GETTING STARTED:

Understanding RUGs IV Payment©

This document provides an overview of the potential changes in Medicare payment rates for each RUG group as it relates to the new RUGs IV payment classification system. This resource is the first step in understanding how to correctly assess your future payments based on how residents will classify into the RUG IV groups with the elimination of the exception for the "lookback" period, estimated therapy, and concurrent therapy[1].

Background

The 2010 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Final Rule, was released August 11, 2009. In addition to updates for FY 2010, this final rule also included provisions for FY 2011, due to the anticipation of the new Minimum Data Set (MDS) 3.0 and the refinement of the payment system (i.e. Resource Utilization Groups, RUGs IV), *effective Oct. 1, 2010*. This document focuses primarily on the RUGs IV refinement.

RUGs IV

The new RUGs IV case-mix classification system is based on results of ongoing analysis of nursing home staff time measurement (STM) data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. There will be an additional 13 RUGs, increasing the total number from 53 to 66 (see Appendix A). This new refinement will redistribute payment from RUGs that have therapy services to those RUGs that have only nursing services. The rule also changes the way residents are classified into the new categories (details in next section).

With the implementation of the new RUGs IV system in FY 2011, many skilled nursing facilities need more detailed information on how to correctly interpret the various changes to the new classification system as they assess payment for 2011. This document provides a starting point on how to understand payment changes as a result of the RUG refinement by clarifying differences between RUGs III and RUGs IV. It is important to note, however, that this exercise does *not* include information on how to classify residents into the different RUG IV groups based on the new MDS 3.0 resident assessment, which is something all nursing facilities will have to learn before the implementation of the MDS 3.0 by October 1, 2010.

[1] RUGs IV 2011 rates for all tables based on federal rates (Appendix A).

Translating the Rule into Payment

With the introduction of the RUGs IV classification system effective Oct 1, 2010, there are major changes ahead. These include:

1. The improved MDS 3.0 affects how some of the RUG groups are reorganized:

a. IV-meds/feeding moved from "extensive services' to "clinically complex" : new data shows that the resource need for people getting IVs in the nursing home is significantly less than people getting other extensive care services, so CMS decided to move the IVs to clinically complex RUGs. With this change, the "extensive services" category has been reserved to "respiratory" care only, which includes post admission ventilator/respirator care, tracheotomy care, and a new category for "infection isolation" care (see excel file above to find out what qualifiers are included in each RUG group);
b. Parental/IV feeding qualifiers moved from "extensive services" to the "Special Care High" category;
c. Split Special Care category into "high" and "low" for more accurate case-mix indexes (CMIs)
d. Combined "impaired cognition" and "behavior category" into one – new data found that there was no correlation between behavior problems and increase resource use;
e. Click on the article Modified Characteristics by RUG Category for more detailed information on all RUG qualifier modifications.

Change in Payment in the "extensive service" and "clinically complex" categories: *(reference Table 1)*

→ The "extensive services" (SE) category shows substantial increases in payment from RUGs III to RUGs IV (Table 1):

- For SE1, the increase in payment from RUGs III to RUGs IV is from $362 to $646, a 78.5% increase;
- For SE2, the increase is from $309 to $506, a 63.7% increase;
- For SE3, the increase if from $276 to $450, a 63.04% increase.

➔ Payment for the "clinically complex" category also increases substantially to account for the increased cost associated with IV meds/feeding that are now qualifiers for these groups. (Table 1)

- For CE2, payments increase from $270 to $352, an increase of 30.5%;

- For CE1, payments increase from $248 to $326, an increase of 31.45%

Table 1:

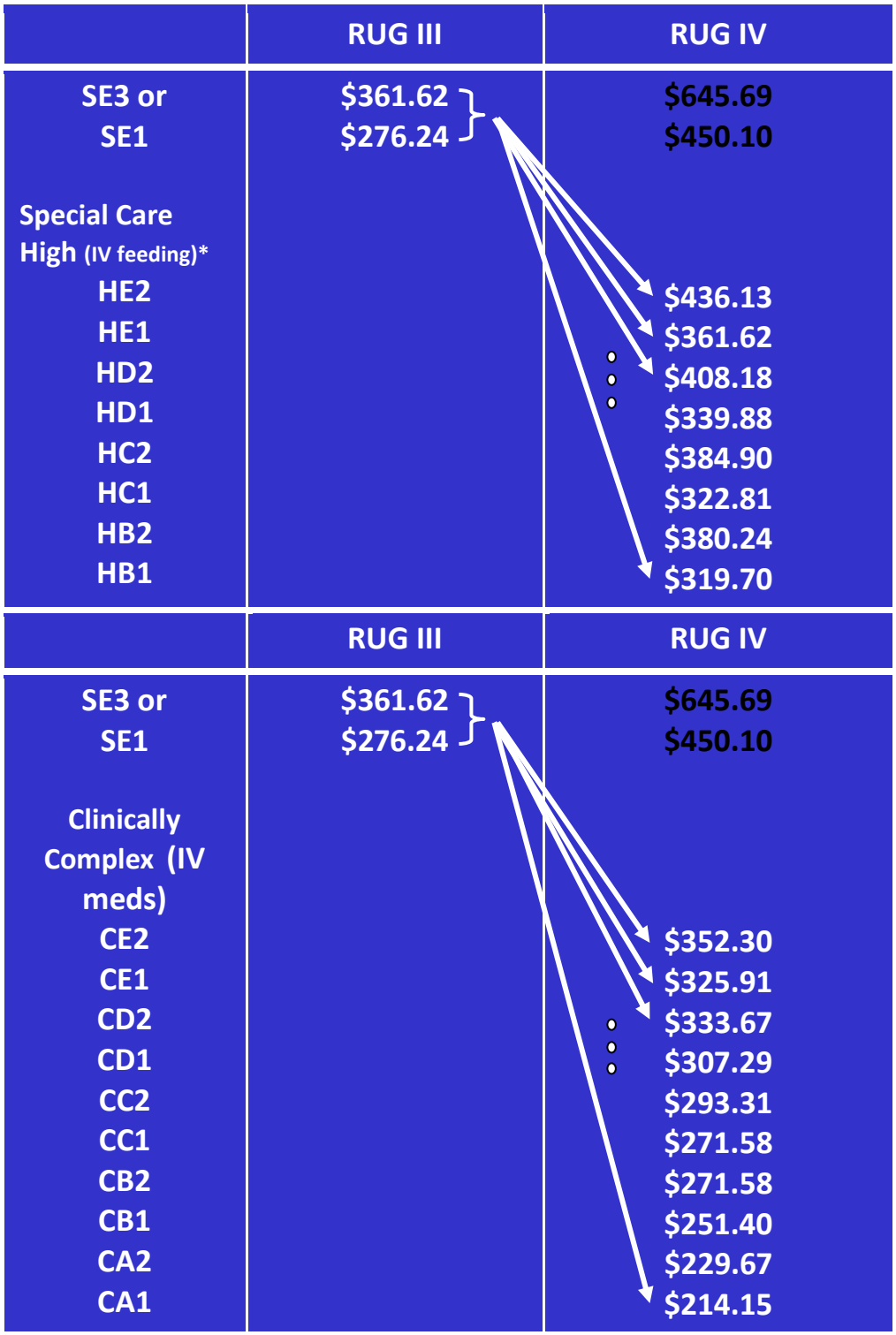
	RUG III	RUG IV
SE3	$361.62	$645.69
SE2	$308.84	$505.98
SE1	$276.24	$450.10
CE2	$270.03	$352.30
CE1	$248.30	$325.91

For a more precise reclassification of residents, use the RUG-III and RUG IV Comparison Charts.

The "extensive service" qualifier effect: *(reference Table 2)*

→ If you are no longer able to classify your resident(s) into the "extensive category" RUG because the IV meds/feeding can no longer be used as a qualifier, your payment will not change much from 2009 (RUGs III rates). Note that with IV feeding/IV meds, you will have to reclassify the resident(s) into a "special care" or "clinically complex" RUG category, with mostly substantially greater payments than what your facility was getting for the "extensive service" category for RUGs III, unless you are only able to reclassify residents into the very low groups (Table 2).

Table 2:



For a precise reclassification of residents, use the RUG-III and RUG IV Comparison Charts. *Note: Depression end-splits will now have an impact on both the clinically complex and the special care RUGs. In RUGs III, it had only impacted clinically complex. This change will increase reimbursement significantly.*

(*) Note that rates for Special Care LOW in RUGs IV are also higher than the SE groups in RUGs III, with the exception of RUG group LB2, which has a per diem rate of $270 (see Appendix A).

Overall effect in RUG Distribution for Medically Complex Groups

Table 2a below shows the proportion of residents who are expected to remain in each of the medically complex RUG groups. Because the "IV medication" and "IV feeding" are no longer qualifiers for the "extensive service" category in RUGs IV (the highest paid medically complex category), most residents who were once classified under the "extensive service" category under RUGs III will have to be re-classified under the "special care" and "clinically complex" categories in RUGs IV. In fact, only 1.04% of the residents will be able to classify under "extensive services" under RUGs IV, as opposed to 4.26% in RUGs III. This reduction in number of patients able to classify in "extensive services", however, does not necessarily imply a decrease in payment for those same patients. As illustrated in Table 2 above, the payment amount for the "special care" and "clinically complex" categories in RUGs IV remains fairly constant as compared to payments under "extensive service" categories in RUGs III, so that the overall affect of patients moving from the "extensive services" category to "special care" or "clinically complex" may be neutral. The exact effect will depend on each facility's case mix distribution.

Table 2a: RUG Distribution for All Medically Complex Groups

	RUGs III	RUGs IV
SE	4.26%	1.04%
CC	3.22%	5.58%
SS	3.03%	10.11%
TOTAL Medically Complex	10.51%	16.73%

Source: http://www.cms.hhs.gov/SNFPPS/09_RUGRefinement.asp#TopOfPage March 2010

2. The effects of the elimination of three provisions that SNFs currently use to classify their patients into certain RUGs:

a. Allocating minutes for **Concurrent therapy**: this type of therapy refers to services where one therapist is treating multiple residents receiving different treatments. The SNF PPS is based on resource utilization and costs. When a therapist treats two patients concurrently for an hour, it does not cost the SNF twice the amount (or 2 hours of the therapist's salary) to provide those services. Under RUGs IV, the therapist would then receive one hour's salary for the hour of therapy provided, regardless of whether the therapist treated one patient individually or two patients concurrently for that hour. These changes will affect some therapy companies that have heavily used the

concurrent model; but this is not how the majority of therapy companies have worked. Many have used concurrent therapy sparingly and staff generally for most, if not all, on a 1 to 1 basis.

b. No more **"look back" period** for payment purposes: In RUG III, SNF are able to "look back" a certain number of days (14 days for IV meds and 7 days for IV feeding) into the hospital stay of the patient to code five items that identified a resident as needing high level of staff time, even if this care wasn't received in the SNF itself, which could then be combined with therapy services to qualify the resident into the rehab plus extensive RUGs. These five codes are: i) ventilator/respirator; ii) tracheostomy ; ii) suctioning; iv) IV medications; and v) Transfusions. When RUGs III was first developed, CMS used these codes as a proxy of medical complexity and thus, higher resource use – more care and more monitoring. But, with new data, CMS found that, prior hospital use of these five services DOES NOT predict higher resource use. In fact, the data showed 2 important findings. One was that the services are NOT given in the SNF, they are just used for coding and billing. The other is that there is no difference in resource use provided to patients who received treatments in the hospital than patients who didn't. Both these finding suggest that the loss of "extensive services" in the look-back period more accurately classified the resident into an appropriate therapy RUG group when they are receiving therapy. These two findings are what prompted CMS to address these exceptions and require SNFs to code for only those services provided at the SNF. Providers are still able to code for those services received in the hospital on MDS 3.0 for care planning purposes.

c. No more **estimated therapy** (section T of MDS 2.0): Currently, on the first MDS assessment a patient can be categorized into a high, medium, or low rehabilitation group using an estimate of the amount of therapy that will be provided, rather than the actual amount provided. Section T of the MDS is used to estimate how much therapy a resident will receive in the first 14 days of a SNF stay, which drives RUG classification. With the elimination of Section T, only actual minutes delivered will be reported on MDS 3.0. This provision is based on GAO findings that patients were inappropriately classified into High or Medium therapy categories based on "projection" minutes when compared to actual minutes delivered. GAO found that one-quarter of the patients classified using the estimated therapy minutes did not receive the amount of therapy they were assessed as needing. MedPac has also documented these finding for many years.

These exceptions have all been legal, and nearly all homes have thus been dependent to some degree on them. The new rates are set such that if your home has been using an "average" amount of these exceptions, you will not lose on the change to the new RUGs IV.

The "average" amount used for each exception is the following:

- *If all therapy in your facility is done concurrently in about 30% of the cases, your facility is considered to have an "average" amount of this type of therapy;*
- *For the "look-back" exception, CMS expects only about 10% of the patients previously in the rehab ultra will still be there after the change -the rest of the residents will most likely re-classify under the rehab-only RUGs. Therefore, if your facility can only keep 10% of your patients in the Ultra High category, you will still break even with RUGs IV;*
- *On "estimated" therapy it is not clear how much was being done.*

The "look back" effect: *(reference Table 3)*

➔ If your facility is no longer able to classify your resident into RUX (ultra high with extensive services and with 720 minutes of therapy) because you can no longer use the "look back" provision to account for extensive services in the hospital, then you will have to reclassify that resident into RUC (ultra high withOUT extensive services and with 720 minutes of therapy). Note that your payment under RUGs IV will be slightly higher, increasing from $617 to $621 per day, a 0.6% increase.

➔ If your facility is no longer able to classify your resident into RVX (very high with extensive services and with 500 minutes of therapy) because you can no longer use the "look back" provision to account for extensive services in the hospital, then you will have to reclassify that resident into RVC (very high withOUT extensive services and with 500 minutes of therapy). Note that your payment under RUGs IV will be higher, increasing from $468 to $539 per day, a substantial increase of 15%.

➔ If you follow this same pattern as illustrated by the Table 3 below, you will note that even without being able to classify your resident to higher rehab RUGs due to the elimination of the "look back" period, your payments for the same resident will not change significantly with the implementation of RUGs IV:

- From RHX to RHC, per diem payment increases substantially by 20.5%;
- From RMX to RMC, payment decreases, but only slightly by 6%;
- From RLX to RLB, per diem payment increases substantially by 32%.

Table 3:

	2010 RUG III	2011 RUG IV
RUX (720 min/wk) RUC (720 min/wk)	**$617.07** $528.59	$848.95 **$620.76**
RVX (500 min/wk) RVC (500 min/wk)	**$467.62** $421.05	$769.09 **$539.35**
RHX (325 min/wk) RHC (325 min/wk)	**$395.59** $364.54	$706.39 **$476.65**
RMX (150 min/wk) RMC (150 min/wk)	**$448.67** $335.35	$652.69 **$424.50**
RLX (45 min/wk) RLB (45 min/wk)	**$318.88** $294.04	$579.20 **$420.87**

For a precise reclassification of residents, use the RUG-III and RUG IV Comparison Charts.

The Concurrent therapy effect: *(reference Table 4)*

- If your facility is no longer able to classify your resident into RUX (ultra high with extensive services and with 720 minutes of therapy) because you are now required to use allocated time for your residents under concurrent therapy, you will have to reclassify that resident into a lower rehab group. If you are able to qualify that resident into the next lower rehab group RVX (very high with extensive services and with a minimum of 500 minutes of therapy/wk), your payment under RUGs IV will increase from $617 to $769 per day, a significant increase of 25%. If you can only classify that patient into a "high" or even "medium" rehab RUG, your payments will still increase by 15% and 5.7%, respectively. Only if you are not able to qualify that patient into the higher rehab RUGs will they fall in the lowest rehab RUG, RLX, which results in a slight decrease in payment of about 6.2%.

- If you follow this same pattern for other lower rehab RUGs (i.e. from RVX to RHX, or from RVX to RMX, or from RVX to RLX), you will note that you will always experience a substantial increase in per diem payment:

  RVX → RHX = increase by 51%; RVX → RMX = increase by 39%; RVX → RLX = increase by 24%

  RHX → RMX = increase of 65%; RHX → RLX = increase by 51%

Table 4:

	2010 RUG III	2011 RUG IV
RUX (720 min/wk)	$617.07	$848.95
RVX (500 min/wk)	$467.62	$769.09
RHX (325 min/wk)	$395.59	$706.39
RMX (150 min/wk)	$448.67	$652.69
RLX (45 min/wk)	$318.88	$579.20

For a precise reclassification of residents, use the RUG-III and RUG IV Comparison Charts.

Overall effect in RUG Distribution for Rehabilitation Groups

Table 4a shows that the distribution for patients in the highest rehabilitation groups with extensive services goes down substantially, so that only patients with really severe needs will be able to classify into those categories. Most, if not all the patients that will no longer classify into the highest RUGs, will be re-classified under the rehab-only groups. This change in distribution, however, does not imply lower total payment. As illustrated on Tables 3 and 4, as most residents are re-classified from the highest RUG groups to the lower RUG groups, total budgetary change under RUGs IV is neutral or higher than under RUGs III, depending on the facility case mix.

Table 4a: RUG Distribution for all Rehab Groups

	RUGs III	RUGs IV
Rehab + Ext	36.49%	3.82%
Rehab only	51.75%	75.93%
TOTAL Rehab	88.23%	79.75%

Source: http://www.cms.hhs.gov/SNFPPS/09_RUGRefinement.asp#TopOfPage March 2010

Case-Mix Indexes under RUGs IV

With the payment classification system transitioning into RUGs IV, both therapy and nursing have change as a result. Table 5 below shows that the percent change in payment for the nursing component has increased by 18%, while the percent change in payment for the therapy component has decreased by 38%. It is incorrect, however, to assume that the net result equates to the difference between the percentage changes, or 20% drop in total payment. It is important to note that ALL RUG groups have a "nursing component", including all therapy RUGs, from RUX to RLA, so that despite the decrease in the therapy portion of the RUG rate, there is also an increase in the nursing component in every group, outweighing some of the negative pressure in therapy.

Table 5: Percent Change in Payment for Therapy and Nursing CMIs

Rate Component	
Nursing CMIs	18%
Therapy CMIs	-38%

Source: CMS presentation at AAHSA's Future of Aging Services Spring Meeting, Feb 22, 2010

Moreover, the nursing component in all RUGs are weighed much more heavily (70%) than the therapy component (30%) in the calculation of each RUG, so that the decrease in payment from the therapy portion of the RUG rate is , in every RUG, offset by the increase in payment from the nursing portion of the rate (Table 6).

Table 6: Comparing Nursing and Therapy Indexes for RUGs III and RUGs IV

RUG III FY 2010			RUG IV FY 2011				
	Nursing Index	Therapy Index		Nursing Index	Therapy Index	Nursing Index %Ch	Therapy Index %Ch
RUX	1.77	2.25	RUX	3.55	1.87	100.56%	-16.89%
RUL	1.31	2.25	RUL	3.41	1.87	160.31%	-16.89%
RVX	1.44	1.41	RVX	3.48	1.28	141.67%	-9.22%
RVL	1.24	1.41	RVL	2.92	1.28	135.48%	-9.22%
RHX	1.33	0.94	RHX	3.40	0.85	155.64%	-9.57%
RHL	1.27	0.94	RHL	2.86	0.85	125.20%	-9.57%
RMX	1.80	0.77	RMX	3.28	0.55	82.22%	-28.57%
RML	1.57	0.77	RML	2.92	0.55	85.99%	-28.57%
RLX	1.22	0.43	RLX	3.01	0.28	146.72%	-34.88%
RUC	1.20	2.25	RUC	2.08	1.87	73.33%	-16.89%
RUB	0.92	2.25	RUB	2.08	1.87	126.09%	-16.89%
RUA	0.78	2.25	RUA	1.32	1.87	69.23%	-16.89%
RVC	1.14	1.41	RVC	2.00	1.28	75.44%	-9.22%
RVB	1.01	1.41	RVB	1.48	1.28	46.53%	-9.22%
RVA	0.77	1.41	RVA	1.47	1.28	90.91%	-9.22%
RHC	1.13	0.94	RHC	1.92	0.85	69.91%	-9.57%
RHB	1.03	0.94	RHB	1.59	0.85	54.37%	-9.57%
RHA	0.88	0.94	RHA	1.22	0.85	38.64%	-9.57%
RMC	1.07	0.77	RMC	1.81	0.55	69.16%	-28.57%
RMB	1.01	0.77	RMB	1.62	0.55	60.40%	-28.57%
RMA	0.97	0.77	RMA	1.12	0.55	15.46%	-28.57%
RLB	1.06	0.43	RLB	1.99	0.28	87.74%	-34.88%
RLA	0.79	0.43	RLA	0.94	0.28	18.99%	-34.88%

FINAL STEP:

Once you have reviewed this document with your clinical staff and understand how payment changes with the implementation of the new RUGs IV, you should use the RUG-III and RUG IV Comparison Charts to help determine where residents in *YOUR* facility will reclassify under the new rules for RUGs IV. This step will requires more education and training not provided in this article. Once you have determined the days for each RUG IV group, use the RUG IV Rate Calculation Tool to obtain your Medicare Part A per diem rates for FY 2011.

Summary Analysis:

The RUGs IV essentially recalibrates the RUGs III case-mix weights to add dollars into more complex patients that require more nursing services. This is done in a budget neutral manner by shifting payments from the therapy groups to more adequately cover costs of complex patients with higher nursing care needs and high drug costs. In other words, payment for services that require more intensive nursing care will rise substantially, while total payment for therapy groups are projected to remain fairly constant. This re-distribution of dollars away from therapy groups to nursing groups addresses a long standing problem of over-reimbursing for therapy services and under-reimbursing for medically complex residents. Because non-profit homes take care of a disproportionately large share of these medically complex patients, most non-profits will benefit from the new RUGs IV classification system by addressing problems that have disadvantaged non-profit homes for years.

MDS Resident Assessment Manual can be downloaded at:
http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

Chapter 6 of the RAI manual deals with the Medicare SNF PPS
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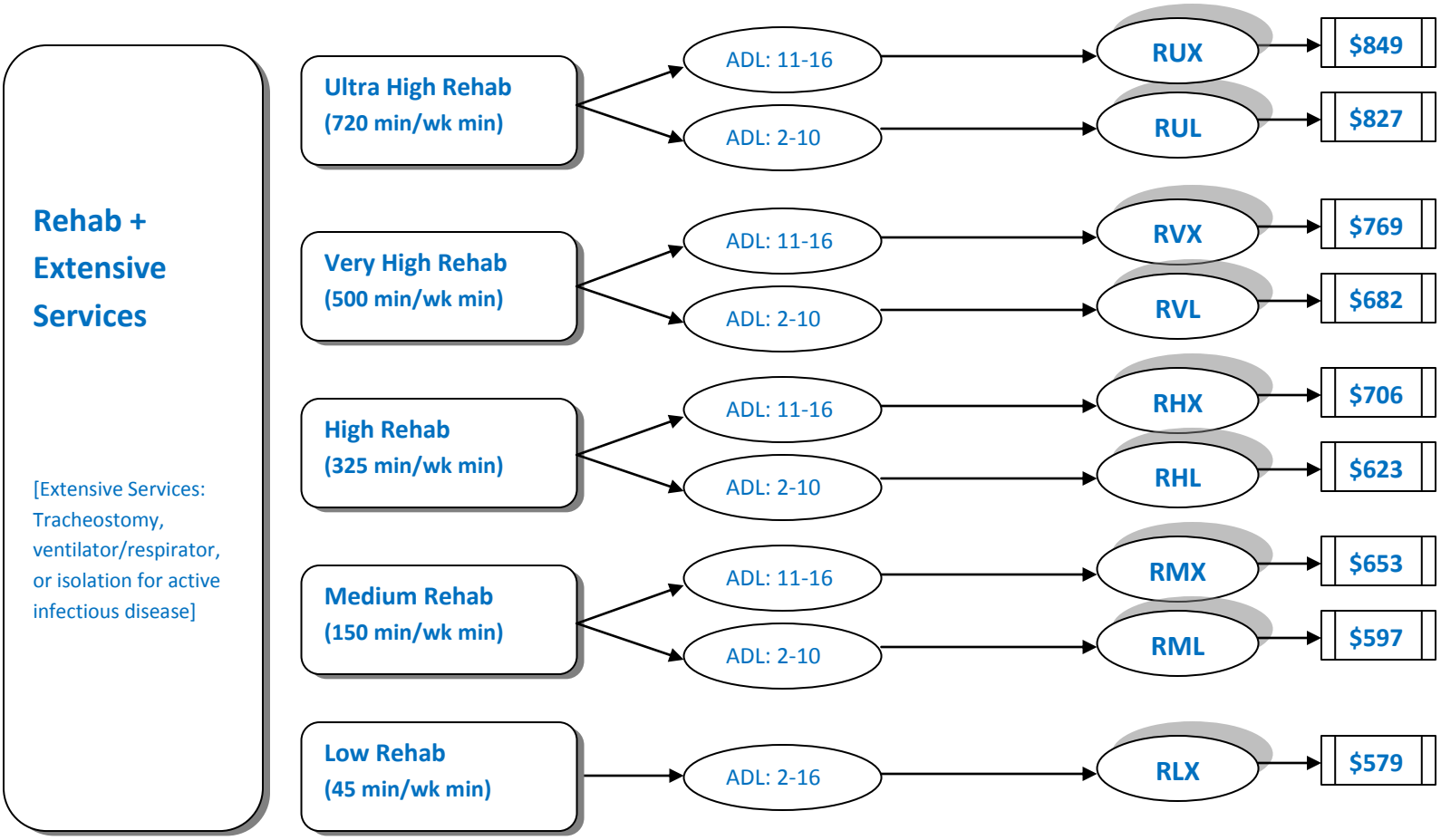
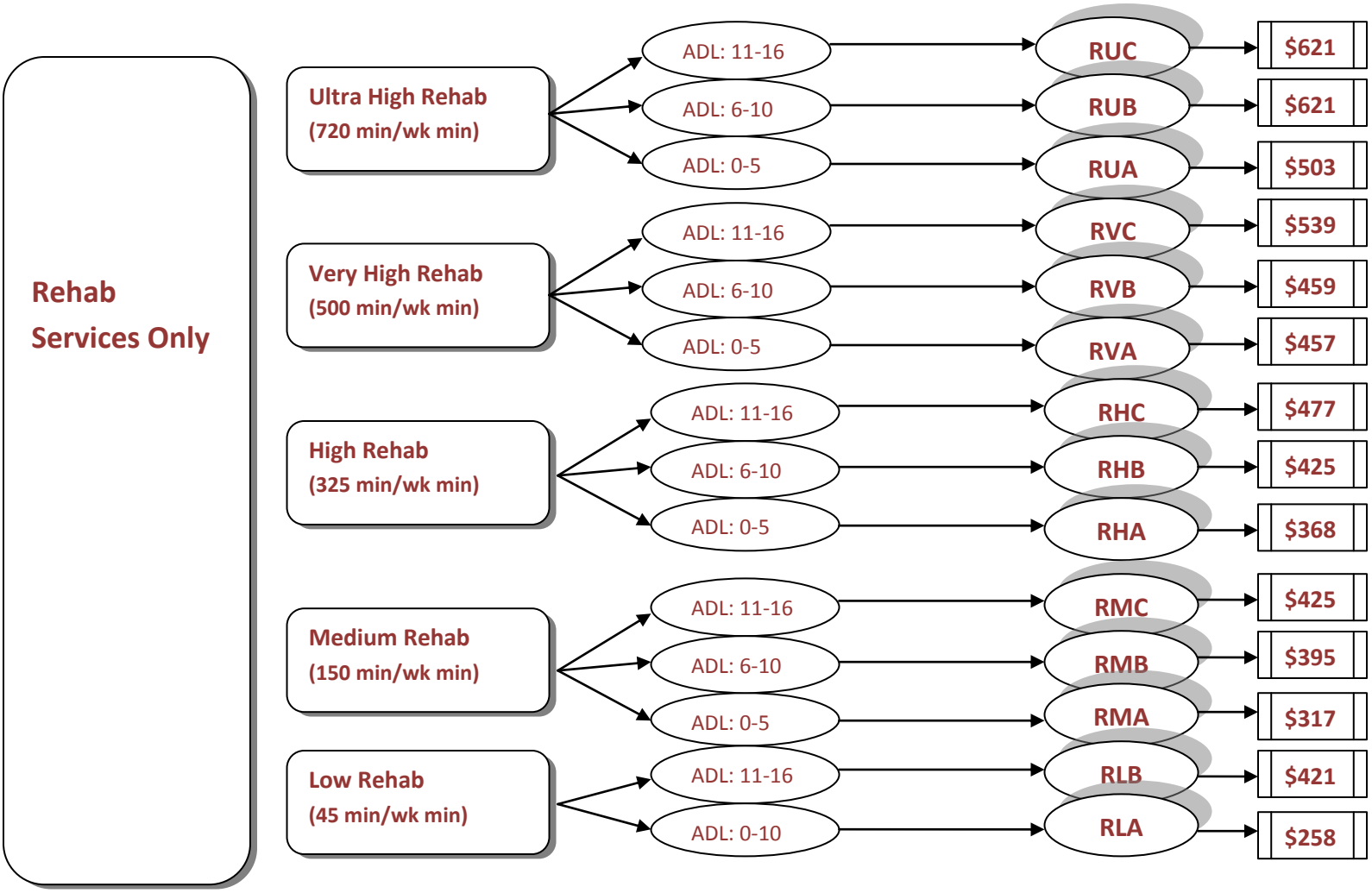
APPENDIX A: Skilled Nursing Facility Prospective Payment System for 2011 – the new Resource Utilization Groups (RUGs) IV (effective Oct 1, 2010).



Rates have been rounded to the nearest decimal. Rates are based on using FY 2010 unadjusted Urban Federal Rate per Diem as published in the August 11, 2009 SNF PPS Final Rule (74 FR 40293). The rates reflect payment as if RUG-IV were to start in FY 10 or as if there were no market basket increase for and the wage index budget neutrality factor FY 11 were equal to 1.0.

APPENDIX A (cont)



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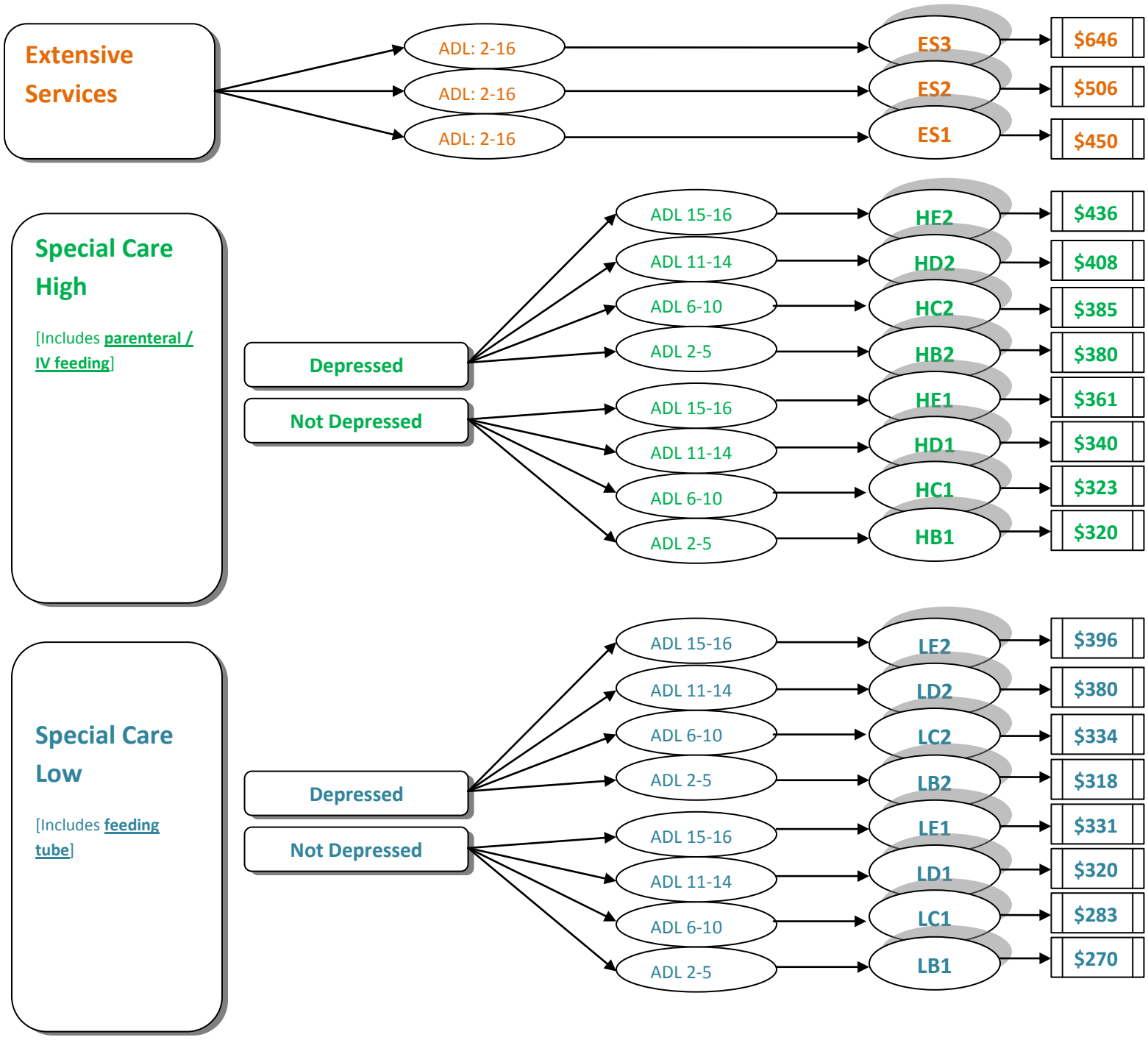

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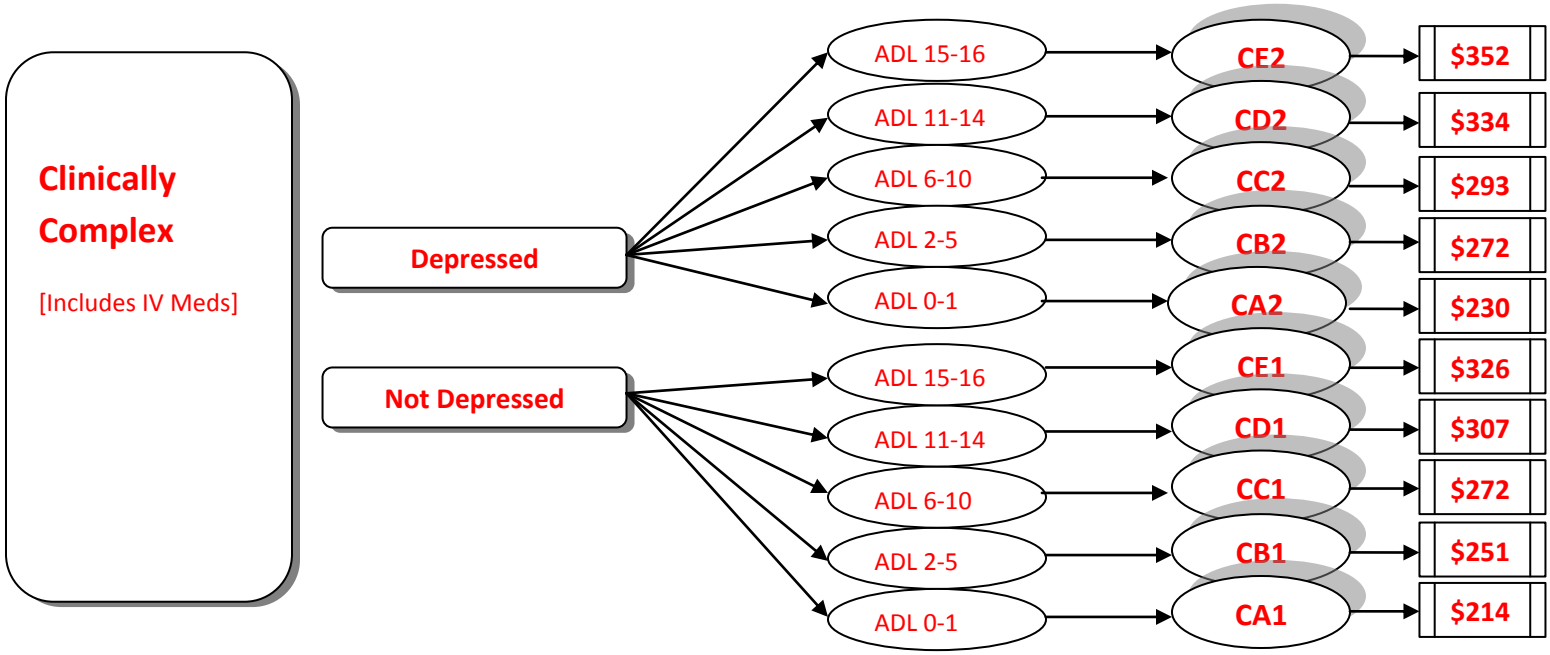

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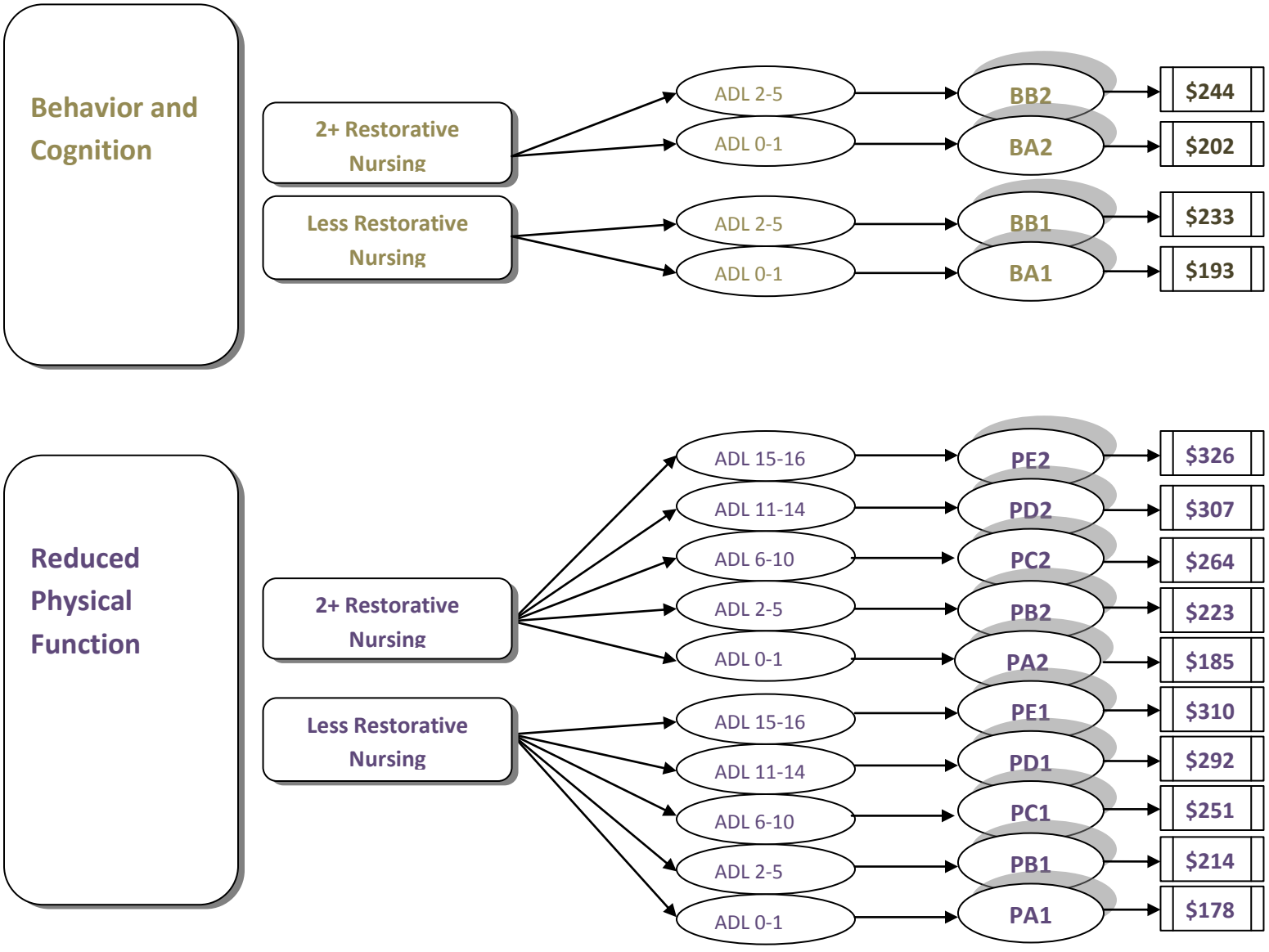

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APPENDIX B: Federal Urban per diem Rates. Rates change depending on where your facility in located. For a tool that calculates your facility's specific per diem rates, please go to the AAHSA website.

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	3.55	1.87	551.07	218.66		79.22	848.95
RUL	3.41	1.87	529.33	218.66		79.22	827.21
RVX	3.48	1.28	540.20	149.67		79.22	769.09
RVL	2.92	1.28	453.27	149.67		79.22	682.16
RHX	3.40	0.85	527.78	99.39		79.22	706.39
RHL	2.86	0.85	443.96	99.39		79.22	622.57
RMX	3.28	0.55	509.15	64.31		79.22	652.68
RML	2.92	0.55	453.27	64.31		79.22	596.80
RLX	3.01	0.28	467.24	32.74		79.22	579.20
RUC	2.08	1.87	322.88	218.66		79.22	620.76
RUB	2.08	1.87	322.88	218.66		79.22	620.76
RUA	1.32	1.87	204.90	218.66		79.22	502.78
RVC	2.00	1.28	310.46	149.67		79.22	539.35
RVB	1.48	1.28	229.74	149.67		79.22	458.63
RVA	1.47	1.28	228.19	149.67		79.22	457.08
RHC	1.92	0.85	298.04	99.39		79.22	476.65
RHB	1.59	0.85	246.82	99.39		79.22	425.43
RHA	1.22	0.85	189.38	99.39		79.22	367.99
RMC	1.81	0.55	280.97	64.31		79.22	424.50
RMB	1.62	0.55	251.47	64.31		79.22	395.00
RMA	1.12	0.55	173.86	64.31		79.22	317.39
RLB	1.99	0.28	308.91	32.74		79.22	420.87
RLA	0.94	0.28	145.92	32.74		79.22	257.88
ES3	3.55		551.07		15.40	79.22	645.69
ES2	2.65		411.36		15.40	79.22	505.98
ES1	2.29		355.48		15.40	79.22	450.10
HE2	2.20		341.51		15.40	79.22	436.13
HE1	1.72		267.00		15.40	79.22	361.62
HD2	2.02		313.56		15.40	79.22	408.18
HD1	1.58		245.26		15.40	79.22	339.88
HC2	1.87		290.28		15.40	79.22	384.90
HC1	1.47		228.19		15.40	79.22	322.81
HB2	1.84		285.62		15.40	79.22	380.24
HB1	1.45		225.08		15.40	79.22	319.70
LE2	1.94		301.15		15.40	79.22	395.77
LE1	1.52		235.95		15.40	79.22	330.57
LD2	1.84		285.62		15.40	79.22	380.24
LD1	1.45		225.08		15.40	79.22	319.70
LC2	1.54		239.05		15.40	79.22	333.67
LC1	1.21		187.83		15.40	79.22	282.45

LB2	1.44		223.53		15.40	79.22	318.15
LB1	1.13		175.41		15.40	79.22	270.03
CE2	1.66		257.68		15.40	79.22	352.30
CE1	1.49		231.29		15.40	79.22	325.91
CD2	1.54		239.05		15.40	79.22	333.67
CD1	1.37		212.67		15.40	79.22	307.29
CC2	1.28		198.69		15.40	79.22	293.31
CC1	1.14		176.96		15.40	79.22	271.58
CB2	1.14		176.96		15.40	79.22	271.58
CB1	1.01		156.78		15.40	79.22	251.40
CA2	0.87		135.05		15.40	79.22	229.67
CA1	0.77		119.53		15.40	79.22	214.15
BB2	0.96		149.02		15.40	79.22	243.64
BB1	0.89		138.15		15.40	79.22	232.77
BA2	0.69		107.11		15.40	79.22	201.73
BA1	0.64		99.35		15.40	79.22	193.97
PE2	1.49		231.29		15.40	79.22	325.91
PE1	1.39		215.77		15.40	79.22	310.39
PD2	1.37		212.67		15.40	79.22	307.29
PD1	1.27		197.14		15.40	79.22	291.76
PC2	1.09		169.20		15.40	79.22	263.82
PC1	1.01		156.78		15.40	79.22	251.40
PB2	0.83		128.84		15.40	79.22	223.46
PB1	0.77		119.53		15.40	79.22	214.15
PA2	0.58		90.03		15.40	79.22	184.65
PA1	0.54		83.82		15.40	79.22	178.44

Rates are based on using FY 2010 unadjusted Urban Federal Rate per Diem as published in the August 11, 2009 SNF PPS Final Rule (74 FR 40293). The rates reflect payment as if RUG-IV were to start in FY 10 or as if there were no market basket increase for and the wage index budget neutrality factor FY 11 were equal to 1.0.