Arnall Golden Gregory LLP

Client Alert

Contact Attorneys Regarding This Matter:

Hedy S. Rubinger
404.873.8724 - direct
404.873.8725 - fax
hedy.rubinger@agg.com

Jessica Tobin Grozine
404.873.8526 - direct
404.873.8527 - fax
jessica.grozine@agg.com

CMS Reduces Payments to Skilled Nursing Facilities for FY 2012

On Friday July 29, 2011, the Centers for Medicare & Medicaid Services (CMS) announced a final rule establishing the Medicare skilled nursing facility Prospective Payment System (SNF PPS) for fiscal year (FY) 2012 (the Final Rule). The updated FY 2012 SNF PPS results in a $3.87 billion, or 11.1 percent reduction, from the FY 2011 rates.

CMS describes the reduction as an effort to address "an unintended spike in payment levels and better align Medicare payments with costs." To to adjust the payments, CMS is recalibrating the case-mix indexes (CMIs) for FY 2012. CMS found that the parity adjustment made in FY 2011 that was intended to maintain spending levels with the implementation of Resource Utilization Groups Version 4 (RUG-IV) actually resulted in a significant increase to Medicare payments.

The recalibration of the CMIs will result in a reduction to SNF payments of $4.47 billion or 12.6 percent, but this amount will be partially offset by the update to payments to SNFs that includes an increase of 1.7 percent, or $600 million for FY 2012 according to CMS. This increase reflects a 2.7 percent market basket increase, which is reduced by a 1.0 percent multi-factor productivity (MFP) adjustment mandated by the Patient Protection and Affordable Care Act.

The result of the MFP-adjusted market basket increase combined with the FY 2012 recalibration equals a total reduction of $3.87 billion, or 11.1 percent. According to CMS, the adjustment was determined using claims and assessment data from the first eight months of FY 2011.

According to CMS, the increase in SNF PPS expenditures during FY 2011 was a result of changes in the utilization of therapy modes under the new RUG-IV system. In response, the Final Rule addresses modifications relating to SNF therapy reimbursement requirements. CMS notes that the "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."

Arnall Golden Gregory LLP
Attorneys at Law
171 17th Street NW
Suite 2100
Atlanta, GA 30363-1031
404.873.8500
www.agg.com

The nursing home industry has expressed its disappointment with the Final Rule. The American Health Care Association (AHCA), the nation's largest association of long term and post-acute care providers, released a statement on Friday saying that "[t]he CMS rule makes reductions beyond what is necessary for budget neutrality. This will threaten our ability to provide quality care to America's seniors. Coupled with changes in group therapy definitions, this drastic reduction will be especially challenging for skilled nursing facilities to manage." AHCA adds that it will "continue to work with CMS and lawmakers to implement policies that preserve the level of care seniors deserve."

In addition to the recalibration of the SNF PPS rates, CMS highlights that the Final Rule addresses a number of additional items:

- Modifies the patient assessment windows and grace days to minimize duplication and overlap in observation periods between assessments
- 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 five- or seven-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

The final rule is scheduled to be published in the Federal Register on August 8, 2011, and will go into effect on October 1, 2011. A copy of the final rule is available here.[1]

1 http://www.ofr.gov/OFRUpload/OFRData/2011-19544_PI.pdf