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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

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**Medicare Program; Prospective Payment
System and Consolidated Billing for
Skilled Nursing Facilities for FY 2010;
Minimum Data Set, Version 3.0 for
Skilled Nursing Facilities and Medicaid
Nursing Facilities; Proposed Rule**

on the proposed changes to the ADL index.

Table 12. RUG-IV Category Level ADL Splits

RUG Category	Rehab Level	ADL Levels				
		0-1	2-5	6-10	11-14	15-16
Rehabilitation+ Extensive	Ultra High		RUL		RUX	
	Very High		RVL		RVX	
	High		RHL		RHX	
	Medium		RML		RMX	
	Low		RLX			
Rehabilitation	Ultra High	RUA	RUB		RUC	
	Very High	RVA	RVB		RVC	
	High	RHA	RHB		RHC	
	Medium	RMA	RMB		RMC	
	Low	RLA			RLB	
Extensive Services		ES1, ES2, ES3				
Special High		HB	HC	HD	HE	
Special Low		LB	LC	LD	LE	
Clinically Complex		CA	CB	CC	CD	CE
Behavioral Symptoms and Cognitive Performance		BA	BB			
Reduced Physical Function		PA	PB	PC	PD	PE

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d. “Look-Back” Period

The RUG-III case-mix classification system includes items in the MDS 2.0 that may be coded for services provided to the resident prior to admission into the SNF. When RUG-III was developed, these items were deemed to be a proxy for medical complexity. In the SNF PPS final rule for FY 2000 (64 FR 41668-69, July 30, 1999), a commenter suggested that we eliminate the “look-back” period for completion of items in the MDS, as its use could trigger a RUG assignment based on services that occurred solely during the prior acute hospital stay and were no longer being furnished by the time of SNF admission. This would result in SNF coverage even though the resident was no longer receiving any skilled care at that point. While we did not have the data needed to evaluate the impact of making this change to the RUG-III model, we continued to monitor how the inclusion of pre-admission services affected the RUG-III classification model.

In the FY 2000 SNF final rule (64 FR 41668 through 41669, July 30, 1999), we stated that

* * * the use of the ‘look-back’ period in making RUG-III assignments is essentially a clinical proxy that is designed to serve as an indicator of situations that involve a high probability of the need for skilled care. Thus, our expectation is that the occurrence of one of the specified events during the ‘look-back’ period, when taken in combination with the characteristic tendency * * * for an SNF resident’s condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances * * *. If it should become evident in actual practice that this is not the case, it may become appropriate at that point to reassess the validity of the RUG-III system’s use of the ‘look-back’ period in making assignments.

We subsequently discussed changing the “look-back” period on specific items in the MDS in the SNF PPS proposed and final rules for FY 2006 (70 FR 29079 through 29080 and 70 FR 45034 through 45035). Some commenters stated that changing the look-back period for some items in the MDS would negatively affect the care planning process for

individuals. Many recommended that any changes should be coordinated with other CMS initiatives, such as MDS 3.0 and the STRIVE project. We agreed to address the issue of the look-back period within the broader context of the MDS 3.0 and the STRIVE project.

In addition, MedPAC, in its reports (for example, Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; http://www.medpac.gov/documents/Jun07_EntireReport.pdf), recommended that we eliminate the look-back period for specific treatments and that we include in the RUG payment system only those services that are provided after admission to the SNF.

As part of the STRIVE project, we expanded the data collection by adding a STRIVE addendum that allowed us to distinguish between preadmission and postadmission utilization of a specific set of MDS items that serve as qualifiers to classify residents into the highest levels of the RUG-III hierarchy. In order to minimize burden on the nursing homes participating in the study, we limited the number of additional data

items collected, and concentrated on those special treatments that are often provided in a hospital but are not often provided in a SNF after hospital discharge. For these reasons, we concentrated on the use of IV medications, tracheostomy care, suctioning and ventilator/respirator services, and transfusions (which are rarely performed in SNFs). We did not collect pre- and post-admission data on those special treatments we expected to require longer term care such as dialysis, IV feeding, radiation therapy and chemotherapy. However, in all cases, the staff time data collected through STRIVE reflects the care furnished after admission to the facility.

Analysis of the STRIVE data shows that: (1) the "look-back" period does in fact capture services that are provided solely prior to admission to the SNF; and (2) there is a much lower utilization of staff resources for individuals who received certain treatments solely prior to the SNF stay (that is, during the qualifying acute hospital stay) compared to those who received these services while a resident of the SNF. In fact, the STRIVE data showed that those patients who received specific services solely prior to admission to the SNF have similar resource utilization to those who never received the service (prior to admission or during the SNF stay). Therefore, the capture of preadmission services by the "look-back" does not provide an effective proxy for medical complexity for SNF residents. Instead, it results in payments that are inappropriately high for many non-complex medical cases.

Accordingly, we now propose to modify the look-back period under RUG-IV for those items in section P1a of the MDS 2.0, Special Treatments and Procedures, to include only these services that are provided after admission (or readmission) to the SNF. The modified look-back would apply to all treatments and procedures that are currently listed in section P1a of MDS 2.0. As discussed above, in order to reduce the burden on facilities, the STRIVE study looked at preadmission and postadmission utilization for a subset of P1a services. Because the STRIVE project data showed that the capture of preadmission services by the "look-back" does not provide an effective proxy for medical complexity and thus is not an effective predictor of subsequent resource intensity during the SNF stay, we believe that it would be appropriate, and consistent with the STRIVE data, to modify the look-back period for all P1a services. Thus, the proposed change to the look-back period is supported by the STRIVE data. In

addition, the proposed change to the look-back period is consistent with the policy that has been in effect for reporting therapy services, another critical component of the RUG model, since the start of the SNF PPS in July 1998.

On the MDS 3.0 item set, there will be two ways to code for each of these procedures and treatments. In the first column (while not a resident) the provider would mark each treatment and procedure that was provided to the patient within the last 14 days while not a resident of the facility and would only be required to complete this column if the patient were admitted within the last 14 days. In the second column (while a resident) the provider would mark those procedures and treatments that have been performed while a resident of the facility within the last 14 days.

We agree that information regarding the resident's status prior to admission to the SNF is important to develop a comprehensive care plan. We note that the MDS collects information on numerous clinical items that affect a person's condition (medical, physical, psychological, etc.), which need to be taken into account in developing care plans but do not significantly alter the staff resources needed to provide quality care to that patient. It is the responsibility of all providers to properly assess, care for, and provide treatment for all patient care needs regardless of whether these needs/services are specifically included in the case-mix classification model used for payment. Furthermore, to make sure that comprehensive information is available to facility staff for the care planning process, as noted above, we have expanded the MDS 3.0 for the Special Treatments and Procedures items to 2 columns instead of only one. The first column allows the provider to code those services that were provided prior to the individual being admitted to the facility, while the second would be completed for only those services that are provided to the patient after admission/readmission to the facility. In this way, we capture information that may be important for care planning while continuing to provide adequate and appropriate payments for those patients who actually receive these services while a SNF resident. At the same time, modifying the look-back period eliminates inappropriately high reimbursement for services that are solely provided prior to admission to the SNF. We solicit comments on our proposed changes to the look-back period.

e. Organizing the Nursing and Therapy Minutes

The proposed RUG-IV model uses the same basic methodology that was used to develop the RUG-III model that is in use today. A detailed description of the RUG-III model is included in the May 1998 interim final rule with comment period (63 FR 26252). In addition, a detailed comparison between the RUG-II and RUG-IV models has been included in the Addendum to this proposed rule, in Table C.

In developing the RUG model, we look for clinical conditions that show a difference in mean staff time resource use (that is, wage weighted staff time or WWST) between residents with a clinical characteristic and residents without the condition. For a detailed description of the methods used to calculate the WWST for nursing and therapy, please see section III.C. of this proposed rule. In the STRIVE study, we linked nursing and therapy staff time collected on site at 205 facilities with contemporaneous MDS data for those same residents. Facility staff generally completed the STRIVE MDS during the same week as the time study was being collected. In the STRIVE study, we did have certain advantages that were not available when the RUG-III staff time measurement study was conducted. At that time, there was no national MDS data collection process. We now have a repository of MDS data covering the same period as each of the STRIVE time studies. Thus, we were able to use the national MDS data base to correct for missing data or other minor discrepancies in the "as reported" STRIVE MDSs.

In addition, in the STRIVE study, we were able to assign average hourly wage rates more appropriately to the different staff categories (as explained below), and use this data to construct the wage-weighted staffing time (WWST) used to compare the resource intensity of different conditions and services during the analysis discussed below, and to establish the CMI or relative weights for each group in the proposed RUG-IV hierarchy.

For STRIVE, we used the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey (North American Industry Classification System 623100—Nursing Care facilities) wage data to determine the relative wages for the staff types participating in the STRIVE study. The RUG-III model relied primarily on data furnished by industry sources that provided fewer staff categories and wage weights. Thus, the WWST used in the STRIVE study better represents actual