



WISCONSIN HOSPITAL
ASSOCIATION

Summary of Final Rule

for

Medicare Prospective Payment System
and
Consolidated Billing for Skilled Nursing Facilities

Federal Fiscal Year 2004 Update

September 4, 2003

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OVERVIEW OF CHANGES—SNF PROSPECTIVE PAYMENT SYSTEM

On August 4, the Centers for Medicare and Medicaid Services (CMS) issued a final rule updating the Skilled Nursing Facility Prospective Payment System (SNF PPS) and consolidated billing provisions. The final rule updates the per diem payment rates under the SNF PPS for federal fiscal year (FFY) 2004, which will be effective for services beginning on October 1, 2003. CMS estimates the financial impact resulting from the provisions in the notice to be an increase in payments of \$850 million or 6.4% across the nation. This is mainly attributable to the 3.0% marketbasket based update to the unadjusted federal rates from the prior year as well as the 3.26% adjustment to make up for previous years marketbasket increases.

In a change from the proposed rule, CMS has decided to forgo the use of FFY 2003 hospital wage index in adjusting the SNF PPS rates. Instead, CMS will use the most current available hospital wage index data.

Other provisions of the final rule include defining a SNF as a “distinct part” or “composite distinct part” of a hospital or other entity and continuing the administrative presumption of Medicare coverage for any beneficiary correctly assigned to one of the upper 26 Resource Utilization Group (RUG) III groups, as a result of the completion of the initial five-day Minimum Data Set (MDS).

PPS RATE PAYMENT CALCULATION

Marketbasket Update

In the proposed rule, CMS planned to update the unadjusted federal rates by 2.9%, which represents the full marketbasket increase. Based on updated data, the increase will be 3.0%. In addition, CMS will add another 3.26% to the unadjusted Federal rate. This is in order to adjust for the cumulative error in estimating the SNF marketbasket increase from FFY 2000 to FFY 2002. CMS also states that this will be an annual adjustment to the SNF PPS rates and will take into account both upward and downward adjustments. CMS will use 0.25 percentage points as a threshold before applying this adjustment.

Rate Component Add-Ons

The Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 each included provisions to increase the SNF PPS rates that continue in FFY 2004. The two add-ons that are continued are:

- the BBRA-mandated 20% add-on to the case mix-adjusted rate for the 12 specified RUGs found in the Extensive Services, Special Care, and Clinically Complex categories (BBRA mandated the add-on for 15 specified RUGs and BIPA subsequently revised this); and
- the BIPA-mandated 6.7% add-on to the case mix-adjusted federal per diem rate for all 14 rehabilitation RUGs.

These two add-ons will remain in effect until the implementation of a refined case mix classification system. CMS’ research into the refinement of the case mix classification system is ongoing. CMS is charged with reporting to Congress on those research results by January 1, 2005.

The unadjusted federal rates are as follows:

Unadjusted Federal Rates

Area	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non-Case Mix
Urban	\$129.96	\$97.89	\$12.89	\$66.32
Rural	\$124.16	\$112.89	\$13.77	\$67.55

All components reflect the 3.0% marketbasket adjustment as well as the 3.26% marketbasket forecast error adjustment.

SNF Wage Index

In the proposed rule, CMS planned to use the FFY 2003 hospital wage index to adjust SNF PPS payments for FFY 2004. This marked a policy change in the SNF PPS, in which CMS would use the wage index based on the most recently published final hospital wage index data, which in this case was the FFY 2003 wage index. As a result, CMS would conform to other post-acute systems such as home health agencies and inpatient rehabilitation hospitals. Also, pre-finalized wage index versions have been subject to mid-year revisions that have affected the accuracy of CMS PPS rates. However, because of public comments, CMS will continue its policy of using the most recent available hospital wage index instead of the most recently published final version. In addition, for FFY 2004, the labor-related portion of the federal rate is 76.372%. This is a change from the proposed rule portion of 76.435%

SWING BED FACILITIES

In FFY 2004, the PPS transition period ends. Therefore, the SNF PPS will apply to all swing bed services delivered in non-Critical Access Hospitals.

OTHER PROPOSED ITEMS

Presumption of Coverage for SNF Level of Care

CMS continues the administrative presumption of coverage for a SNF level of care. This presumption is based on a beneficiary's correct assignment into one of the upper 26 RUG III categories based on completion of the initial five-day Medicare required MDS assessment. This circumstance automatically classifies the beneficiary as meeting the SNF level of care definition up to the assessment reference date (ARD) of that MDS. For days of stay beyond the five-day assessment's ARD, traditional Medicare eligibility and coverage rules apply.

Additions to the Consolidated Billing Exclusions List

The Social Security Act grants authority to the Health and Human Services Secretary to designate additional services be added to the exclusions list, provided they fall within the four specified service areas:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

This final rule adds two new radio-pharmaceuticals, Zevalin and Bexxar, to the exclusions list, effective January 1, 2004.

Definition of SNFs as “Distinct Part” or “Composite Distinct Part”

CMS outlines the criteria that defines a SNF as a distinct part of a hospital or other institution. The definition reflects the 1980 “hospital-based” criteria that focus on issues of common ownership and control, financial integration, and location and adds existing criteria currently in the *State Operations Manual* and survey and certification letters from CMS to state survey agencies. CMS also specifies that a facility must submit a written request, with supporting documentation, for consideration as a distinct part and that the agency must pre-approve all proposed changes to bed numbers in the distinct part.

CMS also creates a “composite distinct part” designation to maintain its policy of allowing only one distinct part SNF per institution. A single composite distinct part is created when two separate hospitals, each with its own SNF, merge. A SNF would also be termed a composite distinct part when it is not co-located on the hospital’s campus, but is acquired by a hospital that already has a distinct part SNF.

CMS has added criteria to require that a composite distinct part be treated as a single distinct part of the institution to which it is based, and as such, the part has only one provider agreement. Moreover, it must be independently compliant with specific survey and certification requirements that include residents’ rights, posting of state advocacy contacts, displaying facility information and survey results, providing organized resident and family groups, equal access of residents to activities and social services, and certain personnel and environmental requirements.