

News Currents

In Brief

PPS Rule Proposes Two Rate Scenarios

Options Are Widely Divergent

The Centers for Medicare & Medicaid Services (CMS) has released its proposed rule for fiscal year (FY) 2012 skilled nursing facility payments, in which two vastly different payment adjustments are presented as options.

The first option is a 12.8 percent payment cut, offset by a 1.5 percent market basket increase, for a net payment reduction of 11.3 percent effective Oct. 1, 2011.

“This proposal would have a debilitating impact on nursing facilities, the economic benefits they bring to communities, and the care they provide to millions of older Americans,” said Gov. Mark Parkinson, American Health Care Association president and chief executive officer, in a statement responding to the proposed rule.

CMS claims that resource utilization group (RUG) IV payments have not been budget-neutral, resulting in “overpayments” that must be recaptured.

At the same time, the agency acknowledges that the payment information that drives this conclusion is limited and may be overstated.

It is possible that the “apparent magnitude of the overpayments may itself represent a temporary aberrance resulting from the limited FY 2011 data that are available at this point in time,” the rule says.



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CMS presents a second option in the proposed rule for a 2.7 percent market basket update, offset by a 1.2 percent productivity adjustment, resulting in a net increase of 1.5 percent, or \$530 million in additional Medicare reimbursement.

“AHCA appreciates the willingness of CMS to accept comments from those in the profession while it considers these two options,” Parkinson said.

“We plan to demonstrate that adoption of the more drastic rule would negatively impact every nursing home and potentially harm those who depend on Medicare to supplement declining Medicaid rates.”

Noting that the long term care sector employs 3.1 million Americans, Parkinson said, “The last thing our country needs is a blow to a vital economic force.”

—Lynn Wagner

Part D Co-Pay Fix Set For January 2012

The Centers for Medicare & Medicaid Services (CMS) recently released a final rule that sets the earliest possible date—Jan. 1, 2012—to eliminate Medicare Part D co-pays for dual eligibles who are receiving home- and community-based services (HCBS), including those in assisted living.

“We proposed that this provision would take effect on Jan. 1, 2012, because we believed it was important to provide this benefit at the earliest possible date to an estimated 600,000 beneficiaries a year,” said CMS in its rule.

The benefit, CMS says, provides “greater access to prescription drug coverage for a population that traditionally has high medical needs.”

Individuals whose co-pays will be eliminated are receiving HCBS under states’ Section 1115 waivers, Medicaid managed care plans, and the Section 1915(i) state plan amendment.

“We applaud CMS’ decision to eliminate Medicare Part D co-pays for dual-eligible residents in assisted living and other community-based settings as early as the Affordable Care Act allows,” says David Kylo, executive director of the National Center for Assisted Living (NCAL). “This is significant to thousands of residents who have relatively little means and rely on their medications to preserve their quality of life.”

NCAL began urging Congress to eliminate cost sharing for dual eligibles in assisted living and other community-based settings shortly after the new Medicare Part D program became law in January 2006. Before Part D, dually eligible beneficiaries had full medication coverage under Medicaid.

—Lisa Gelhaus