reform recommendations which will result from the analysis. For example, AMRPA:

- recommends how various secondary data sources should be used in the analysis,
- identifies what they feel to be the appropriate unit of analysis for determining payment,
- critiques their interpretation of the sampling framework used in data collection,
- questions what they believe to be the budget of the project, and
- suggests additional analyses of interest.

Response:

CMS appreciates the feedback and input on the analysis. The suggestions offered were based on what they had inferred from the data collection instruments presented not from a review of the work plan or analysis plan. There were many excellent points and the CMS plan already included many of the suggestions.

The OMB-PRA process is designed to review new data collection efforts. The materials released do not include the proposed analysis approach, budget, or other materials not related to the data collection tools being reviewed. Consequently, issues of analysis and interpretation of findings are better left to a different venue.

2. Comments on CFO interview protocols.

Comment: Several suggestions were offered for ways to ensure the interview protocols reached the best respondent.

Response: CMS appreciates the comments on operational methods for using the interview protocols. The details of how the data collection tools will be implemented are not the focus of this review process. The suggestions for better implementing the interviews were already part of the RTI planned approach.

Comment: Concerns were raised about the comparability of providers' estimates of fixed and variable costs and their relation to more well-established cost-finding concepts, such as direct and indirect costs.

Response: CMS appreciates the concerns about identifying fixed and variable costs. The legislation establishing this demonstration dictated that CMS measure fixed and

variable costs in the participating providers. Standard definitions of "fixed" and "variable" costs applicable to all providers do not exist. Some providers may have constructed their own estimates, but those estimates will undoubtedly be provider-specific, and some providers may not have estimated their fixed and variable costs. The intent of the questions is to examine the variations in how these concepts are defined. Thus, the lack of consistent definition is the point of the question and not an oversight.

3. Concerns over therapy/nursing interview protocols.

Comment: Several suggestions were offered to improve the data collected by the nursing and therapy protocols. Suggestions included adding nurse and therapy ratios in addition to counts of the number of each type of staff on each unit.

Response: These interview protocols are being used to collect information on each unit to monitor and interpret data collected during the CRU data collection periods. Specific data regarding intensity will be collected with the CRU tools. The suggestions are appreciated and will be taken into account where appropriate.

Comment: Suggestions were made to more specifically account for different length shifts being staffed in the interview.

Response: The suggestion was incorporated in the interview.

4. Comments on Staff Logs.

Comment: Several suggestions were offered for improving the quality of data collection. In particular, it was suggested that staff be able to complete the data collection instruments throughout the day rather than at the end of the day. It was also suggested that staff receive training on how to use the data collection instruments and that these instruments be pilot tested. Finally, it was suggested that CMS utilize a "gold standard," such as concurrent data collection by an observer, to assess the accuracy of data collection.

Response: CMS appreciates these concerns about data accuracy. Several of the suggestions will be implemented.

- The instructions for the data collection instruments, printed on the reverse of each form, already advise staff to update the forms every 1 to 2 hours. CMS plans on providing extensive instruction on using the forms and will provide training and oversight of the data collection effort.

- The forms have been pilot tested in three post-acute settings, and numerous modifications were made to improve staffs' ease of using them.

- Regarding a "gold standard," CMS does not plan on concurrent data collection by an observer because such a requirement would place undue burden on participants in the demonstration. As an alternative, CMS will compare results of staff time per person from the primary data collection to responses from the therapy/nursing interviews to estimate the overall accuracy of the data collection. In addition, the coordinators will be trained to monitor the staff responses on a daily basis as forms are submitted.

Comment: It was suggested that CMS make modifications to the forms to include several types of staff: recreational therapy, RN case managers, PPS coordinators, admission and pre-admission staff, ancillary support staff (e.g., housekeeping, dietary, maintenance).

Response: CMS has modified the forms so that recreational therapists and PPS coordinators can specifically indicate their position. CMS feels that the forms will already adequately capture time devoted to patients in participating units by all case managers. CMS views the activities of pre-admission screening and ancillary support staff as regular costs of providing care for all patients and so are adequately addressed by spreading those costs equally across all patients. CMS feels that requiring all provider staff to record their time would be unduly burdensome without adding significantly to the analyses to be performed.

Comment: Concerns were raised about the specificity of definitions of "group therapy" activities.

Response: CMS appreciates that different post-acute settings may have different regulatory requirements and definitions of "groups" and also that there may be a great deal of variation in the number of patients and type of activities conducted in a group. To address the potential for different interpretations of a "group," CMS has, for the purposes of this data collection, specified in the instructions that a group is defined as 2 or more patients. CMS feels that the current form and associated instructions for completing the therapy log will adequately collect data on group therapy activities by not pre-defining a set of group activities but rather to let each individual staff person report time that they and their patients spend in up to 6 groups.

5. Comments on the Ancillary Service Log.

Comment: Several comments and concerns were made about the data collection instrument for ancillary services. These include suggestions 1) to reorder the list of services, 2) for important services to add to the form, and 3) to include additional spaces to record services not preprinted on the form.

Response: CMS appreciates these concerns and has made several of the suggested changes to this form in order to foster easier use of the form.

1) Ancillary services are now grouped into three categories: imaging/ radiology, other diagnostics, and complex treatments.

2) As recommended, several complex treatments have been added, including complex bowel management, continuous cardiac monitoring/telemetry, intermittent bladder catheterization, ventilator management for patients being weaned from a ventilator, and negative pressure wound therapy. This will result in less need to write in treatments and thereby reduce burden.

3) There are now places to report "other" imaging, diagnostic, and complex treatments as well as a more flexible approach to reporting ultrasounds.

6. Comments on the Consultant Log.

Comment: A suggestion was made to include physicians on the consultant log.

Response: Consulting physicians' professional fees are billed either by the physicians themselves or by the provider for the physician. Information on physicians is therefore available from a secondary data source (claims). In the interest of minimizing burden to respondents, CMS will not include physicians on the consultant log.

Comment: CMS was advised that the term "consultant" is confusing and could be interpreted differently based on staffing structure in individual settings.

Response: CMS understands that the term "consultant" could be used differently in different providers depending on their specific staffing patterns. To reduce confusion over whether physicians should complete this log, CMS has changed the name of this form to "Non-Physician Consult Log Form."

CMS intends to work with each participating provider to determine which staff would be best suited to use the longer staff activity form and which staff would be better suited using the consultant log. CMS feels this more flexible approach will reduce burden and improve reporting.

7. Comments on cost data collection efforts

Comment: Questions were raised regarding the inadequacy of the interview tool and the CRU to capture cost variations among providers. Specifically, neither data collection tool captures cost differences associated with variations in plant facilities, system membership, or other characteristics that allow organizations to share costs across larger units.

Response: Specific cost data will be collected through Medicare cost reports not through the interviews or CRU tools. The use of this secondary data source will reduce the data collection burden to providers.

Comment: Comments were raised regarding the burden estimate for the CRU tool completion times.

Response: These time estimates are based on the results of the pilot tests. Estimates are not based on one or two attempts at using the form but instead based on several days' use of the tools. Average times reflect both the long times associated with completing the first couple forms and the short times associated with completing the last forms

Another factor which may impact the commentor's perception of burden is not having received training on the proper way to complete the form. In the pilot test, staff completed the tools throughout the day so each update did not take require much effort (2 to 5 minutes every 2 hours).