

June 24, 2013

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On May 31, 2013, Cynthia Morton, Executive Vice President of the National Association for the Support of Long Term Care (NASL) and Donna Doneski, Director of Policy and Membership (NASL) met with Linda Oliver, Christianna Barnhart, Mark Walker of the Wireline Competition Bureau, Wireline Competition Bureau interns Erica Larson and Jaimie Douglas, and Maya Uppaluru of the Consumer and Governmental Affairs Bureau, all of the Federal Communications Commission. NASL is a national trade association representing providers of both ancillary services and products to long term and post-acute care (LTPAC) sector, including skilled nursing facilities (SNFs). NASL member companies provide speech-language pathology; physical, occupational and respiratory therapy; portable x-ray/EKG and ultrasound; pharmacy services; information technology services and solutions; and other ancillary services. NASL members also provide products such as complex medical equipment; parenteral and enteral supplies, equipment and nutrients; and additional specialized supplies for post-acute care settings. While the majority of NASL members deliver the ancillary services that support SNFs, NASL also has several member companies that provide skilled nursing, assisted living and care in other LTPAC settings. The purpose of the meeting was to discuss the SNF industry and the broadband needs of SNFs in order to help inform the Commission on the design of the SNF Pilot Program.

NASL made the following observations during the meeting:

Medicare Billing. The group discussed the processes involved in billing Medicare for skilled nursing care and ancillary services. NASL explained that Medicare billing changed when the Centers for Medicare & Medicaid Services (CMS) ushered in the SNF prospective payment system in the late 1990s. Medicare consolidated billing, as mandated by the *Balanced Budget Act of 1997 (BBA)* and later amended by the *Benefits Improvement & Protection Act of 2000 (BIPA)*, requires the SNF to bill for all care provided to a Medicare beneficiary during a covered Part A SNF stay. A handful of services excluded from consolidated billing are billed separately such as: a physician's professional services; certain dialysis-related services; certain ambulance services (*e.g.*, beneficiary transport to receive dialysis or certain types of intensive or emergency outpatient hospital services); certain chemotherapy or radioisotope services; and customized prosthetic devices.ⁱ

Physical and occupational therapy and speech-language pathology services remain subject to consolidated billing,ⁱⁱ and may be billable to Medicare Part B when furnished to a beneficiary during a non-Medicare A-covered SNF stay. SNF providers often contract with ancillary providers, who deliver therapy services for SNF patients/residents. Typically with such arrangements, the SNF will bill Medicare as required under consolidated bidding, and then reimburse the ancillary therapy services provider for delivering therapy services to the SNF patient/resident.

Medicare billing is mostly electronic and relates to information contained in the Minimum Data Set (MDS) 3.0 standard patient assessment tool. Electronic billing as required (save for limited exceptions) under Section 3 of the *Administrative Simplification Compliance Act (ASCA)*, *Public Law 107-105* (see *42 CFR 424.32*) and which went into effect October 16, 2003ⁱⁱⁱ was the first significant application that required SNFs to have data connections. NASL rarely hears from its members that SNFs lack sufficient connectivity for electronic billing, although the amount of data transmitted through MDS is relatively minimal and does not require substantial bandwidth. However, NASL mentioned the possibility that Medicare could require the collection of additional clinical assessment data, which could necessitate greater bandwidth. Additionally, NASL believes that SNFs increasingly will be involved in health information exchange as the HHS Office of the National Coordinator for Health Information Technology (ONC) defines meaningful use criteria in Stage 2 & 3 as involving data exchange between acute care and SNFs, which will add to SNF/LTPAC settings' broadband needs.

Cost Shifting. NASL explained that a SNF's Medicare payments oftentimes subsidize costs that are not covered due to Medicaid underfunding. For example, the average Medicaid reimbursement is only \$180 per day, whereas Medicare reimbursement for a patient in the highest Resource Utilization Group (RUG) category can be as much as \$800 per day. Approximately 10-15% of patients in the average, 130-bed SNF are covered by Medicare Part A, another 10% of patients may have insurance, 5-9% may be private pay, which means the vast majority of SNF patients rely on Medicaid for the care they need. The higher Medicare A reimbursement is frequently counted on to help to cover the costs associated with the under reimbursement for Medicaid patients. NASL emphasized that the SNF Medicare reimbursement is in stark contrast to the acute-care environment, where the complaint is often that Medicare reimbursement is too low.

Dual Eligibility. The group also discussed the issues around so-called "dual eligible" patients. NASL explained that these individuals are eligible for benefits under both Medicare (over the age of 65) and Medicaid (low-income, low-asset). NASL gave the example of a dual eligible patient, who had a 3-day qualifying stay in the hospital for a broken hip and who requires post-acute rehabilitative care in a SNF. Medicare will pay up for up to 100 days of care in a SNF (Medicare pays all costs for the first 20 days and requires beneficiaries to pay a co-pay of \$148 per day beginning on the 21st day through day 100). At the end of the 100-day period, if the patient still requires care at the SNF, a dually eligible patient would be covered under Medicaid. While Medicaid may be the primary payer after day 100, or even before if Medicare Part A skilled criteria is not met and benefits are denied, outpatient therapy services (*i.e.*, physical therapy related to the broken hip) may still be covered under Medicare Part B even after the 100-day period expires.

Hospital Readmission. NASL emphasized that a hospital's readmission metrics and associated penalties could play a substantial role in the development of closer relationships between SNFs and hospitals. NASL explained that prior to the *Affordable Care Act*, which allows CMS to reduce payments to hospitals with excessive readmission rates, there was little incentive for hospitals to follow up with patients discharged to a SNF. NASL expects this to change due to the new readmission penalties. NASL emphasized that SNFs also need the ability to communicate with hospitals to better coordinate a patient's transition of care. Currently, when a hospital discharges a patient to a SNF, a full medical record is rarely provided.

Electronic Health Records. NASL noted that long term and post-acute care providers were left out of the *Health Information Technology for Economic & Clinical Health (HITECH) Act*, and are largely ineligible to participate in CMS' EHR Incentive Programs, which center around the meaningful use of electronic health records (EHRs). Regardless, software solutions designed for the hospital or ambulatory care

setting do not address the substantially different needs and requirements that SNFs have. NASL is not aware of any vendor that is creating and selling EHR software designed to serve the needs of both hospitals and SNFs; nor are the standards in place yet to ensure the interoperability of software for different care settings. This lack of EHR interoperability further confounds the effort to increase connectivity and communications between hospitals and SNFs, although CMS Innovation projects and efforts wholly funded by some providers are paving the way for this type of information exchange.

Current Broadband Needs. NASL explained that increased broadband connectivity for SNFs is not a top priority for its members. Instead, NASL members are focused on the development of standards through the work of the ONC's Standards & Interoperability Framework, and tracking the developments around health information exchange (HIE), to include HHS' Offices of the Assistant Secretary of Planning & Evaluation (ASPE) and ONC efforts to encourage state and regional HIEs and related initiatives. Telemedicine or other telehealth applications are a lesser priority for the group at this time.

Future Broadband Needs. The group discussed potential drivers for increased broadband connectivity in the future. NASL explained that bundled payments from Accountable Care Organizations (ACOs) create an incentive for SNFs to integrate more closely with hospitals and other health care providers. SNFs understand that if they do not become more connected with other health care providers, they may be left behind. However, many SNFs are already financially strapped and struggling with reduced Medicare and Medicaid reimbursements. NASL further explained that consumer preferences for broadband connectivity may drive SNF adoption, rather than the adoption of telehealth applications. NASL is beginning to see a shift with "baby boomers" that want the SNF to have broadband connectivity to enable more interactive communications (e.g., Skype) with their families while receiving care at a SNF. NASL acknowledged that staffing shortages (e.g., lack of qualified nurses and physicians), particularly in rural SNFs, could also drive future broadband adoption to enable remote care by qualified medical professionals through telemedicine and other telehealth applications.

Respectfully submitted,

_____/s/
Mark A. Walker
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Wireline Competition Bureau

ⁱ See CMS' SNF Consolidated Billing Overview at <http://cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>

ⁱⁱ Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that physical, occupational, and speech-language therapy services are subject to consolidated billing. See CMS background on consolidated billing at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html>

ⁱⁱⁱ See CMS *Medicare Claims Manual*, Section 90 – Mandatory Electronic Submission of Medicare Claims (Rev. 2181, Issued 03.25.11, Effective/Implementation Date of 04.25.11), <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf>