If your organization provides long-term care as a skilled nursing facility, and if it has relied heavily upon Medicare payments in the past, get ready to tighten your belts and train your employees.

Over the next five years, Congress expects to save $9.5 billion as a result of the changes to Medicare reimbursement for SNFs that it required in the Balanced Budget Act of 1997. The money is going to have to come from somewhere and, as you may have guessed, Congress intends to take it out of your pocketbook through various measures in the BBA.

Now this does not mean that every SNF is going to lose money. Rather, it will be those SNFs that were used to the retrospective, reasonable-cost-based payment system under which they lived before the BBA and that will be unable to adjust to the tighter restraints imposed by the BBA that will face problems. The key is not to be one of them.

The Way It Was

Before the BBA, SNFs received full reimbursement for ancillary costs (for specialized services including therapy, drugs and laboratory tests directly attributable to a patient) and capital costs (for the land, building, equipment and financing of these items). They also received reimbursement, which could be limited by Medicare, for routine costs (for, among other things, a room, dietary services, nursing services and minor medical supplies).

The BBA, however, changed all this by requiring the implementation of a prospective payment system. Under the PPS, SNFs now will receive reimbursement for ancillary, capital and routine costs, except for costs associated with operating approved educational activities, through a per-diem rate that varies based on the intensity of the resources that a patient uses. The per-diem rate includes all services typically billed under Part B that are provided to a patient in a covered Part A stay.

This means that, to succeed under the PPS, SNFs must be able to bring their costs in line with the per-diem rate that they will receive for each patient. SNFs also must carefully analyze their patient mix to ensure that costs are covered by the per-diem rate received.

The BBA imposed other requirements that will drastically change the way SNFs conduct business. These changes include a requirement of combined or consolidated billing and a cap of $1,500 on outpatient therapy services. What will SNFs need to do to remain profitable?

The PPS

By July 1, 1999, all SNFs participating in Medicare will be on the PPS, under which a facility is paid a per-diem rate for each patient based on the intensity of the resources utilized by the patient.

In May 1998, the Health Care Financing Administration issued regulations implementing the BBA provisions regarding SNFs. The regulations established the operating procedures for the PPS as well as the initial rates and mechanisms for transitioning from the retrospective reasonable-cost-based system to the PPS.

The BBA itself provided for a three-year transition period for SNFs that had received their first payment for services under Medicare and/or Medicaid before October 1, 1995.

During the transition period, SNFs would receive per-diem rates based on a combination of a federal rate and a
ty-specific rate. During the first year, the SNF would receive 75 percent of its facility-specific rate and 25 percent of the federal rate. During the second year, the SNF would receive 50 percent of the facility-specific rate and 50 percent of the federal rate. In the final transition year, the facility would receive 25 percent of the facility-specific rate and 75 percent of the federal rate.

Following the transition period, all SNFs would receive the federal rate. SNFs that did not receive their first payment from Medicare and/or Medicaid before October 1, 1995, would automatically begin receiving the federal rate.

Rate Assessments
The HCFA regulations also set forth the criteria for establishing the federal and facility-specific rates and established the mechanism for determining what rate applied to each patient.

Under the regulations, every Medicare- or Medicaid-certified SNF is required to complete an assessment of every patient — regardless of age, diagnosis, length of stay or payer source — by the fifth day after admission.

By Corrine Parver, JD, PT, and Jason Wallach, JD

This assessment is known as the Minimum Data Set. A second assessment must be performed by the 14th day after admission. Either the fifth- or 14th-day assessment must be comprehensive. This includes the MDS and the Resident Assessment Protocols. The MDS must thereafter be completed on the 30th, 60th, and 90th days following admission or after any significant change in the patient’s status.

Based on the MDS, the patient is placed into one of 44 categories. The categories are known as the resource utilization group or RUGs-III categories and are divided into seven groups: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems and reduced physical function.

Each of the 44 categories represents a different level of resource utilization and has a specific rate assigned to it. Any person falling within the top 26 categories automatically satisfies the Medicare requirements for receiving SNF care. Persons falling within the lower 18 categories will be assessed on an individual basis to determine their qualifications for SNF care.

Each assessment of the patient applies to specific days that the patient resides at the SNF. For example, the fifth-day assessment covers payments for days 1-14 and the 14th-day assessment covers payments for days 15-30. As a result, the RUGs-III category and the corresponding per-diem rate for a patient can vary over the length of the patient’s stay, depending upon each assessment.

A SNF’s failure to make the required assessments by certain dates results in the payment of a default rate for the days the SNF is not in compliance. The regulations provide some leeway for tardy assessments; for example, an SNF has until the ninth day after admission to complete the fifth-day assessment before it is penalized: i.e., paid the default rate.

Regional Differences
The initial default rates and federal rates in effect from July 1, 1998, until
September 30, 1999, for the RUGs-III categories were set forth in the May 1998 HCFA regulations. The default rates are $117.15 for urban areas and $116.85 for rural areas. The federal rates range from $117.15 to $384.21 for urban areas and $116.85 to $408.19 in rural areas.

The federal rates were, and the facility rates will be, calculated based on the allowable costs for the fiscal 1995 cost-reporting period. The BBA prohibited any administrative or judicial review of the methodology for computing the federal per-diem rates and the facility-specific rates, except for determination of the reasonable costs used as the basis for determining the facility-specific rate.

The federal rates are adjusted by a geographic wage index to account for differences in area wage levels. This adjustment is accomplished by taking the labor portion of the federal rate, which is set forth in the HCFA regulations, and multiplying it by the applicable area wage index.

**Consolidated Billing**

Another important provision of the BBA requires that SNFs bill Medicare directly for almost all services provided to a resident. As a result, outside suppliers cannot submit claims to Medicare, but, rather, must rely upon the SNFs for reimbursement.

The consolidated billing requirements currently apply only to beneficiaries in a Part A stay in a SNF that has converted to PPS. HCFA has indefinitely delayed implementing consolidated billing for SNFs that are not on PPS and Part B services provided to a patient not in a covered Part A stay. Outside suppliers can continue to bill Medicare directly for such Part B services.

The only services to which the consolidated billing requirements do not apply are those provided by a physician; a physician’s assistant working under the supervision of a physician; a nurse practitioner or clinical nurse specialist working in collaboration with a physician; certified nurse-midwives; qualified psychologists and certified registered nurse anesthetists; or for dialysis, erythropoietin for dialysis, and, for 1998 only, transportation costs of electrocardiogram equipment for test services.

Physical, occupational or speech-language therapy services, however, are subject to consolidated billing regardless of whether such services are provided by or under the supervision of a physician or other health care professional.

**The Implications**

The major implication of the BBA and the resulting PPS is that SNFs must better control their costs. As a result, SNFs are now confronted with the task of balancing their duty to their patients with the fact that they will receive a flat rate for the services they provide regardless of their actual costs.

For some SNFs, the PPS may mean little or no change to their bottom lines. For others, however, the PPS could spell bankruptcy. Cost efficiency and control will be key.
As long as a SNF can keep its costs per patient under the per-diem rate it is receiving without sacrificing quality of service, everyone benefits from the PPS. On the other hand, if a perfect balance is not possible, then either the patient or the SNF will suffer.

**What to Do**

To set the proper balance, SNFs must evaluate their capabilities and what they are paying for the services they provide. The only way to win the game is for SNFs to know their revenues precisely and structure all expenses accordingly. This may mean negotiating new contracts with outside suppliers and employees.

Furthermore, SNFs must prepare their employees for the task of conducting accurate and precise assessments. The MDS is the critical component to determining the rate to which the facility is entitled. A slight error in assessment could result in a significantly lower per-diem rate than the rate to which the SNF should be entitled for the services it is providing. A blatant error in the facility’s favor, on the other hand, could constitute fraud. A significant change in a patient’s status also could result in a significant change in the per-diem rate. Accurate categorization depends on an employee’s accurate and precise assessment.

The timely submission of assessments also is critical. A patient who requires significant services, for which the SNF might be entitled to a rate of $408.19, but whose assessment is completed late, could cost the SNF $291.34 (the difference between the appropriate rate for the patient’s RUGs-III category and the default rate) for every day that the assessment is late.

There is no way to win on late assessments, because the default rate is the lowest rate payable for any of the RUGs-III categories. Staff in the SNF must be aware of the timetables for assessments.

The consolidated billing requirements also pose significant administrative challenges for SNFs. Accounting personnel will bear a large burden in handling outside suppliers’ bills for which the SNF must now apply to Medicare for reimbursement.

The SNF also will need to establish new internal mechanisms for distributing Medicare reimbursements to Part B service providers and for processing service provider invoices.

If your SNF is not ready for these changes, you better get going. Establishing a PPS compliance program is a great first step. As you can tell, every day counts — and costs.

Corrine Parver is a partner and Jason Wallach is an associate in the Health Law Services Group of Dickstein Shapiro Morin & Oshinsky, 2101 L St., NW, Washington, D.C. 20037; 202/785-9700; e-mail: parverc@dsmo.com; wallachj@dsmo.com