Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012

Final Rule

Summary

On July 29, 2011, the Centers for Medicare & Medicaid Services (CMS) posted for public inspection a final rule (FR) for policy changes to the skilled nursing facility prospective payment system (SNF PPS) for Federal fiscal year (FY) 2012. The FY 2012 begins for discharges on or after October 1, 2011 and ends for discharges on or before September 30, 2012. The FR is scheduled to be published in the *Federal Register* on August 8, 2011.

The FR examines recent changes in provider behavior relating to the implementation of the Resource Utilization Groups, version 4 (RUG-IV) case-mix classification system and consequently recalibrates the case-mix indexes so that they more accurately reflect parity in expenditures between RUG-IV and RUG-53, the previous case-mix classification system.[1] The FR also includes a discussion of a Non-Therapy Ancillary component under development within CMS. In addition, the FR discusses the impact of certain provisions of the Affordable Care Act (ACA).

I. Impact

CMS estimates that the aggregate impact of this FR would be a net 11.1 percent decrease of $3.87 billion in payments to SNFs, resulting from a $600 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment.

The following table is extracted from Table 11 of the FR to highlight the implications of CMS' decision to recalibrate the case-mix adjustment.

TABLE 11: RUG-IV Projected Impact to the SNF PPS for FY 2012

SNF Categories	Number of Facilities	Revised CMIs	Updated Wage Data	Total FY 2012 Change
Group:				
Total	14,706	-12.6%	0.0%	-11.1%
Urban	10,321	-12.8%	0.0%	-11.3%
Rural	4,385	-11.9%	0.1%	-10.3%

[1] In the proposed FY 2012 SNF PPS rule, CMS listed two options for updates to the SNF PPS payment rates: one would involve the recalibration of the case-mix indexes and second option would not. CMS, after further study of the data, selected the former option.

SNF Categories	Number of Facilities	Revised CMIs	Updated Wage Data	Total FY 2012 Change
Hospital-based Urban	454	-12.4%	0.1%	-10.8%
Freestanding Urban	9,867	-12.8%	0.0%	-11.3%
Hospital-based Rural	341	-11.3%	0.0%	-9.8%
Freestanding Rural	4,044	-11.9%	0.1%	-10.3%
Ownership:				
Government	769	-12.4%	-0.1%	-11.0%
For-Profit	10,172	-12.6%	0.0%	-11.1%
Non-Profit	3,765	-12.7%	0.0%	-11.2%

II. FY 2012 Annual Update of Payment Rates under the SNF PPS

A. Federal Prospective Payment System

The FY 2012 rates reflect an update using the latest market basket index, reduced by the multifactor productivity (MFP) adjustment[2]. The FY 2012 market basket increase factor is 2.7 percent which is reduced by the 1.0 percentage point MFP adjustment.

The following tables replicate Table 2 and Table 3 in the FR which show the estimated unadjusted Federal rate per diem for urban and rural SNFs.

Table 2: FY 2012 Unadjusted Federal Rate Per Diem – Urban

Rate Component	Nursing – Case-Mix	Therapy – Case-Mix	Therapy – Non-Case-Mix	Non-Case-Mix
Per Diem Amount	$160.62	$120.99	$15.94	$81.97

Table 3: FY 2012 Unadjusted Federal Rate Per Diem – Rural

Rate Component	Nursing – Case-Mix	Therapy – Case-Mix	Therapy – Non-Case-Mix	Non-Case-Mix
Per Diem Amount	$153.46	$139.51	$17.02	$83.49

[2] The MFP is applicable to SNFs by section 3401 of the ACA starting in FY 2012 and each subsequent fiscal year. The MFP adjustment is equal to "the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity."

B. Case-Mix Adjustments

Of the two options considered in the proposed rule (recalibrate or not to recalibrate) CMS will recalibrate the SNF PPS case mix to assure aggregate payment parity between the RUG-53 and RUG-IV case-mix classification systems based on the agency's assessment.

CMS says that the agency applied an upward adjustment of 61 percent to the RUG-IV nursing case-mix indexes (CMIs) to achieve aggregate payment parity between the RUG-53 and RUG-IV models, based on an analysis using final FY 2009 claims data. At the time of the analysis, CMS said that as actual data for RUG-IV utilization became available, the agency intended to assess the effectiveness of the parity adjustment and, if necessary, to recalibrate the adjustment in future years.

The subsequent analysis was based on actual first quarter data for FY 2011. This FR is based on claims and Minimum Data Set (MDS) 3.0 assessments data for the first 8 months of FY 2011 (October 1, 2010 through May 31, 2011). In the proposed rule, CMS said that these data show that ". . . actual RUG-IV utilization patterns differ significantly. . ." from projections using the FY 2009 claims data. In particular, CMS noted that ". . . the proportion of patients grouped in the highest-paying RUG therapy categories greatly exceeded our expectations." The actual claims data also suggest a ". . . significant increase in the utilization of individual and group therapy, which, given current MDS coding instructions, may also account for the high proportion of SNF residents classified in the Ultra High Rehabilitation RUG categories." In the FR, CMS says that, ". . . we determined that the utilization patterns identified in our analysis of the first quarter 2011 data continued throughout the entire 8-month period . . .."

In addition, CMS says, the increased expenditure levels due to the implementation of the RUG-IV system has been validated by the Office of the Inspector General (OIG) in a separate review of SNF payments during the first 6 months of FY 2011. According to a preliminary analysis by OIG, the utilization trends related to the shifts in the modes of therapy and the classification of high percentages of SNF beneficiaries into the highest-paying RUG-IV groups were even more pronounced in the FY 2011 second quarter than in the first quarter. This OIG report is available at: http://oig.hhs.gov/oei/reports/oei-02-09-00204.asp.

Based on the above first quarter claims data from FY 2011, CMS determined in the proposed rule that the adjustment, which had originally produced an increase of 61 percent to the nursing CMIs, would need to be decreased to 22.55 percent to achieve budget neutrality if applied equally to all nursing CMIs as CMS has done in the past.

CMS, however, adopts its proposal that the adjustment (reducing the 61 percent parity adjustment) be applied only to the nursing CMIs for the RUG-IV therapy groups and not

to the nursing CMIs for the RUG-IV non-therapy groups. Using this recalibration methodology in the FR, CMS estimates that the nursing CMIs of the RUG-IV therapy groups would be updated by 19.84 percent.

CMS says the above approach is equitable because it focuses the recalibration on the therapy RUG categories which accounted for the most notable differences between expected and actual RUG-IV utilization. The FR includes Tables 4 and 5, which illustrate the payment rates respectively for urban and rural SNFs that would be derived from nursing CMIs reflecting this recalibration increase.

CMS says this isn't the first time for such a parity adjustment. CMS notes for 3 of the past 6 years, specifically in FY 2006, FY 2010 and FY 2011 the agency has attempted to restore budget neutrality in the transition to a new case-mix classification system by applying a parity adjustment. CMS says that in both case-mix transitions (from RUG-44 to RUG-53 and from RUG-53 to RUG-IV) ". . . we found that, rather than achieving budget neutrality, application of the parity adjustment to the new case-mix system resulted in excess payment to providers, because actual utilization patterns under the new case-mix system were different than we originally projected, thus necessitating a recalibration of the adjustment."

In response to comments that CMS consider the possibility of phasing-in a recalibration over the course of several year, CMS says that phasing-in the recalibration would continue to reimburse facilities at levels that significantly exceed intended SNF payments. Further, CMS cites a report by MedPAC, which found in 2009 that the aggregate Medicare margin for freestanding SNFs, which represent more than 90 percent of all SNFs, was 18.1 percent, up from 16.6 percent in 2008. CMS says in the FR that ". . . given these high Medicare margins, we do not believe that a phase-in approach is justified."

C. Wage Index Adjustment to Federal Rates

Since the inception of the SNF PPS, CMS has used hospital wage data in developing a wage index to be applied to SNFs; however, the SNF PPS does not use the hospital's area wage index's occupational mix adjustment. CMS will continue this practice in FY 2012.

CMS says that the labor-related share for FY 2012 will be 68.693 percent; in FY 2011 the labor-related share is 69.311. Tables 6 and 7 in the FR show the finalized Federal rates for RUG-IV by the labor-related and non-labor-related components by urban and rural SNFs. See Table 9 in the FR for a summary of the updated labor-related share for FY 2012 compared to FY 2011.

Finally, CMS adopts a budget neutrality factor of 1.0007 for FY 2012.

D. Updates to the Federal Rates

The FY 2012 payment rates in this FR reflect an update of 1.7 percent, which is equal to the full SNF market basket, estimated at 2.7 percentage points, reduced by the MPF adjustment of 1.0 percentage points.

E. Relationship of Case-Mix Classification System to Existing SNF Level-of-Care Criteria

CMS includes in each update of the Federal payment rates the designation of those specific RUGs under the classification system that represent the required SNF level of care. This designation reflects an administrative presumption under the 66-group RUG-IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG-IV groups on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare required assessment.

CMS is once again designating the upper 52 RUG-IV groups as those encompassing the following RUG-IV categories:

- Rehabilitation plus Extensive Services;
- Ultra High Rehabilitation;
- Very High Rehabilitation;
- High Rehabilitation;
- Medium Rehabilitation;
- Low Rehabilitation;
- Extensive Services;
- Special Care Low; and
- Clinically Complex.

III. Resource Utilization Groups, Version 4 (RUG-IV)

A. Prospective Payment for SNF Non-therapy Ancillary (NTA) Costs

At the inception of the SNF PPS, payment for the NTA service component was included in the 44-group RUG system of case-mix groups.

CMS says that to date its analysis has produced a conceptual model. The model provides that the payment associated with a new NTA component of the SNF PPS would be financed by reallocating that portion of the current nursing component which has been previously considered to account for NTA costs. CMS' intent in adding a separate NTA component, distinct from the nursing component, is to provide greater predictive ability, promote more equitable NTA reimbursement, and achieve a more cost-effective payment structure for SNFs.

In the FY 2012 SNF PPS NPRM, CMS said that the NTA payment would be broken into two parts: a routine NTA bundled payment (RNP) and a tiered non-routine NTA payment (TNP). The RNP would constitute a base payment for every patient day, distinct from the tiered NTA payment and separate from the nursing component, to cover the costs of routine NTA services that are commonly given to a wide range of SNF patients. The TNP would track relative variations in NTA costs and utilization.

IV. Ongoing Initiatives under the Affordable Care Act (ACA)

A. Value-Based Purchasing

ACA requires the development of a plan to implement a value-based purchasing program for SNFs, with a report to Congress due by October 1, 2011. CMS says it is in the process of developing the SNF value-based purchasing implementation plan and report. CMS says that it intends is to meet the above deadline.

B. Payment Adjustment for Hospital-Acquired Conditions (HACs)

ACA requires a study on expanding the already-existing HAC policy (applicable to acute care hospitals in the Medicare program) to payment made in various post-acute settings, including SNFs. The study's conclusions are supposed to be reported to Congress no later than January 1, 2012. CMS says it is in the process of developing such a study and intends to meet the reporting deadline.

C. Nursing Home Transparency and Improvement

ACA requires SNFs to report expenditures separately for direct care staff wages and benefits on the Medicare cost report for cost reporting periods beginning on or after 2 years after the date of enactment (March 23, 2010). Within 30 months of enactment, ACA requires that the financial expenditures be categorized for each SNF into specific functional accounts on an annual basis.

D. Other issues

A. Required Disclosure of Ownership and Additional Disclosable Parties Information

ACA requires Medicare SNFs and Medicaid nursing facilities to make available on request by CMS and others certain information on ownership, including a description of the governing body and organizational structure of the relevant Medicare SNF or Medicaid nursing facility, and information regarding additional disclosable parties.

In response to section 6101 of ACA, CMS is revising the reporting requirements that Medicare SNFs and Medicaid nursing facilities must meet at the time of enrollment and when any change of ownership occurs. These proposed revisions include:

1. Adding a definition for "additional disclosable party." CMS proposed to define an "additional disclosable party" to mean, with respect to the Medicare SNF or Medicaid nursing facility, ". . . as person or entity that exercises financial, operational, or managerial control over the facility; provides policies or procedures for any of the operations of the facility, including policies or procedures that establish clinical decision making capabilities directed related to resident care; provides financial or cash management services to the facility; leases or subleases real property to the facility or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or provides management or administrative services, management or clinical consulting serves, or accounting or final services to the facility." CMS said that this proposed definition, "broadly defined" mirrors the statutory language.

2. Adding a definition of "organizational structure." CMS said that the proposed definition of "organization structure" mirrors the statutory definition for the term.

3. Adding a revision to the definition for a "managing employee." Such a revision would include ". . . consultants and any individual who directly or indirectly manages, advises or supervises any element of the practice, finances, or operations of the facility."

CMS does not finalize the proposed revisions in the FR, and CMS says, "[t]o respond properly to all of the comments received related to the disclosure of information requirements, we will publish a separate final rule specifically addressing these provisions at a later date." CMS says that this separate final rule would be published in early CY 2012.

B. Therapy Student Supervision

CMS removes the requirement for line-of-sight supervision for a therapy student in the SNF setting and instead allows each SNF to determine for itself the appropriate manner of supervision of therapy students.

C. Group Therapy and Therapy Documentation

When the original RUG-III model was developed, most therapy services were furnished on a one-to-one basis and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. Lately, however, CMS has found that a significant amount of therapy was provided on a concurrent basis. As a result, with the introduction of the RUG-IV, CMS modifies the way providers report and are reimbursed for concurrent therapy services such that allocated concurrent therapy minutes are used to assign patients to RUG-IV groups. Providers can no longer be reimbursed for therapy time for each of the Medicare beneficiaries treated concurrently.

CMS initially did not look at group therapy because it was used sparingly and that utilization had not changed significantly since the inception of the SNF PPS in 1999.

Recently, CMS has identified two very significant changes in provider behavior related the provision of therapy service to Medicare beneficiaries in SNFs under RUG-IV. CMS saw both a major decrease in the amount of concurrent therapy performed in SNFs and a significant increase in the amount of group therapy services, which are not subject to the allocation requirement. CMS is thus naturally concerned that this increase in group therapy indicates an inappropriate payment incentive to perform the less intensive group therapy in place of individual therapy.

CMS finalizes its proposal that the most appropriate group therapy size for the SNF setting is four. Group therapy time will be divided by four in determining the reimbursable therapy minutes for each group therapy. (For the purpose of coding group therapy for Medicare Part A SNF payment, the existing definition of group therapy is 2-4 patients.) CMS believes that groups of fewer than four participants do not maximize the group therapy benefit.

In addition, CMS made a number of clarifications with regard to clinical documentation requirements related to a patient's plan of care.

D. Changes to the MDS 3.0 Assessment Schedule and Other Medicare-Required Assessments

Upon review, CMS believes that the combination of the current grace period allowance and observation period can cause MDS assessments to be performed in such a way that some of the information coded on a subsequent assessment is duplicative of the previous assessment. Given the implications of this for both care quality and payment accuracy, CMS is modifying the current Medicare-required assessment schedule to incorporate new assessment windows and grace days.

Further, CMS is eliminating the distinction between 5-day and 7-day facilities for purposes of setting the Assessment Reference Date (ARD) for the End-of-Therapy Other Medicare-Required Assessment (EOT-OMRA). Instead effective October 1, 2011, an EOT-OMRA for a patient classified in a RUG-IV therapy group will be required if that patient goes three consecutive calendar days without being furnished any therapy services. In addition, CMS, effective October 1, 2011, will require facilities to compete a Charge of Therapy (COT) OMRA for patients classified in a RUG-IV therapy category, whenever the intensity of 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.

E. Consolidated Billing

In the FY 2012 SNF PPS proposed rule, CMS specifically invited public comments identifying codes in any of the four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. In the FR, in response to one commenter, CMS agrees to add, as a new exclusion, the particular chemotherapy drug, TREANDA® (Healthcare Common Procedure Coding System (HCPCS) code J9033) because it meets the "high-cost, low probability" standard in the SNF setting. This addition will be effective July 1, 2011.