NYAHSA | New York Association of Homes & Services for the Aging

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MEMORANDUM

TO: RHCF Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: May 29, 2009

SUBJECT: **SNF Proposed Rule**

ROUTE TO: Administrator, CFO

ABSTRACT: CMS provides more details on the Medicare SNF PPS proposed rule.

Introduction

The Centers for Medicare and Medicaid Services (CMS) has announced its proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) rule for federal fiscal year (FY) 2010. The final rule will be effective from October 1, 2009 through September 30, 2010. The proposed rule went on display on May 1, 2009 at the Office of the Federal Register's Public Inspection Desk under "Special Filings" at: www.federalregister.gov/inspection.aspx. Providers can also refer to www.cms.hhs.gov/snfpps for more details.

Public Comment Period

As with any proposed rule, we are now in the public comment phase. To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 30, 2009 and reference file code: CMS-1410-P.

1. Electronically. Please go to http://www.regulations.gov, and follow the instructions under the "More Search Options" tab.

2. By regular mail. Please mail written comments to the following address and allow sufficient time for comments to be received before the close of the comment period:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1410-P, P.O. Box 8016, Baltimore, MD 21244-8016.

NYAHSA and AAHSA are currently in the process of reviewing and analyzing the proposed rule and will be submitting comments on behalf of our members.

Open Door Forum

NYAHSA Doc. ID # N00003461 provided members with some initial details on the proposed rule. On May 29th, NYAHSA participated in a CMS SNF Open Door Forum focused on the proposed rule, which provided some additional clarifications. Following is a summary of the CMS presentation.

Recalibration

Most of the presentation focused on the recalibration issue, which was first introduced in the FY 2009 proposed rule, but dropped in the final rule pending an opportunity for CMS to further evaluate the data. The practical impact of the recalibration is a decrease in Medicare rates by approximately $1.05 billion.

CMS, however, is going to great lengths to explain that this is not intended to be reduction in Medicare rates. By way of background, they explained that the FY 2006 RUGs refinement, which expanded the number of categories from 44 to 53, had always been intended to be budget neutral. CMS analysis has shown, however, that the expansion of the classifications has resulted in a 3.3 percent per year overpayment to providers. Instead of viewing the recalibration as a cut, CMS is framing it in terms of a prospective adjustment. It is prospective in the sense that CMS is looking to make the corrections going forward, but is not taking any action to recoup what they view as the prior years' overpayments.

CMS is also making the case that the negative payment adjustment is partially offset by the 2.1 percent Market Basket Index increase of approximately $600 million, resulting in a net negative impact of $390 million.

RUG-IV, MDS 3.0 and RAPs

The forum presentation also went into considerable detail on the implementation of the new RUG-IV and MDS 3.0. Under RUG-IV, CMS is proposing an additional expansion of the classifications from 53 to 66. The system update is designed to incorporate data and insights gathered from the recent Staff Time and Resource Intensity Verification (STRIVE) project.

CMS believes that the results of the STRIVE project demonstrate that there have been significant changes in the way in which nursing homes are delivering care, and the refinements to both the MDS and RUGs are designed to better capture these changes. The initial roll out of the new system is slated for October 1, 2009, and providers and vendors will have one year to gear up before the official implementation date in October 2010 (FY 2011). CMS advises that it is still premature to invest time in training on the new MDS since the final version is not going to be released until October of this year.

CMS has conducted some "crosswalk" analysis between the current and revised RUG systems and they hope to publish the results of this analysis over the next couple of weeks.

CMS does expect that the new system will result in major shifts in the classification of skilled patients, with a greater focus on the relative differences between major categories. CMS also believes that within categories, the ranking of residents according to activities of daily living (ADL) function will be more consistent. In other words, there should be a clearer distinction between residents scoring in two different RUG categories, but their ADL scores should be consistent if they are equivalent in functional status. Also, regarding ADL function, CMS believes that RUG-IV will be more accurate and comprehensive in capturing the patient's true needs and the staff time and resources devoted to those needs.

Perhaps the most significant change anticipated with the new system is the elimination of the requirement to use resident assessment protocols (RAPs), which have become a mainstay of the current care planning process in nursing homes. Instead, CMS is implementing the concept of care area triggers (CATs). Under CATs, the decision to care plan and the protocols to follow are left to the discretion of the care plan team, which CMS believes will open the door to a wider variety of clinical practice guidelines.

Section Q of the new MDS is being revised to reflect the intent of the Deficit Reduction Act of 2005 and the Money Follows the Person (MFP) Rebalancing Demonstration. The question regarding the patient's intent to return to the community is being revised to include a requirement that the SNF make a referral to a community placement entity in the event of a positive response. CMS did clarify that in cases where it is clear that community placement is unrealistic, the facility will have the option of documenting such and can avoid the repeated raising of the issue.

Section S of the MDS is reserved for specific data items used by the states. With the recent transition in New York from the PRI to the MDS, providers are aware of the new Section S questions that were added. According to CMS, over half the states use this section of the MDS for some form of data gathering, mostly related to Medicaid payment systems. CMS is currently working on providing state Medicaid agencies with a comprehensive mapping of data elements in the MDS 3.0 as compared to MDS 2.0 to assist these agencies in determining whether they will require any changes in their Section S elements. In fact, the MDS 3.0 Section S format is being designed to allow states the ability to customize the data elements without having to go through CMS.

Conclusion

It is clear that significant changes are in process on the Medicare front. NYAHSA and AAHSA are carefully monitoring these developments and will advise members accordingly. As we develop our response to the proposed rule, NYAHSA is interested in our members' input and advice. Please address your comments or questions to me at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.