



## Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in health care consulting, puts Polaris Group in limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.



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### Therapy Cap Exception Process Update

On Tuesday, June 24, the House voted to pass Medicare Relief legislation that includes extending the therapy cap exception process through December 2009. The House action sets the stage for a vote in the Senate, where reports suggest that a bipartisan compromise agreement is possible. Polaris Group will continue to monitor legislative action.

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### Medicare Payment Advisory Commission Recommends a Revised Prospective Payment System for Skilled Nursing Facilities

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise the U. S. Congress on issues affecting the Medicare program. In addition to advising Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for-service program, MedPAC is tasked with analyzing access to care, quality of care and other issues affecting Medicare.

Reports issued in March and June each year are the primary sources for Commission recommendations. In the June 2008 Report to the Congress: Reforming the Delivery System, the Commission:

- Describes a direction for Medicare payment and delivery system reform
- Makes recommendations to promote primary care
- Examines hospital-physician collaborative relationships
- Recommends a new payment design bundling payments around hospitalization episodes
- Explores issues in creating an entity to develop

information on the comparative effectiveness of alternative therapies

- Examines public reporting of physician's financial relationships with manufacturers and facilities
- Recommends a revised payment system and improved data reporting for skilled nursing facilities
- Evaluates Medicare's hospice benefit

MedPAC identified two key problems with Medicare's Prospective Payment System (PPS) for Skilled Nursing Facility (SNF) Services.

- 1st: It does not adequately adjust payments to reflect the variation in facility costs for nontherapy ancillary (NTA) services such as intravenous (IV) medications, respiratory therapy, and drugs.
- 2nd: Payments vary with the amount of therapy (e.g., therapeutic exercise and therapeutic activities) furnished, creating an incentive to furnish therapy services for financial rather than clinical reasons. In addition, the PPS does not include an outlier policy to defray the exceptionally high costs of some patients, which could make some providers reluctant to admit patients who are likely to be high cost.

MedPAC recommends implementing a revised PPS design that incorporates:

- ◇ A separate nontherapy ancillary (NTA) payment component
- ◇ A revised therapy payment component
- ◇ An outlier policy based on exceptionally high ancillary costs per stay

Compared with the existing SNF PPS, MedPAC concludes that such a revised design would better target payments to stays with high NTA costs, more accurately calibrate therapy payments to therapy costs and afford some financial protection to SNFs that treat stays with exceptionally high ancillary costs. Because the revised PPS would establish more accurate payments, MedPAC believes SNFs would be less likely to avoid patients whom hospital discharge planners report having difficulty placing—those who require IV antibiotics, expensive medications and ventilator care. For these beneficiaries, the end result would be improved access to care.

The Commission also recommends directing the Centers for Medicare and Medicaid Services (CMS) to require facilities to report more accurate diagnostic and service use



information by requiring that:

- ◇ Claims include detailed diagnosis information and dates of service
- ◇ Services furnished since admission to the skilled nursing facility be recorded separately in the patient assessment
- ◇ Skilled Nursing Facilities report their nursing costs in the Medicare Cost Reports

MedPAC indicates that CMS could implement the revised PPS without the recommended data; however, it concludes that the enhancement to information would simplify implementation, further improve payment accuracy and enable the value of care to be assessed by linking payments, costs, service use and resident outcomes.

MedPAC cautions that one drawback common to all prospectively set payments is that facilities may be encouraged to furnish fewer services inside an episode of care. In this case, less therapy than is clinically appropriate during a SNF stay. The Commission suggests that, under a revised SNF Prospective Payment System:

- CMS would need to monitor therapy provision and resident outcomes, underscoring the need to require SNFs to assess patients at discharge
- A Pay-for-Performance program that links SNF payments to resident outcomes would help counter incentives to stint on services, as poor beneficiary outcomes would result in lower payments
- A low utilization payment adjustment that pays for therapy services on a cost basis for stays with therapy costs well below predicted levels may help discourage facilities from under providing therapy services

The June 2008 MedPAC Report to Congress can be viewed in it's entirety at [www.polaris-group.com/news\\_releases.asp](http://www.polaris-group.com/news_releases.asp)

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### **CMS TO RATE NURSING HOME QUALITY NEW FIVE-STAR SYSTEM TO BE ADDED TO NURSING HOME COMPARE SITE**

The Centers for Medicare & Medicaid Services announced it will launch a ranking system of America's nursing homes, giving each a "star" rating. The five-star rating system will begin to be published on the Agency's Nursing Home Compare web site in December 2008.

"The new "five-star" rating system will provide a composite view of the quality and safety information currently on Nursing Home Compare to help beneficiaries, their families, and caregivers compare nursing homes more easily," said Kerry Weems, CMS acting administrator.

The Star Rating System is the latest addition to the Nursing

Home Compare web site, following the agency's first nationwide identification of chronically underperforming nursing homes. Facilities enrolled in the Special Focus Facility (SFF) initiative are placed under special scrutiny and undergo twice as many inspections as other homes.

"Nursing Home Compare's new rating system will also provide an incentive for nursing homes to strive toward earning a five-star rating by providing an environment of better quality care," Weems said.

CMS plans to work with additional health care providers and consumers to make similar rating systems available for hospitals, home health agencies, and end-stage renal disease facilities in the future. The agency is considering adding new information to that already available on Nursing Home Compare such as whether a nursing home specializes in caring for patients with dementia, on ventilators, or in need of specialized rehabilitation services. Information on patient and family satisfaction with services at a facility may also be added to Nursing Home Compare at some point in the future.

Descriptive information about the quality star rating system including a sample screen shot of the proposed ratings may be viewed at: [www.polaris-group.com/news\\_releases.asp](http://www.polaris-group.com/news_releases.asp)

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### **PAYMENTS FOR OUTPATIENT SERVICES ON BEHALF OF BENEFICIARIES IN SKILLED NURSING FACILITY STAYS**

#### **Office of Inspector General Semiannual Report to Congress**

The mission of the Office of Inspector General (OIG) is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of the beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations and inspections.

The OIG's Semiannual Report to Congress identified that during Calendar Years (CY) 2001 and 2002, Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient hospital, laboratory, and radiology services on behalf of beneficiaries in Skilled Nursing Facility (SNF) stays during which these services were already covered by Part A. The potential overpayments occurred because CMS did not have Common Working File (CWF) edits in place during most of this period. Without the edits, fiscal intermediaries could not properly identify or recover potential overpayments. For CY 2003, edits were fully implemented and potential overpayments were reduced to \$22.7 million.



The OIG estimated that contactors (fiscal intermediaries and carriers) had not yet recovered \$17.9 million of the CY 2003 overpayments. Unrecovered overpayments continued to occur because the edits did not identify all overpayments or because the edits identified the overpayments, but contractors experienced claim processing system problems, misunderstood recovery instructions, or made errors during the recovery process. The OIG recommendations to CMS include:

- Direct contractors to review the \$106.9 million in potential overpayments for CYs 2001—2002 and make appropriate recoveries
- Direct contractors to initiate recovery of the estimated \$17.9 million in overpayments for CY 2003
- Continue to test and refine the CWF edits to ensure that they properly identify claims subject to consolidated billing
- Ensure that contractors have established proper controls to recover overpayments that the CWF edits identify.

CMS agreed with the OIG recommendations. As CMS works to recover these overpayments from the service providers, SNFs can expect to receive Consolidated Billing claims for services dating back to CY 2001.

**Q & A**

**“Where No Question Goes Unanswered!”**

- Q. How should therapy progress notes that are written by assistants be documented?
- A. Reports written by assistants supplement the Progress Reports required to be written by clinicians. Assistants may write reports that include, e.g., date of the beginning of the reporting period that the report refers to, date that the report was written, signature, or for dictated documentation, the identification (name and professional identity) of the qualified professional who provided the service and wrote the report and the date, objective report of the patient’s subjective statements if relevant, objective measurements (preferred) or a description of changes in status relative to each goal currently being addressed in treatment. Note that assistants may not make clinical judgments about why progress is or is not being made or change the treatment without the approval for the supervising therapist. Descriptions should make identifiable reference to the goals in the current plan of care. Clinicians may include the objective reports of assistants in their Progress Reports by referring to the report written by the assistant with the date of the report. (Source: CMS Frequently Asked Questions).

**TELECONFERENCE TRAININGS**

Polaris Group is pleased to present the following

**CEU approved** teleconference trainings

**Live Teleconference Trainings**

<b>Topic</b>	<b>Date</b>
New Texas RUGs	6/26
Pain Management	7/1
MDS Fundamentals	7/8
MDS Accuracy for RUG	7/9
Coding ADLs and Therapy	7/10
RAPS and Care Plans	7/15
Medicare Part A Basics	7/16
Skilled Medicare Nursing Documentation	7/17
PPS and Case Management of MDS	7/22
QI/QM Report Review	7/23
F-Tag Review	7/24
Survey Process and Preparation	7/29
Writing a POC	7/30
MDS for Administrators	7/31

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**Contributors:**  
Gayle Atherton  
Victor Kintz  
Marty Pachciarz

**Editor:**  
Chuck Cave

**Production Manager:**  
Cindy Hernandez