

Frequently Asked Questions About Health Care Reform

January 12, 2010

AHCA staff has prepared the following questions and answers about health care reform from the House bill, the *Affordable Health Care for America Act* (H.R. 3962), and the Senate bill, the *Patient Protection and Affordable Care Act* (H.R. 3590), as passed by both chambers. This document will be updated to reflect forthcoming compromise legislation.

RUG IV, Concurrent Therapy, and Look Back

1. What is meant by “RUG IV”, “Concurrent Therapy” and “Look Back”?

- **RUG** stands for “Resource Utilization Group”. RUGs are significant because they are the core of the SNF payment system under Medicare Part A since July 1, 1998, and have been modified several times. At present, SNFs are paid under the RUG-III system, which has 53 categories. As of October 1, 2010, per the FY 2009 CMS SNF Final Rule, SNFs will begin using RUG-IV, which has 20 new categories (7 categories were removed) for a total of 66, with patients moving towards new categories for medically complex patients. SNFs have raised concerns about the accuracy of the data upon which RUG-IV is based, since it was not based on the Minimum Data Set (MDS) 3.0 data collection. The MDS is a patient assessment instrument used by every SNF to capture patient clinical and functional characteristics, to generate quality indicators, and to determine payment categories. The transition from RUG-III to RUG-IV is supposed to be budget neutral in the aggregate.
- **Concurrent Therapy:** Physical and Occupational therapists as well as Speech/Language Pathologists provide and bill for services under one of three clinically accepted modalities: 1) one on one individual therapy; 2) “group” therapy for patients with similar goals and interventions; or 3) “concurrent” therapy, to multiple patients at the same time under direct therapist supervision. Under RUG-IV, CMS significantly changes the rules for concurrent therapy by apportioning payment among patients treated concurrently and by counting as “treatment” minutes only the apportioned therapist time rather than the actual number of therapy minutes performed by patients. By apportioning minutes and not counting the actual number of therapy minutes experienced by patients in concurrent sessions, patients are assigned to lower RUG categories with lower payment levels. Most entities that submitted comments to CMS on the rule, including MedPAC, disagree with these changes.
- **Look back:** Part of the MDS process allows clinical staff to “look back” at certain conditions and services/treatments provided to the patient over a designated period of time. For example, on admission, MDS permits the nurse to look back at the hospital chart to note treatments that were provided, such as intravenous therapy, which will need to be followed up on in the nursing home. Under the FY

2009 CMS SNF Final Rule, the look back information can be used only for clinical purposes and not for billing purposes. It is important to note that following up on hospital services in the nursing home takes skilled clinical time and care, thus having a cost to the facility. The new rule would not allow the facility to be paid for that time.

2. When is the elimination of look back and what happens in the future? The look back is eliminated as of October 1, 2010 for payment purposes.

3. What did CMS say about these issues in the final rule?

For individual and group therapy, the performed therapist and resident minutes would be used for categorization of the resident for payment purposes. For concurrent therapy, a maximum of two residents could receive services at the same time. The therapist minutes performed during concurrent therapy would then be allocated to each resident. This allocated therapy time would be utilized for payment purposes.

It was determined during the STRIVE project that the resources needed for residents that received extensive services during their hospital stay but not during their nursing home stay was not greater than the resources that were needed for residents that did not receive those extensive services during their hospital stay or nursing home stay. Extensive services would be recorded on the MDS at the location of the service, in the hospital and/or nursing home setting. Only those extensive services that were received in the nursing home setting would be recognized for payment classification purposes.

4. How many new RUGS will there be per new rule? RUG-IV would add 20 new categories and delete 7 categories, for a net increase of 13, for a total of 66.

5. What do the current House and Senate bills say? The House bill does not speak to RUGs. However, the Senate bill delays implementation of the RUG-IV payment system changes for one year to October 1, 2011, but the implementation of the concurrent therapy adjustment and the look back period change would begin on October 1, 2010.

Medicare Cuts

1. What is the amount of cuts in the House and Senate? The House bill contains \$23.9 billion in reductions over a ten year period while the Senate reductions total \$14.6 billion over the same time frame. Specifically, the House eliminates the SNF market basket from January 1, 2010 through September 30, 2010 and implements a productivity factor adjustment beginning in Fiscal Year (FY) 2011, which begins October 1, 2010. In contrast, the Senate only implements a productivity adjustment beginning in FY 2012, commencing on October 1, 2011.

2. **Can we determine year by year, what the House and Senate bills would mean in overall cuts?** For the House bill, the cuts would range from \$0.4 billion in FY 2010 to \$4.9 billion in FY 2019. For the Senate bill, the cuts would range from \$0.3 billion in FY 2012 to \$3.7 billion in FY 2019.
3. **Given House or Senate Medicare cuts, what would be the overall annual cuts given amount of cuts via the rule and recalibration?** For the House bill and final rule, the total is estimated to be \$35.9 billion, ranging from \$1.2 billion in FY 2010 to \$6.7 billion in FY 2019. The cuts under the Senate bill and final rule are estimated at \$26.6 billion, ranging from \$0.8 billion in FY 2010 to \$5.5 billion in FY 2019.

House Medicaid Provision

1. **What is the House provision and what would it do? When would it begin and end?** The House bill would provide for payments directly from CMS to dually certified facilities with high rates of Medicare and Medicaid patient days to assist them in meeting the costs of care to Medicaid beneficiaries over a four year period, beginning in 2010 and ending in 2013. A total of \$6 billion would be available equally divided among the four years, approximately \$1.5 billion per year.
2. **What are the restrictions?** Many of the details of implementation are left up to the Secretary, but the bill does contain a number of restrictions. These include:
 - The Secretary must determine that the facility's Medicaid reimbursement must be significantly less, as determined by the Secretary, than the allowable costs.
 - The facility must not be in the highest quartile of costs per day as adjusted for case mix, wages and type of facility.
 - The facility must provide quality care to Medicaid beneficiaries as determined by the Secretary
 - The facility must not have been cited for any immediate jeopardy deficiencies in the most recent standard survey available.
 - The facility must maintain an appropriate staffing level to attain or maintain the highest practicable well-being of each resident as defined by the Secretary.
 - The Facility must not be listed as a Special Focus Facility (SFF) by CMS or the state.

In addition, there is no administrative or judicial review of any of the Secretary's determination of the eligibility of a facility for payment or the determination of the amount of payment.

3. **How much would each state receive, and which states would benefit?** In order to be eligible for the extra Medicaid funding, states must not have cut their base payment rate prior to June 16, 2009. Therefore the following states are ineligible,

since they levied rate cuts prior to the aforementioned date: Arkansas, District of Columbia, Indiana, Iowa, Kansas, Maryland, Michigan, North Carolina, Oregon, and Rhode Island. For the remaining states, please see Appendix 1 for a chart of the estimated amount of supplemental Medicaid funding to be received. (It should be noted that the amounts provided in Appendix 1 are preliminary estimates that could significantly change when CMS finalizes the approval and payment methodology process.

FMAP Extension

- 1. What is the status?** The House bill extended for 6 months, until June 30, 2011, the ending date for the increased federal medical assistance percentage (FMAP) funds to states with high unemployment rates that maintain access to Medicaid services during the recession that was originally provided by the *American Recovery and Reinvestment Act*. The funding was tied to the states maintaining their effort on eligible beneficiaries. The Senate bill did not contain a similar provision. Therefore, the House included a similar provision in the *Jobs for Main Street Act* (H.R. 2847), passing it on December 16, 2009. The Senate is expected to take action on this bill in early 2010.
- 2. How much is the extension worth in terms of overall dollars?** CBO scored the extension as \$22.79 billion.
- 3. How is it distributed?** The *American Recovery and Reinvestment Act (ARRA)* furnished states with an increased Federal Medical Assistance Percentage (FMAP) for 27 months between October 1, 2008 and December 31, 2010; an additional \$87 billion was provided for this activity. For a state to be eligible for the increased FMAP, *ARRA* stipulated that states must ensure that neither eligibility standards, methodologies, nor procedures are more restrictive during this time for its Medicaid State Plan, waiver, or demonstration programs than those in effect on July 1, 2008. The funds will be distributed to states using the following formula: the percentage difference between the pre-*ARRA* FMAP and the increased FMAP multiplied by the estimates of appropriate expenditures submitted by each State. The amount of additional funding will be determined at the beginning of each quarter and may accessed on an ongoing basis. Note that all states will receive a 6.2% increase in their FMAP, and those states that would otherwise have a decrease in their FMAP will be held harmless. States may still change benefit and reimbursement levels, but may not alter eligibility requirements. States are also required to adhere to prompt pay requirements.

Medicare Commission and MedPAC

- 1. What does it do? Will it set rates? Can it be overruled by Congress?** Under the Senate bill, a Medicare Advisory Board would be established, comprised of 15 members appointed by the President and confirmed by the Senate, to develop and

submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. Qualifications for members of the Board would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Members would serve six-year, staggered terms and would continue to serve until replaced. The Board is tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts.

Congress would take up the recommendations under an expedited procedure. Congress would have the option of modifying the recommendations of the Board but would have to achieve the same level of savings. If Congress fails to act on the recommendations of the Board, the recommendations would go into effect by an established deadline.

- 2. What happens to MedPAC?** MedPAC would continue to exist in its current form as an advisory body to Congress.
- 3. What does the Wyden Amendment do?** The Senate bill includes language offered as an amendment by Senator Ron Wyden (D-OR) that requires MedPAC to report Medicaid data as to trends in spending, utilization, and financial performance for those providers having a significant portion of either revenue or services from Medicaid. The section also expands the mission of the Medicaid and CHIP Payment and Access Commission (MACPAC), another Congressional advisory body, to include assessment of adult services in Medicaid including those for dual eligibles in conjunction with MedPAC.

Bundling

- 1. How do we become a bundler or how do we get included as part of the bundle under the proposed pilot project?** The details have yet to be decided on, and will be issued by CMS after the final package is passed and signed into law.
- 2. Will it be a demonstration or pilot project and which is better and why?** Both the House and the Senate bills specify that a pilot shall be undertaken by CMS, which unlike a demonstration project, does not need explicit permission from Congress for continuation—the agency holds all the power. In fact, the House bill converts the existing acute care episode demonstration project into a pilot program. We are concerned that absent a requirement for Congress to weigh in, CMS will perpetuate the bundling concept forward, even if the outcomes of the pilot are not positive.

Appendix 1

Projected Medicaid Payments to States Under the Nursing Facility Supplemental Payment Program

State	Estimated Medicaid Supplemental Payment Year 1	Estimated Medicaid Supplemental Payment 4 Years
Alabama	36,549,991	146,199,964
Alaska	2,080,412	8,321,648
Arizona	15,352,013	61,408,052
Arkansas	0	0
California	111,116,652	444,466,608
Colorado	3,280,636	13,122,544
Connecticut	43,928,313	175,713,252
Delaware	4,262,806	17,051,224
District of Columbia	0	0
Florida	98,340,278	393,361,112
Georgia	39,839,221	159,356,884
Hawaii	738,285	2,953,140
Idaho	0	0
Illinois	93,455,392	373,821,568
Indiana	0	0
Iowa	0	0
Kansas	0	0
Kentucky	17,550,931	70,203,724
Louisiana	34,403,290	137,613,160
Maine	10,259,288	41,037,152
Maryland	0	0
Massachusetts	80,085,679	320,342,716
Michigan	0	0
Minnesota	42,434,293	169,737,172
Mississippi	19,794,515	79,178,060
Missouri	37,442,326	149,769,304
Montana	2,427,542	9,710,168
Nebraska	11,488,166	45,952,664
Nevada	3,685,847	14,743,388
New Hampshire	6,057,672	24,230,688
New Jersey	50,852,828	203,411,312
New Mexico	7,799,904	31,199,616
New York	192,937,863	771,751,452
North Carolina	0	0
North Dakota	102,152	408,608
Ohio	134,757,710	539,030,840
Oklahoma	13,537,956	54,151,824
Oregon	0	0
Pennsylvania	130,433,706	521,734,824
Rhode Island	0	0
South Carolina	8,150,701	32,602,804
South Dakota	6,458,075	25,832,300
Tennessee	12,989,597	51,958,388
Texas	107,924,072	431,696,288
Utah	7,827,042	31,308,168
Vermont	4,109,834	16,439,336
Virginia	21,763,853	87,055,412
Washington	34,918,306	139,673,224
West Virginia	3,345,623	13,382,492
Wisconsin	43,132,868	172,531,472
Wyoming	3,992,558	15,970,232
Total	1,499,608,196	5,998,432,784

States with zero payments may be explained as follows: IA, ID, IN, KS, MD, NC and RI are ineligible since they levied rate cuts prior to 6/16/09. AR, DC, MI, and OR are ineligible because their Medicaid rates exceed Medicaid allowable cost.