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CMS announces more accurate FY 2012 payments for Medicare skilled nursing facilities

Case-mix indexes recalibrated to better align payments with costs

Also requires a new assessment to capture changes in therapy services, and allocation of group therapy time to ensure payment accuracy

The Centers for Medicare & Medicaid Services (CMS) today announced a final rule reducing Medicare skilled nursing facility (SNF) Prospective Payment System (PPS) payments in FY 2012 by \$3.87 billion, or 11.1 percent lower than payments for FY 2011. The FY 2012 rates correct for an unintended spike in payment levels and better align Medicare payments with costs.

“CMS is committed to providing high quality care to those in skilled nursing facilities and to pay those facilities properly for that care,” said CMS Administrator Donald M. Berwick, M.D. “The adjustments to the payment rates for next year reflect that policy.”

CMS is now recalibrating the case-mix indexes (CMIs) for FY 2012 to restore overall payments to their intended levels on a prospective basis. The SNF PPS uses a resource classification system known as Resource Utilization Groups Version 4 (RUG-IV), which assigns a patient to a RUG group to determine a daily payment rate. Each RUG group consists of CMIs that reflects a patient’s severity of illness and the services that a patient requires in the skilled nursing facility (SNF). In transitioning from the previous classification system to the new RUG-IV, CMS adjusted the CMIs for FY 2011 based on forecasted utilization under this new classification system to establish parity in overall payments. SNFs have been paid under RUG-IV since Oct. 1, 2010.

CMS found that the parity adjustment made in FY 2011, which was intended to ensure that the new RUG-IV system would not change overall spending levels from the prior year, instead resulted in a significant increase in Medicare expenditures during FY 2011. This increase in spending was primarily due to shifts in the utilization of therapy modes under the new classification system differing significantly from the projections on which the original parity adjustment was based.

“Additional data analyzed by CMS since publication of the proposed rule confirmed the extent of the overpayments that have occurred since implementation of the RUG-IV system,” said Jonathan Blum, deputy administrator and director of the Center for Medicare. “We are also making several improvements to our payment system to strengthen its integrity.”

The FY 2012 recalibration of the CMI will result in a reduction to skilled nursing facility payments of \$4.47 billion or 12.6 percent. However, this reduction would be partially offset by the FY 2012 update to Medicare payments to skilled nursing facilities. The update — an increase of 1.7 percent or \$600 million for FY 2012 — reflects a 2.7 percent increase in the prices of a “market basket” of goods and services reduced by a 1.0 percent multi-factor productivity (MFP) adjustment mandated by the Affordable Care Act. The combined MFP-adjusted market basket increase and the FY 2012 recalibration will yield a net reduction of \$3.87 billion, or 11.1 percent.

For FY 2012, the recalibration will reflect the intent of the new RUG-IV system to pay SNF providers more accurately based on the service needs of Medicare beneficiaries in their care. The adjustment was determined using claims and assessment data from the first eight months of FY 2011. It will ensure that payments more accurately reflect the resources required to provide care for the range of SNF patients, including those requiring more medically complex care.

It is important to note that this recalibration removes an unintended spike in payments that occurred in FY 2011 rather than decreasing an otherwise appropriate payment amount. Even with the recalibration, the FY 2012 payment rates will be 3.4 percent higher than the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels.

Along with recalibrating and updating the SNF PPS payment rates for FY 2012, this final rule makes a number of additional revisions aimed at enhancing SNF PPS accuracy and integrity. The rule modifies the patient assessment windows and grace days to minimize duplication and overlap in observation periods between assessments. The final rule also:

- Clarifies circumstances when SNFs must report breaks of three or more days of therapy.
- Eliminates the distinction between facilities regularly furnishing therapy services on a 5- or 7-day basis for purposes of setting the date for the End of Therapy (EOT) Other Medicare Required Assessment (OMRA).
- Streamlines procedures for documenting situations involving a brief interruption in therapy, where therapy resumes without any change in the patient’s RUG-IV classification level.
- Introduces a new Change of Therapy (COT) OMRA to capture those changes in a patient’s therapy status that would be sufficient to affect the patient’s RUG-IV classification and payment, even though they may not increase to the level of a significant change in clinical status.
- Provides for the allocation of a therapist’s time for group therapy (defined in the rule as a single therapist leading four patients in a common activity) to ensure that Medicare

payments better reflect resource utilization and cost for these services, and specifically that the therapist's time is being appropriately counted and reimbursed.

- Discusses the impact of certain provisions of the Affordable Care Act, and announces that proposed provisions regarding ownership disclosure requirements set forth in the Affordable Care Act will be finalized at a later date.

More information on this SNF PPS final rule and other health care related news can be found at www.healthcare.gov, a new web portal made available by the U.S. Department of Health and Human Services. For further information, see www.cms.hhs.gov/center/snf.asp. A copy of the final rule is available on the CMS website at: <http://www.federalregister.gov/inspection.aspx>.

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