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# Department of Health and Human Services

## Centers for Medicare & Medicaid Services

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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**

States within 30 days after a facility completes a resident's assessment on a monthly basis for all assessments conducted during the previous month.

At the time of the national implementation of this requirement, CMS did not have a system in place that could receive and validate the required data and report back to the facility effectively. CMS did, however, develop a plan to install a CMS-owned system at each of the (53) State Survey Agencies (SAs) for collecting survey information. After further analysis, it was determined that this was in fact a viable option in order to receive both MDS and survey data, which could then be replicated to CMS, as required by the regulation.

Although this process met the requirement for LTC facilities submitting MDS data to CMS (albeit indirectly through the SA), it was not an optimal solution. This process requires fifty-three separate assessment editing and reporting processing modules, which entails overhead, maintenance, and support expenses. The pending implementation of MDS 3.0 has presented CMS with an opportunity to reevaluate the current environment. As CMS's systems capability evolved, it was determined that a single assessment processing system would reduce the overhead, maintenance, and support expenses for assessment processing without affecting any other processes or user needs. It would also allow CMS to move the assessment data to a fully secure and controlled CMS-managed environment which would meet HHS, CMS, and Federal Information Security Management Act (FISMA) requirements.

In summary, each LTC facility is required to submit resident assessment data to CMS. Initially, an intermediate step was necessary in order to have the data submitted to the CMS-owned system residing at the SA, which was then copied to a CMS national database. With the evolution of the CMS data platform, we believe that this intermediary step is no longer needed, allowing for direct submission to CMS.

To this end, and to afford CMS the ability to receive MDS data in a more timely, efficient, and effective manner, for use by CMS quality measurement and payment programs, we now propose to require LTC facilities to transmit MDS data to the national CMS System, instead of the States, within 14 days after the facility completes a resident's assessment. We seek comments on the appropriateness and practical implications of a 14-day timeframe for the transmission of MDS data. The specific instructions would be specified in the RAI manual, as part of the SOM issued by CMS (CMS Pub 100–07), and in the regulations at § 483.20 and § 483.315.

At the same time, we are aware that in the 10 years since the introduction of the SNF PPS, States have developed a variety of MDS-related system applications to support their survey, payment, and quality programs. Although our systems analysis showed that the transition to a national CMS data collection system would retain all existing functionality, we have been working closely with the SAs to verify that the transition will be seamless for the States. We are developing a comprehensive list of all State functions currently using the MDS so we can test and document the ways SAs will be able to access the data once we adopt the MDS 3.0 format and the national data collection structure. We are interested in stakeholder comments on the MDS 3.0 data transmission process, and we are specifically soliciting comments from SAs on the effect the MDS 3.0 transition is expected to have on State programs.

### *D. Proposed Change to Section T of the Resident Assessment Instrument (RAI) Under the MDS 3.0*

As discussed previously, sections 1819(f)(6)(A)–(B) and 1919(f)(6)(A)–(B) of the Act require the Secretary to specify a minimum data set of core elements and common definitions for use by nursing homes in conducting assessments of their residents, and to designate one or more instruments which are consistent with these specifications. Since the beginning of the SNF PPS, a SNF has been required to record the rehabilitative therapy services (physical therapy, occupational therapy, and speech-language pathology services) that have been ordered and are scheduled to occur during the early days of the patient's SNF stay. This was done because rehabilitation services often are not initiated until after the first MDS assessment's observation period ends. Therefore, we believed it was appropriate to permit a SNF to record on the Medicare-required 5-day assessment therapy services that are scheduled to occur but have not yet been provided.

Section T of the Resident Assessment Instrument (RAI), version 2.0, provides information on special treatments and therapies not reported elsewhere in the patient assessment. Items T1.b, T1.c, and T1.d apply only to the Medicare-required 5-day assessment. Item T1.b allows the SNF to recognize therapy services ordered or scheduled to begin in the first 14 days of a patient's SNF stay. Item T1.c allows the SNF to calculate the total number of days that at least one therapy service is expected to be delivered through the resident's 15th day of admission based on the initial evaluation and subsequent treatment plan. Item T1.d allows the SNF to estimate the total number of minutes of therapy expected to be delivered through the resident's 15th day of admission. This allows the SNF to receive payment for therapy services that it plans to provide to a beneficiary in the first 15 days of the stay.

In August 2002, the Government Accountability Office (GAO) issued Report No. GAO–02–841, entitled ''Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System by Changing Practices'' (available online at *www.gao.gov/new.items/d02841.pdf*), which found that SNFs increasingly used estimates of therapy needed, rather than actual therapy delivered, to assign patients into the High, Medium, and Low therapy categories for the first 14 days of care. The GAO found that because payments are based on these estimates, payments for some patients were higher than they would have been if the payments were based on actual therapy provision (because some patients did not actually receive the amount of therapy estimated). Moreover, if a patient is classified into one of these rehabilitation categories using an estimate, but actually receives less than the amount of therapy necessary to qualify into that group, payments to the SNF for the initial assessment period are not reduced. As a result of its analysis, the GAO found that of the patients who could be evaluated (that is, patients who stayed long enough to have a second assessment where the actual minutes of therapy during the last 7 days were recorded), one-quarter of the patients classified using estimated minutes of therapy did not receive the amount of therapy they were assessed as needing, while three-quarters eventually did. Furthermore, the GAO found that in 2001, half of the patients initially categorized in the Medium and High groups did not actually receive the minimum amount of therapy required to be classified into those groups, due in part to the use of estimated therapy minutes for classification. CMS's response to this report indicated that it would examine whether therapy provided is consistent with payment levels and ADL coding accuracy through its program safeguard contractor (PSC) project known as the Data Assessment and Verification Program (DAVE).

The original DAVE PSC contract was awarded in September 2001 to Computer Sciences Corporation. Under DAVE, the contractor conducted both on

and off-site medical record review and analysis of MDS data in order to support improvements to the accuracy of nursing home resident assessment data, largely for payment-related purposes. The results from the DAVE project were consistent with those found by the GAO.

Industry groups have also commented on prior rules that they are not properly reimbursed for the provision of therapy services that begin in between Medicare-required assessments, as there is no mechanism to change the payment group due to the onset of therapy services (for example, the use of a Significant Change in Status Assessment (SCSA) is limited to the situations set forth in Chapter 2 of the RAI Version 2.0 Manual). For example, the patient begins therapy services on day 9 of the covered stay. Days 1 through 14 of the covered stay are generally paid based on a Medicare-required 5-day assessment. The assessment window for the Medicare-required 5-day assessment (in other words, the day on which the ARD must be set to receive payment) is day 1 though 8 of the covered stay. Day 9 is outside of the assessment window and, therefore, therapy services provided from day 9 through day 14 will not be reflected in the SNF's payment for days 1 through 14 if such therapy services were not recorded on the assessment as ordered and scheduled to occur during the first 15 days of the patient's SNF stay.

Thus, in order to address the concerns brought to light by the GAO report, the DAVE PSC project, and industry groups, and to ensure that SNFs are receiving accurate payments for therapy services provided to Medicare beneficiaries, we are proposing to revise the manner in which therapy services are reported effective with the MDS 3.0 (that is, effective October 1, 2010), as discussed below. In addition, because basing payments on therapy services ordered and scheduled to occur (but not yet provided) can lead to inaccurate RUG classifications and, thus, inaccurate payments (as discussed above), we are proposing to eliminate section T of the RAI effective October 1, 2010.

### 1. Short Stay Patients

To ensure that providers receive accurate payments for those residents who are discharged early in the stay, that is, prior to day 14, and have not been able to complete 5 days of therapy (that is, have completed only 1 to 4 days of therapy), we are proposing that we calculate the appropriate therapy level by using items that will be reported on the MDS 3.0: The actual number of therapy minutes provided, the date of admission, the date therapy started, the patient's ADL level, and the assessment reference date (ARD), to assign a therapy group. For example, if an assessment with an ARD of day 5 shows that the patient started therapy on day three, actual therapy minutes should be reported for that patient for 3 days. We propose to calculate the average daily number of therapy minutes for each of those 3 days and assign a therapy category as follows: If therapy services are actually provided for between 15–29 minutes on average per day, the record would be assigned to the Low Rehabilitation category (RLx). If the patient receives 30 or more therapy minutes on average per day, the record would be assigned to the medium rehabilitation category (RMx). The actual RUG–IV group would be assigned based on the ADL level reported for that patient on the five day assessment and the average therapy minutes received. We believe the Medium and Low groups represent the most typical levels of therapy actually provided during the short stay. We determined the minimum minute requirements set forth above based on the minutes required to be assigned into the Low (at least 15 minutes each day for three days) and the Medium groups (an average of 30 minutes each day for five days). However, we solicit public comment on whether an alternative methodology should be considered.

As therapy is not being provided throughout the observation period, both the therapy and the non-therapy group will be calculated and reported to the facility to facilitate billing. Detailed instructions will be developed for the MDS 3.0 Manual and the Claims Processing Manual to assist providers.

For example, physical therapy is started on day 4 and the resident is discharged to the hospital on day 7; the resident received 25 minutes of therapy on day 4, 35 minutes on day 5, 33 minutes on day 6, and 37 minutes on day 7. The total days of physical therapy are 4, and the total minutes of physical therapy are 130. Because the average minutes of therapy provided on a daily basis is greater than 30 (total minutes (130) divided by number of therapy days (4) equals average minutes (32.5)), the RUG assigned would be RMx. The provider would bill the non-therapy RUG for days 1 to 3 and the RMx RUG for days 4 to 6 (day 7 is the day of discharge and payment is not provided for the day of discharge). Please note that this policy applies only for short stay patients who received fewer than 5 days of therapy before either discontinuing therapy or ending the Part A stay. As set forth in 42 CFR 409.34(a)(2), if skilled rehabilitation services are not available 7 days a week, those services must be needed and provided at least 5 days a week to meet the daily basis requirement in § 409.31(b)(1). Therefore, if a patient receives five or more days of therapy during the short stay, the patient has received the amount of therapy required for a skilled level of care and for classification in any of the Rehabilitation and Rehabilitation Plus Extensive Services RUG categories, and thus the revised procedures discussed above would not be necessary. We solicit comments on our proposed changes to the manner in which therapy levels are calculated for short-stay patients.

### 2. Starting Therapy Between MDS Observation Periods

Under the current system, SNFs are required to complete an OMRA 8 to 10 days following the cessation of all therapies for patients in the Rehabilitation plus Extensive Services and Rehabilitation categories who continue to need skilled SNF services. Currently, therapy services started in the middle of a payment period would not trigger a change in the payment rate until the next scheduled MDS is submitted. We are now proposing that the OMRA be used to signal the start of therapy services as well as the end of therapy services. To capture the start of therapy services, we are proposing that the SNF would have the option of completing an OMRA with an assessment reference date (ARD) that is set 5 to 7 days from the first day therapy services are provided. The 5 to 7 day window will allow providers to record the required therapy for a skilled SNF level of care, which, in accordance with § 409.31(b)(1), is daily (as set forth in 42 CFR 409.34(a)(2), if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week). Payment for the start of therapy would begin the day that therapy is started. For example, when therapy begins on day 9 of the stay, the provider could complete a start of therapy OMRA on day 13, 14, or 15, and the assigned Rehabilitation category would begin on day 9 of the stay, not on day 15 (the first day of the next Medicare payment window) or on the ARD of the start of therapy OMRA (day 13, 14 or 15). We believe that this revised reporting procedure will provide a more accurate record of therapy services actually provided to the patient, allowing for more accurate RUG classification and payment based on services provided rather than estimated. We solicit

comments on this proposed change to the OMRA reporting procedures.

3. Reporting the Discontinuation of Therapy Services

In addition, to report the end of therapy services, the SNF would be required to complete an OMRA with an assessment reference date that is set 1 to 3 days from the last day therapy services were provided. Under the current system, an OMRA is completed 8 to 10 days after the cessation of therapy (as discussed above), and payment under the patient's existing rehabilitation RUG continues to be made until the OMRA ARD. This methodology was developed before we had the capability to calculate and report both a therapy and a medical RUG group for payment. At that time, an MDS submitted earlier than 7 days after therapy was discontinued would still be classified into a therapy group (because all therapy provided within the past 7 days had to be reported on the OMRA). Thus, we delayed the submission of the OMRA, which meant that we continued payment under the patient's existing Rehabilitation RUG for several days after therapy was discontinued. As CMS has now developed a system to report both a therapy and non-therapy group on each assessment in which therapy is reported, it is no longer necessary to wait 8 to 10 days. Payment for the non-therapy RUG would begin the day after therapy services end. We are proposing the revised reporting procedures described above to allow for more accurate classification of patients based on services actually needed by and provided to the patient at the time therapy ended, leading to more accurate payment. We solicit comments on these proposed changes to the OMRA reporting requirements.

As discussed previously, we would initiate the revised reporting procedures described above with MDS 3.0, that is, effective October 1, 2010. We would include these changes in the MDS 3.0 RAI manual/instructions and the SOM. In addition, at the same time, we would require that the date that physical therapy, occupational therapy, and/or speech-language pathology services started and ended appear on the claim when billing a rehabilitation RUG (that is, a RUG in the Rehabilitation plus Extensive Services or the Rehabilitation categories). We would adjust our manuals to reflect this requirement. We believe that these revised reporting procedures will provide a more accurate record of therapy services actually provided to the patient, allowing for more accurate RUG classification and payment based on services provided rather than estimated. As noted previously, we solicit comments on our proposed changes to the therapy reporting procedures discussed above.

## V. Other Issues

### *A. Invitation of Comments on Possible Quarterly Reporting of Nursing Home Staffing Data*

Although we are not proposing specific regulatory language in this area under this proposed rule, we are requesting public comment on a possible requirement for nursing homes to report nursing staffing data to CMS on a quarterly basis. The data would be reported through an electronic system and would be based on nursing home payroll data (for regular nursing employees) and invoices (for contract and agency nursing staff). Existing law gives us the authority to impose staffing reporting requirements. (See sections 1819(b)(4)(A)(i), 1819(b)(1)(A), and 1819(d)(4)(B) of the Act.) Further, sections 1819(f)(1) and 1919(f)(1) of the Act specify the Secretary's duty and responsibility to assure that requirements that govern the provision of care in nursing homes and SNFs ''are adequate to protect the health, safety, welfare, and rights of residents * * *.'' Nevertheless, we believe it is appropriate to invite public comment on the possible use of an electronic, payroll-based staffing data collection, including the paperwork burden and cost for facilities to provide such data.

CMS uses nursing staffing data and nursing home census data in rating nursing homes for quality. Nursing staffing data for an individual nursing home are adjusted for the case mix of the residents of the nursing home and are divided by the nursing home census to establish the average number of hours of care per day provided by registered nurses, licensed practical/vocational nurses, and certified nursing assistants in that nursing home. Optimal hours of care (case-mix adjusted) and average hours of care for each case-mix group are used as a basis for rating the staffing in the nursing home. The data currently used for these calculations are included in the CMS Online Survey Certification and Reporting System (OSCAR). Limitations of the OSCAR data are detailed in later paragraphs of this section. In addition, nursing staffing data are available for consumer use on the CMS Web site at *http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus.*

We note that CMS has collected nursing home staffing data and nursing home census information for more than 30 years. Initially, the data were included in the Medicare/Medicaid Automated Certification System (MMACS), and beginning in 1989, they have been part of OSCAR. The OSCAR data system includes staffing data for all Medicare and Medicaid-certified nursing homes in the United States. Currently, the information on staffing in nursing homes is collected at the time of the annual onsite survey by the nursing home surveyors. The nursing home completes a form CMS 671, reporting data for the 2 weeks prior to survey. ''Annual'' nursing home surveys occur, on average, every 12 months, with no more than a 15-month interval in any particular instance.

However, there have been concerns that the OSCAR staffing data have significant limitations, based on several factors: (1) The data represent a very limited time period of only 2 weeks; (2) the data are collected only once a year; (3) accuracy and reliability of the data have been questioned; and (4) the scope of the staffing measures available based on the data is limited. The use of an electronic system for collection of nursing home staffing data based on payroll would address these concerns and offer other advantages as well:

- Staffing data could be collected quarterly using an electronic payroll-based system.
- Staffing quality measures posted on Nursing Home Compare could be based on data for the most recent quarter for all nursing homes.
- Payroll data could be audited for accuracy. Data on use of agency (contract) staff would be based on invoices—also an auditable source.
- Payroll record data could be used to calculate measures of staffing turnover and retention.
- Payroll extract data specifications could be updated to include the broader array of newer nursing home nursing care staff roles in a meaningful way. Data specifications for the electronic payroll extracts are intrinsically more flexible than paper forms and, thus, would be easier to update in future years.

CMS's Center for Medicaid and State Operations (CMSO), in conjunction with its Office of Clinical Standards and Quality (OCSQ), has been assessing the feasibility of moving to an electronic payroll-based system to collect nursing home staffing data since 2003. At this time, we have accomplished a number of tasks that make the institution of an electronic payroll-based system feasible: (1) Developed data submission