



# POLARIS PULSE®

*A Bi-monthly Informational Bulletin Brought To You By Polaris Group*

## **MEDICARE NURSING HOME PAYMENTS TO INCREASE IN 2007**

The Centers for Medicare & Medicaid Services announced Medicare payments to Nursing Homes will increase by approximately \$560 million in 2007. The FY 2007 rates reflect a market basket increase factor of 3.1 percent. CMS uses a skilled nursing facility “market basket” to measure changes in the prices of an appropriate mix of goods and services included in covered skilled nursing facility stays. The price of items in the market basket is measured each year, and Medicare payments are adjusted accordingly.

Under Medicare’s skilled nursing facility (SNF) prospective payment system (PPS), each facility is paid a daily rate based on the relative needs of individual Medicare patients, adjusted for local labor costs. The daily rate covers the costs of furnishing all covered nursing facility services, including routine services such as room, board, nursing services, and some medical supplies together with related costs such as therapies, drugs and lab services, and capital costs including land, buildings and equipment.

The primary change to daily rate calculation for FY 2007 is the sole use of the Core-Based Statistical Area (CBSA) wage index values.

The SNF PPS Final Rule for FY2006 adopted the Office of Management and Budget (OMB) revised definitions for Metropolitan Statistical Areas (MSA) and Core Based Statistical Areas (CBSA). In adopting the (CBSA) designations, CMS provided for a 1 year transition. For FY 2006, the wage index consisted of a blend of 50% MSA wage index and 50% CBSA wage index. In FY 2007 the full CBSA based wage index will be used.

Unlike the multiple changes included in the RUG Refinement Rule of 2006, the FY 2007 annual update does not initiate policy changes with regard to the SNF PPS.

The 2007 Final Rule maintains:

- 53 RUG Categories including the Case Mix Classification System established in the 2006 final rule.
- Administrative Presumption of Coverage for beneficiaries who are correctly assigned to one of the upper 35 of the RUG-53 groups on the initial 5-day, Medicare required MDS.
- Consolidated Billing requirements during the course of a Part A stay.
- SNF Medicare billing responsibility for Physical Therapy, Occupational Therapy and Speech-Language Therapy received during a noncovered stay (Part B).
- 128% increase in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS).

The update notice also discusses several initiatives including plans to:

- Develop an integrated system of post-acute care payment, to make payments for similar services consistent regardless of where the service is delivered;
- Encourage the increased use of health information technology (HIT) to improve both quality and efficiency in the delivery of post-acute care;
- Assist beneficiaries in their need to be better informed health care consumers by making information about health care pricing and

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quality accessible and understandable; and

- Accelerate the progress already being made in improving quality of life for nursing home residents.

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### **HHS Provides Medicaid Funding for Alternatives to Nursing Home Care**

#### ***“Money Follows the Person”***

States will get additional help from the federal government to support elderly and disabled Medicaid recipients who wish to live in the community rather than institutions.

Through competitive grants, the Centers for Medicare & Medicaid Services (CMS) will give states a total of \$1.75 billion over five years to help shift Medicaid from its historical emphasis on institutional long-term care services to a system that offers more choices for seniors and persons with disabilities from all age groups, including home and community-based services. This *Money Follows the Person* “rebalancing” initiative was included in the Deficit Reduction Act of 2005 (DRA) currently being implemented by CMS.

“With this program, people who need long-term care and prefer to live in their own homes and communities can do so,” HHS Secretary Mike Leavitt said. “States will also get more for their money by giving the elderly and people with disabilities more control over how and where they get the Medicaid-funded long-term care services they need.”

Mark B. McClellan, M.D., Ph.D., CMS Administrator. “We need to move as quickly as possible to make that shift across Medicaid. With new Federal funding, there is no longer any excuse for the status quo.”

States interested in applying for a *“Money Follows the Person”* grant can propose new programs to CMS that are aimed at sustaining people in their homes or communities who would have otherwise received care in a nursing home or other institution. The qualified expenditures may be eligible for an enhanced match rate from the federal government equal to an increase of 50

percent of the usual state Medicaid percentage contribution in addition to the usual match rate. In effect, the federal government will pay for 75 to 90 percent of the costs of transitioning individuals out of nursing homes and into community settings, and the associated long-term care benefit costs. Grant funds may also be used to help control how they receive these services.

The higher matching rate will be applied to certain services provided to an individual for a one year period after the individual moves out of an institution and into the community. Funds can be used not only for alternatives to institutional care services, such as home health care; they can also be used for home modification costs, respite services to augment informal or unpaid caregivers, personal care and assistive devices.

Each state awarded a grant must continue to provide community services after the year of enhanced match as long as the person needs community services and is Medicaid eligible. The deadline for the first year’s applications is Nov. 1, 2006. Demonstration grants will be competitively awarded to states from Jan. 1, 2007 through Sept. 30, 2011. Funds will be available for a five-year period; however, states must participate in the demonstration for a minimum of two consecutive years.

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### **Medicare and Medicaid Payment Hold**

The Centers for Medicare and Medicaid Services will place a hold on payments for all claims during the last nine days of the federal fiscal year (September 22 through 30).

Section 5203 of the Deficit Reduction Act of 2005 mandates these payment delays. No interest will accrue, and Medicare will not pay late penalties to an entity or individual because of this one-time hold on payments, CMS reassures providers. Medicare contractors will pay all claims held during this time on October 2.

This policy applies only to claims subject to payment. It does not apply to full denials, no-pay claims and other non-claim payments such as

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periodic interim payments, home health requests for anticipated payments and cost report settlements, the agency clarifies.

Your Medicare contractor will not stagger payments, nor will you be allowed to make advance payments during the nine-day hold.

Although billing by the tenth of the month is always best practice, processing your August claims by September 5th will help avoid delayed payment as a result of the mandated payment hold. Be certain to follow-up on FISS RTP (return to provider) to validate claims were not returned.

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**Do you have your NPI?**

Don't risk disruption to your cash flow. All HIPAA covered healthcare providers, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the NPI to identify covered entities in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008. Learn how to apply on the CMS website:

[www.cms.hhs.gov/NationalProvIdentStand/](http://www.cms.hhs.gov/NationalProvIdentStand/)

**SOLUTION CENTER Q&A**  
**"Where No Question Goes Unanswered"**

- Q: Can a resident with a 3 day qualifying stay in a Medicare Certified Psychiatric Hospital be admitted for observation and assessment (O&A)?
- A. Skilled observation and assessment may be appropriate for resident's whose primary needs are psychiatric in nature. The resident may exhibit acute psychological symptoms that require skilled O&A such depression, anxiety or agitation. (Source Medicare Benefit Policy Manual, Chapter 8). The need for SNF level of care must be reflected in daily documentation evidenced through physician orders and nurses' notes that support medical necessity. SNF coverage must be reviewed case by case.

**TELECONFERENCE TRAININGS**

Polaris Group is pleased to present the following *CEU approved* teleconference trainings

*Live Teleconference Trainings*

<u>Topic</u>	<u>Date</u>
Medicare Part A Basics	8/1
F-Tag Review	8/2
MDS/RAPS/Care Plan Fundamentals	8/3
SNF Notices and Denial Letters	8/8
Survey Process, Preparation and Mgmt.	8/9
Mastering ADL Coding	8/10
No Payment Bills-The "Ins and Out's"	8/15
New Activity Protocol and Psychosocial Grid	8/16
Right Coding Sections K, P, and T	8/17
Feedback on Performance	8/22
Public Quality Measures	8/23
How to Survive a Medicare Part A Chart Audit	8/29
Working the RAPs	9/7
Medicare Billing—Part I Billing Cycle	9/12
No Payment Billing	9/13
Case Management for PPS	9/14
Medicare Billing—Part II UB92 Completion	9/19
Managing Part B Caps	9/20
Pain Management	9/20
QA/QI Program Implementation	9/21
Medicare Billing—Part III Consolidated Billing	9/26
Taming the Care Plan Monster	9/27
"Super" Supervisor	9/28

*Please join us in our Teleconferences .  
 For further information regarding these seminars, please contact the  
 Seminar Department at: 800-275-6252 ext. 233  
 Or register at: [www.polaris-group.com](http://www.polaris-group.com)*



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