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**Medicare Program; Prospective Payment
System and Consolidated Billing for
Skilled Nursing Facilities for FY 2010;
Minimum Data Set, Version 3.0 for
Skilled Nursing Facilities and Medicaid
Nursing Facilities; Proposed Rule**

receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 35 groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 18 groups.

In this proposed rule, we are continuing the designation of the upper 35 groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG-53 categories:

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

A discussion of the relationship of the proposed RUG-IV classification system to existing SNF level of care criteria appears in section III.D. of this proposed rule.

F. Example of Computation of Adjusted PPS Rates and SNF Payment

Using the hypothetical SNF XYZ described in Table 8 below, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2009. SNF XYZ's total PPS payment would equal \$30,619. We derive the Labor and Non-labor columns from Table 6 of this proposed rule.

TABLE 8—RUG-53 SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300) WAGE INDEX: 0.8992

RUG group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adj.	Medicare days	Payment
RVX	\$327.11	0.8992	\$294.14	\$140.08	\$434.22	\$434.22	14	\$6,079.00
RLX	223.06	0.8992	200.58	95.52	296.10	296.10	30	8,883.00
RHA	227.86	0.8992	204.89	97.57	302.46	302.46	16	4,839.00
CC2	188.88	0.8992	169.84	80.89	250.73	*571.67	10	5,717.00
IA2	128.08	0.8992	115.17	54.85	170.02	170.02	30	5,101.00
.....	100	30,619.00

*Reflects a 128 percent adjustment from section 511 of the MMA.

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

A. Staff Time and Resource Intensity Verification (STRIVE) Project

As noted previously in section II.B.1 of this proposed rule, section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. In first implementing the SNF PPS (63 FR 26252, May 12, 1998), we developed the RUG-III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG-III, but also to create case-mix indexes.

Since that time, we have become concerned that incentives created by the SNF PPS, the public reporting of nursing home quality measures, and the changing beneficiary population using SNF services likely have altered industry practices, and have affected the nursing resources required to treat

different types of patients. Changes to technology might also have affected care methods, while more choices in housing alternatives (such as assisted living and community housing) may have altered the population mix served by nursing homes.

In considering changes to the classification system, we considered alternative models. Since the inception of the SNF PPS, we have investigated ways of developing a predictive model for therapy that could replace the existing methodology. During the demonstration that led to the development of the SNF PPS, we considered a therapy model based on need. However, there was a great deal of concern that by separating payment from the actual provision of services, the system, and more importantly, the beneficiaries would be vulnerable to underutilization. In work that the Urban Institute did for CMS, it developed a model that focused on hospital diagnosis and level of function to predict the need for therapy. That proposal was discussed in a CMS Report to the Congress issued in December 2006, which is available online at http://www.cms.hhs.gov/SNFPSPS/Downloads/RC_2006_PC-PPSSNF.pdf.

While the model had possibilities, it added a level of complexity without increasing the model's predictive power beyond that of the existing RUG-III methodology. In addition, we were concerned about the reliance on data

from the prior hospital stay (which is not currently available to SNFs), and the use of hospital diagnosis to predict post-acute therapy needs. MedPAC has retained the Urban Institute researchers to develop the model further, and has presented a refined methodology in its June 2008 Report to the Congress: Reforming the Delivery System, available online at http://MedPAC.gov/chapters/Jun08_Ch07.pdf. While we will continue to study this model, we believe it would be premature to include it in the RUG-IV model being proposed in this rule for two reasons.

First, in accordance with section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Pub. L. 110-173), the Congress has asked us to look at alternatives to a diagnosis-based model for evaluating facility compliance under the IRF PPS. During the past 3 months, we have spoken with a large number of clinicians and other stakeholders who have expressed strong reservations about using diagnosis as a predictor of therapy need. We have contracted with the Research Triangle, Inc. (RTI) to investigate alternatives, and want to review the results of this research before proceeding with a diagnosis-linked model for therapy in SNFs.

Second, we are working closely with CMS staff on the Post Acute Care (PAC) Payment Reform demonstration project. Data are currently being collected from SNFs, IRFs, home health agencies, and

long-term care hospitals that we believe will help us predict the need for post-hospital care across these four settings. We believe that the results of the PAC Payment Reform demonstration project will assist us in developing a more effective model for therapy reimbursement.

We believe that significant changes in the SNF PPS therapy payment model would be most appropriately considered after the conclusion of research on diagnosis-based models and the PAC demonstration described above. Therefore, the STRIVE therapy model utilizes the same basic structure as the current RUG-III model and relies on updated staff time data collected during STRIVE.

1. Data Collection

To help ensure that the SNF PPS payment rates reflect current practices and resource needs, CMS sponsored a national nursing home time study, STRIVE, which began in the Fall of 2005. Information collected in STRIVE includes the amount of time that staff members spend on residents and information on residents' physical and clinical status derived from MDS assessment data.

Two hundred and five nursing homes from the following 15 States and jurisdictions volunteered to participate in STRIVE: the District of Columbia, Nevada, Florida, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New York, Ohio, South Dakota, Texas, Virginia, and Washington. Once the States were identified, we selected a sample of nursing homes using the procedures set forth in the document entitled "Sampling Methodology" available on the SNF PPS Web site at http://www.cms.gov/snfpps/10_timestudy.asp, and analyzed staff time and MDS assessment data for approximately 9,700 residents. The STRIVE sample is 40 percent greater than the 1994 sample used initially to develop RUG-III, and is 2.5 times larger than the 1995/1997 sample used to revise RUG-III and establish the current CMI rates that are the basis for current Medicare rates.

Identifying the level of staff resources needed to provide quality care to nursing home patients was a primary objective. For this reason, nursing homes with poor survey histories or pending enforcement actions were excluded from the sample. In addition, nursing homes with poor quality measure (QM) scores, low occupancy rates, or large proportions of private pay or pediatric patients were also excluded.

Using the procedures set forth in the document entitled "Sampling

Methodology" that appears on the SNF PPS Web site at http://www.cms.gov/snfpps/10_timestudy.asp, nursing homes were recruited within the following five strata: Hospital-based facilities; facilities with high concentrations of residents on ventilators; facilities with high concentrations of residents with Human Immunodeficiency Virus (HIV); facilities with high concentrations of residents on Medicare Part A stays; and all other facilities. Facilities with large concentrations of residents on ventilators, residents with HIV, or residents on Part A stays were over-sampled in order to assure sufficient numbers of residents in those populations. Nursing homes were voluntarily recruited in random order until enough facilities in each targeted category agreed to participate.

Participating facilities included both not-for-profit entities and corporations, chains and independent operators, nursing homes with populations small to large in size, freestanding and hospital-based facilities, and facilities situated in urban and rural locations. STRIVE began on-site data collection at both SNFs and Medicaid nursing facilities (NFs) in the spring of 2006. STRIVE collected data from both types of facilities because almost half of the States use a version of the RUG-III system for their Medicaid reimbursement systems.

Participating facilities submitted both time and MDS assessment data. Nursing staff recorded their time over 48 hours. Nursing staff included registered nurses, licensed practical nurses, and nursing aides. Therapy staff recorded their time over 7 consecutive days. Therapy staff included physical therapists and aides; occupational therapists and aides; and speech-language pathologists. Each nursing home staff member recorded his or her time at the facility in different categories (for example, resident-specific time (RST), non-resident-specific time (NRST), unpaid time, and non-study time).

Additional detailed information on the STRIVE sampling and data collection process has been posted on the SNF PPS Web site at http://www.cms.hhs.gov/SNFPSS/10_TimeStudy.asp. In addition, more information on the STRIVE data collection process appears at the following Web site: <https://www.qts.com/strive.html>. Items posted there include: Assessment forms distributed by STRIVE; "train the trainer" materials used to teach the data monitors who, in turn, instructed nursing home staff members on how to record their time; and materials from

State teleconferences. Slides presented at STRIVE technical expert panels (TEPs) can also be found on this Web site.

2. Developing the Analytical Data Base

To date, STRIVE has benefited from stakeholder input, starting with the December 2005 Open Door Forum to which the public was invited. The educators, researchers, beneficiary advocates, clinicians, consultants, government experts, and representatives from health care, nursing home, and other related industry associations serving on the STRIVE TEP have provided valuable insights on topics such as sample populations. Beginning in 2005 until its most recent March 2009 meeting, the TEP has met three times and held three teleconferences. Additionally, our contractor established a smaller Analytic Panel consisting of various stakeholders who have met with our researchers to discuss the analysis of the STRIVE data.

In addition, we worked closely with the States to recruit State Medicaid agencies as partners in the data collection process. We held numerous phone conferences with the State agencies to organize the data collection and get State input on potential focus areas for the research. For example, we received suggestions to look at special populations including the ventilator/respirator population, HIV/AIDS, Alzheimer's patients and individuals with behavioral problems. We also investigated differences in relative resource costs for the younger population that would typically be reimbursed through Medicaid rather than Medicare, and for patients with long-term chronic conditions such as deafness and/or blindness. We were able to incorporate the results of some of these analyses into the RUG-IV model. For example, we found that the relative resource use for respiratory conditions such as ventilator/respirator use have increased. Reimbursement for these conditions increases under the RUG-IV model. However, the data did not support a change to the RUG-IV model for other patient populations, such as the bariatric population or residents with behavioral issues. However, we plan to share our findings with the States so that they can consider the STRIVE data in evaluating changes to Medicaid payment systems.

Finally, we have been working closely with colleagues in the Canadian government to broaden our data collection effort. CAN-STRIVE (a recent Canadian time study using the same methodology as the STRIVE project described in this proposed rule) has just

begun its data analysis, using some of the preliminary STRIVE data to focus its data collection efforts. We will continue to work with our Canadian colleagues to confirm our findings and, if possible, to continue our analysis of special populations. For example, the CAN-STRIVE population includes a much larger sample of patients with behavior problems than the STRIVE sample, and the Canadian data may be helpful for future policy analysis.

The STRIVE analyses have shown that the RUG-III model is still effective in determining relative nursing resource use generally across a broad range of conditions for which beneficiaries are treated. At the same time, however, we have found that the resource times associated with specific conditions or service categories, such as diabetes and the use of intravenous fluids or medications, has changed significantly. These analyses have confirmed our initial expectations that the RUG-III model needed to be updated to reflect significant changes in SNF care patterns during the past decade. Therefore, in constructing the analytical data base, we have proposed the changes to the RUG-IV model that are discussed below.

a. Concurrent Therapy

Almost 90 percent of patients in a Medicare Part A SNF stay are receiving therapy services. Under the current RUG-III model, therapy services are case mix-adjusted based on the therapy minutes reported on the MDS. When the RUG-III model was developed, most therapy services were furnished on a one-on-one basis, and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. However, we have long been concerned that the incentives of the current RUG-III classification model have created changes in the way therapy services are delivered in SNFs. Specifically, we have been concerned that, as discussed below, there has been a shift from one-on-one therapy to concurrent therapy that may not represent optimal clinical practice.

Concurrent therapy is the practice of one professional therapist treating multiple patients at the same time while the patients are performing different activities. In the SNF Part A setting, concurrent therapy is distinct from group therapy, where one therapist provides the same services to everyone in the group. In a concurrent model, the therapist works with multiple patients at the same time, each of whom can be receiving different therapy treatments. For concurrent therapy, there are currently no MDS coding restrictions

regarding either the number of patients that may be treated concurrently, or the amount or percentage of concurrent therapy time that can be included on the MDS, whereas with group therapy there are limitations, as discussed in the July 30, 1999 SNF PPS final rule (64 FR 41662).

There are specific MDS coding instructions that limit the amount of group therapy that can be reported on the MDS, and used to calculate the appropriate payment level. For MDS reporting purposes, in order to report the full time as therapy for each participant, the supervising therapist (or assistant) may treat no more than four participants at a time, and may not be supervising any additional patients outside the group. Group therapy minutes may be counted in the MDS, but are limited to no more than 25 percent of the total weekly minutes per discipline for a particular patient.

In the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist's professional judgment. Given that Medicare and Medicaid patients are among the most frail and vulnerable populations in nursing homes, we believe that the most appropriate mode of providing therapy would usually be individual and not concurrent therapy. We believe it is in the beneficiary's best interest that concurrent therapy should never be the sole mode of delivering therapy care to any individual in a SNF setting; rather, it should be used as an adjunct to individual therapy when clinically appropriate, as determined by the individual's current medical and physical status based on a therapist's clinical judgment.

Our concern is that concurrent therapy has become the standard of practice rather than a way to supplement needed individual therapy care. The STRIVE data show that approximately two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent basis rather than on the individual basis that we believe to be the most clinically appropriate mode of therapy for SNF and NF patients. We are also concerned that the current method for reporting concurrent therapy on the MDS creates an inappropriate payment incentive to perform concurrent therapy in place of individual therapy, because the current method permits concurrent therapy time provided to a patient to be counted in the same manner as individual therapy time. For example, under the current method of reporting, if a therapist furnishes 60 minutes of therapy time to

a group of patients concurrently, then a separate 60 minutes of therapy time is counted for each patient. To test the impact of changing the method of reporting concurrent therapy, we designed the STRIVE analytical data base to distinguish between concurrent and individual therapy minutes. We were also able to identify the number of patients treated under the concurrent model, and allocated the total minutes evenly among the total number of patients receiving concurrent therapy care from the same therapist at the same time.

The data showed that under our current RUG-III methodology, which does not allocate time, patients treated concurrently are typically assigned to higher therapy groups (with higher payments) than appropriate based on the therapy resources actually used to provide care for those patients. In order to eliminate this inappropriate incentive, and to better reflect our policy that individual therapy is usually the most appropriate mode of therapy for SNF residents, we are proposing to use allocated concurrent therapy minutes in developing the RUG-IV therapy model. Thus, a therapist who is treating patients concurrently would allocate the total minutes among the patients based on the therapist's clinical judgment of how much therapist time was actually provided to each patient. We note that this change is consistent with our longstanding policy for payment of timed codes (that is, codes that are billed per time unit rather than per visit) for Part B therapy services. As stated in the *Medicare Benefit Policy Manual*, Pub. 100-2, chapter 15, section 230, "Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity." Therefore, in outpatient settings, concurrent therapy is billed the same way as group treatment (and the therapist would bill the HCPCS code for group therapy, not individual therapy, for each individual involved).

Consistent with this policy and with our initiative "to improve consistency in the standards and conditions for Part A and Part B therapy services" (as discussed in the Medicare Physician Fee Schedule final rule with comment period for CY 2008, 72 FR 66222, 66332, November 27, 2007), effective with the introduction of RUG-IV, concurrent therapy time provided in a Part A SNF