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WHITE PAPER

Understanding MDS 3.0 and RUG IV Reimbursement for Nursing Homes

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Introduction

The long-term care industry has anticipated the revision of MDS 2.0 into the new MDS 3.0 for several years. Providers have been looking forward to improvements, such as the standardization of Activities of Daily Living (ADL) scoring, clarification of wound definitions and a more user-friendly format. Consumer groups have been anticipating a refocusing of the data collection to the resident, with more emphasis on resident interviews.

The implementation of the new Minimum Data Set instrument (MDS 3.0) is scheduled for Oct. 1, 2010. Originally, the corresponding updated Resource Utilization Group (RUG IV) reimbursement methodology was supposed to be implemented the same day. During the passage of the Patient Protection and Affordable Care Act (ACA), Congress delayed the implementation of RUG IV until Oct. 1, 2011. Meanwhile, the law requires the MDS 3.0, with its changes to look back periods and concurrent therapy rules on October 1, 2010, as originally planned. Unless there are further changes to legislation, effective October 1, 2010, on an interim basis claims will be paid based on the RUG IV rate system that was finalized in the 2010 SNF PPS final rule. A payment infrastructure will be provided to support the use of MDS 3.0 prior to RUG IV implementation in 2011. Once that infrastructure is developed, claims submitted after October 1, 2010 and before October 1, 2011 will be retroactively adjusted.[1]

How we got here

In 2006, the expansion of RUG categories from 44 to 53 was designed to capture the resources needed to care for people who needed rehabilitation, along with having other medical issues. There were significant changes made, including extending the look-back period for the MDS into the hospital period beyond the date of admission to the skilled nursing facility (SNF). This was joined with the development of the new, highly reimbursed, extensive services categories for residents who received intravenous therapy, blood transfusions, respirator care, etc. during the look-back period of their hospitalization — based on the presumption that these conditions/interventions require increased resource utilization, hence increasing cost to the admitting SNF upon admission.

CMS observed SNF reimbursement climb beyond what they had anticipated as a result of these changes, and they began the Staff Time and Resource Intensity Verification (STRIVE) study to review nursing home reimbursement in relationship to the actual experienced cost of providing care. STRIVE was implemented to assess the effect of medically complex issues managed prior to admission on overall use of labor resources upon admission to the SNF. The study did not support the presumption. The new RUG IV categories are the result of the STRIVE study of RUG III reimbursement and the development of the MDS 3.0 instrument. The new categories and reimbursement rates recalibrate reimbursement to adjust for case mix creep since 2005.

Financial impact of RUG IV

The changes in reimbursement from RUG III to RUG IV are supposed to be budget neutral. The new rate structure was developed based on data from the (STRIVE) project in 2007. This updates case mix structures that were based on data from 1990, 1996, and 1997. The result is an upward adjustment of the nursing CMI's.[2] So while the changes in MDS look back period and concurrent therapy rules are expected to lower the rehabilitation categories, the CMI for nursing care portion of the RUG categories will increase.

Major changes in MDS 3.0 and RUG IV[3]

Among the most significant changes in the RUG IV reimbursement system is within the rehabilitation categories. RUG IV coding requires the therapist to specifically account for the time captured within the look back period, utilizing the three recognized formats: Individual, Concurrent and Group. Furthermore, RUG IV diminishes the impact of concurrent therapy on RUG levels by appropriating only 50 percent of the actual time. The premise is that reimbursement is intended to pay toward utilization of resources; therefore, payment is limited to the total number of labor hours billed by the clinician on any given day. This is a significant change from RUG III, in which concurrent therapy allowed the actual time coded to exceed the actual time the therapist works.

The new format has 23 different Rehab plus Extensive Services and Rehab groups, representing 10 different levels of rehabilitation. There is a concurrent expansion of the Level of Care Presumption. With RUG III, it was the upper 35 RUG scores, and under RUG IV, it will be the upper 52 RUG scores. However, the use of Section T to predict the amount of therapy that is anticipated to be provided during the initial period on the five-day

assessment is discontinued with MDS 3.0. Only the actual time in therapy between admission and the assessment reference date can be utilized for RUG categorization.

Other major differences in MDS 3.0 include a more standardized ADL scoring across the categories, as well as expansion of the use of nursing rehabilitation and depression as end splits in certain RUG categories. There will now be a total of 66 RUG groups, clustered in the following hierarchy:

- Rehab + Extensive
- Rehab
- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Symptoms and Cognitive Performance
- Reduced Physical Function

STRIVE[4] data showed that medical complexity during SNF stays were not affected by utilization of services during the hospital stay. The services that were used with RUG III as qualifiers for these extensive services included:

- Ventilator/respirator
- Trach
- Suctioning
- IV meds
- Transfusions

With RUG IV, this has been significantly changed. The section P1a (Special Treatments and Procedures) look back period is redefined to include only those treatments or procedures performed after admission to the SNF — no longer allowing the capture of these extensive services during the hospitalization period. There has also been a realignment of qualifiers and changes to the groupings under RUG IV. In the Extensive category, suctioning has been removed as a qualifier. The new qualifiers for Extensive Services include only the following:

- Tracheostomy care while a resident
- Ventilator or respirator care while a resident
- Infection control isolation while a resident

The Special Care category has been expanded and split into high or low to offer more specificity. Dehydration has been dropped as a qualifier (regardless of category), as CMS noted that it was too difficult to definitively diagnose. The Clinically Complex category has been expanded from six to 10 groups based on ADL scores, and most significantly, intravenous meds has been moved here from Extensive Services.

The new Behavioral Symptoms and Cognitive Performance category combines two formerly separate categories, with four combined groups instead of the previously separate eight. And the Reduced Physical Function category has an increased case mix for residents in this category who need restorative therapy (through use of an end split), placing more emphasis on nursing rehabilitation in caring for long term care residents. These restorative care items include:

- Urinary toileting program and/or bowel training program
- Passive or Active ROM
- Splint or brace assistance
- Bed mobility and/or walking training
- Transfer training
- Dressing and/or grooming
- Eating and/or swallowing training
- Amputation/prosthesis care
- Communication training

Impact of RUG IV changes

Long-term care leaders need to understand the significant changes brought about by RUG IV. These changes bring opportunities to improve care to residents and to be appropriately compensated for that care — in a way that minimizes the overall reduction in reimbursement for some of the RUG categories that were frequently used under RUG III. Facilities can be successful by understanding this impact, developing clinical programs to meet the CMS objectives, improving the quality of care, and refocusing the efforts of staff.

In the area of rehabilitation, the virtual elimination of the Extensive Rehabilitation categories makes the management of the lower categories much more important. With the reduction of the use of concurrent therapy, rehabilitation staff need to redesign their treatment programs and consider supplementing them with weekend services and group therapy in

order to achieve the same clinical outcomes and get enough therapy time to the resident without excessive increases in staffing or payroll expenses. While the extensive rehabilitation services categories are virtually eliminated with RUG IV, there has been some re-weighting of the lower rehabilitation categories, and facilities that have traditionally cared for residents requiring lower rehabilitation services may actually see some improvement in reimbursement.
As for the redefinition of extensive services, the efforts spent now to obtain clinical information from the hospital for the look-back period of analysis should still be continued for quality of care and appropriate care planning, but it will no longer improve reimbursement. Developing care models to effectively and efficiently provide care to patients with tracheotomies or ventilators may facilitate admitting more of these patients who will meet the qualifier of requiring extensive services during the SNF stay. The change of category for intravenous medications from Extensive Services to Clinically Complex may require a review of the cost of these services, and the exploration of other clinically appropriate, less expensive pharmacological approaches to treatment.

The expansion of the end-splits for restorative rehabilitation and for identification and treatment of depression offer opportunities to improve care and be compensated higher for that quality. Expansion of rehabilitation nursing programs for the lower *physical care* and *behavioral and cognitively impaired* categories will result in this improvement. And focusing clinical staff on earlier recognition and treatment of depression will have a similar result in the Clinically Complex and Special Care categories.

Steps for strategic preparation

It is critical to begin planning now for the implementation of RUG IV so your facility will make the necessary modifications and improvements. The steps for this strategic planning process should begin with an assessment of the impact these changes will have on your specific facility. Therefore, you should:

- Evaluate the impact of the changes in the extensive services category based on what patients you admit and what their needs are
- Evaluate how you deliver rehab and address potential workflow redesigns to address concurrent therapy rule changes, and analyze the resulting payroll costs to meet that redesign
- Evaluate your processes for capturing behavior and cognitive category data elements
- Evaluate data collection for special care categories
- Evaluate the accuracy of your ADL data collection
- Educate your staff on the changes

Then, establish specific work groups to address each of the impact areas described above. Each work group should develop action plans, and the implementation and measurement of these efforts should be monitored by a steering committee. Remember that the primary goal is to improve the quality of care for your residents, consistent with the CMS objectives, and then to make sure you capture appropriately and document that care to be reimbursed for it. This approach will help you to ensure the process improvements you make will meet the scrutiny of clinical appropriateness, and that the documentation will support your claims for reimbursement.

This paper is based on information available at time of publication. Readers should check for additional revisions and clarifications posted on the CMS website (www.cms.gov) for the latest information.

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[1] Federal Register, Vol. 75, Number 140, Thursday, July 22, 2010, Notices.

[2] Federal Register, Vol. 75, Number 140, Thursday, July 22, 2010, Notices.

[3] MDS 3.0 RAI Manual V1.02 July 26, 2010 www.cms.gov

[4] STRIVE National Nursing Home Data Study www.cms.gov