



WISCONSIN HOSPITAL
ASSOCIATION

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**SUMMARY OF THE FINAL RULE FOR
MEDICARE PROSPECTIVE PAYMENT
SYSTEM AND CONSOLIDATED BILLING
FOR SKILLED NURSING FACILITIES**

FEDERAL FISCAL YEAR 2006 UPDATE

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OVERVIEW OF FINAL RULE 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) 2006, certain provisions of which will be effective for services beginning October 1, 2005 and certain other provisions will be effective January 1, 2006. Please note that all provisions of the final rule will also apply to SNF PPS payments to swing bed services in rural hospitals. The provisions in the notice will result in a nationwide increase of \$20 million in payment compared to FFY 2005.

PPS RATE PAYMENT CALCULATION

Elimination of Temporary 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 as follows:

- a 20% add-on to the case-mix adjusted rate for 12 specified Resource Utilization Groups (RUGs) found in the Extensive Services, Special Care, and Clinically Complex categories; and
- a 6.7% add-on to the case-mix adjusted federal per-diem rate for all 14 rehabilitation RUGs.

According to federal regulations, these two add-ons were to remain in effect until the latter of October 1, 2000 or implementation of a refined case-mix classification system. In the final rule, CMS has implemented the revisions to the case-mix classification system for FFY 2006; therefore, CMS has eliminated the temporary add-ons. The resulting decrease in payments is estimated to be 6.0% nationwide.

Case-Mix Refinements

Section 101 of the BBRA mandated that CMS implement case-mix refinements to better account for medically complex residents. In this final rule, CMS has implemented refinements it had proposed. However, due to the correction of minor errors and the use of more recent data, there were changes to the update amounts that are detailed below.

Creation of Nine Additional RUGs Categories

In the proposed rule, CMS concluded that the addition of a combined RUGs category that includes Rehabilitation Services and Extensive Services would improve the accuracy of payments based on clinical needs and appropriate services rendered. As proposed, CMS will implement this provision in the final rule using the addition of nine RUGs at the top of the RUGs III case-mix hierarchy that included beneficiaries who qualify in both the Extensive Services category and Rehabilitation Services category.

In the proposed rule, CMS' methodology of incorporating the nine additional RUGs groups involved revising the case-mix index for both the nursing portion and the therapy portion. However, CMS concluded in the final rule that the adjustment to the therapy portion of the case-mix index was based on data from a sample size that was too small. As a result, CMS will retain the same therapy case-mix weights that are currently used by the 44-RUG model.

In addition, CMS confirmed its position in the proposed rule that the intensity of care identified in the nine new RUGs categories also meets the administrative presumption of skilled level of care and therefore the upper 35 groups of the final new 53-group hierarchy are presumed to meet the SNF level of care. A crosswalk between the existing Rehabilitation Services category and the final combined Extensive Services plus Rehabilitation Services category is available on page 45033 of the August 4 *Federal Register*.

Case-Mix Index Adjustments

To account for the significant variability in non-therapy ancillary utilization both within and across RUGs groups, CMS will increase the case-mix index of all 53 RUGs III groups. As in the proposed rule, CMS is proposing an adjustment that produces a 3% increase in SNF PPS payments. In determining this increase, CMS looked to the outlier pool in the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), which is set at 3% of aggregate payments. However, based on the rate updates in this final rule, the use of more recent data, and the correction of minor errors in the proposed rule, CMS has determined that an increase of 8.51% in the nursing component of the case-mix weights, rather than the 8.4% proposed, would result in an estimated 3% SNF PPS payment increase.

Marketbasket Update

Due to the use of more recent data, CMS has revised the marketbasket update in the proposed rule from 3.0% to 3.1%. This represents the full marketbasket increase and will be effective October 1, 2005.

In addition, CMS confirmed its determination in the proposed rule that a marketbasket forecast error adjustment will not be included in the final FFY 2006 rates.

AIDS add-on

The 128% acquired immunodeficiency syndrome (AIDS) add-on is intended to remain in effect until there is an appropriate adjustment in the case mix that accounts for the costs of care provided to these residents. CMS does not believe the refinements in the final rule address this problem and therefore, proposes to retain the AIDS add-on for FFY 2006. This increase will pertain to those residents with AIDS whose claims have diagnosis code 042.

SNF Wage Index

CMS has determined the labor-related portion of the federal rate to be 75.922% as opposed to 76.087% in the proposed rule. In FFY 2006, CMS will implement the redefined labor market areas, called Core-based Statistical Areas (CBSAs), it had proposed. However, based on input from the long-term care community, CMS will incorporate a transition period. For FFY 2006, the wage index for all facilities will consist of a blend of 50% of the FFY 2006 MSA-based wage index and 50% of the FFY 2006 CBSA-based wage index. Unfortunately, since CMS is applying the transition to all nursing homes instead of only those harmed by the redefinition of wage index areas, some nursing homes will be adversely affected by this policy for FFY 2006.

Unadjusted Federal Rates

The unadjusted federal rates are as follows:

Area	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non-Case Mix
Urban	\$137.59	\$103.64	\$13.65	\$70.22
Rural	\$131.45	\$119.51	\$14.58	\$71.52

All components reflect the 3.1% marketbasket.

Calculation of Payment Amount

The table below provides an example of the computation of adjusted PPS rates for five of the 44 RUGs effective from October 1, 2005 through December 31, 2005.

RUGs Group	Labor Portion	Wage Index	Adjusted Labor	Non-Labor Portion	Adjusted Rate	Percent Adjustment	Adjusted Amount	Medicare Days	Payment
Rehabilitation Very High Category (RVC)	282.30	0.8574	242.04	89.53	331.57	6.7%*	353.79	30	\$10,614
Rehabilitation High Category (RHA)	218.15	0.8574	187.04	69.19	256.23	6.7%*	273.40	30	\$8,202
Clinically Complex 2 Category (CC2)	180.67	0.8574	154.91	57.30	212.21	128%**	483.84	30	\$14,515
Extensive Services 3 Category (SE3)	241.26	0.8574	206.86	76.51	283.37	20%***	340.04	30	\$10,201
Impaired Cognition 2 Category (IA2)	123.22	0.8574	105.65	39.08	144.73	N/A	144.73	30	\$4,342
TOTAL								150	\$47,874

* Represents add-on to the rehabilitation RUGs as mandated by section 314 of the BIPA.

** Represents add-on for AIDS residents as mandated by section 511 of the MMA.

*** Represents add-on for 12 specific RUGs III levels as mandated by Section 101(a) of the BBRA.

The following table provides an example of the computation of the adjusted PPS rate for five of the 53 RUGs effective on January 1, 2006.

RUGs Group	Labor Portion	Wage Index	Adjusted Labor	Non-Labor Portion	Adjusted Rate	Percent Adjustment	Adjusted Amount	Medicare Days	Payment
Rehabilitation Very High Plus Extensive Services Category (RVX)	325.13	0.8574	278.77	103.11	381.88	N/A	381.88	30	\$11,456
Rehabilitation High Category (RHA)	225.47	0.8574	193.32	71.50	264.82	N/A	264.82	30	\$7,945
Clinically Complex 2 Category (CC2)	191.12	0.8574	163.87	60.61	224.48	128%*	511.81	30	\$15,354
Rehabilitation Low Plus Extensive Services Category (RLX)	223.99	0.8574	192.05	71.04	263.09	N/A	263.09	30	\$7,893
Impaired Cognition 2 Category (IA2)	127.40	0.8574	109.23	40.40	149.63	N/A	149.63	30	\$4,489
TOTAL								150	\$47,137
* Represents add-on for AIDS residents as mandated by section 511 of the MMA.									

ADMINISTRATIVE AND IMPLEMENTATION POLICIES

Qualifying Three-day Inpatient Hospital Stay

In the proposed rule, CMS sought comments regarding if it would be appropriate to modify the three-day inpatient hospital stay provision to include counting the time a patient spends in the hospital in an observation status toward the qualifying hospital stay/requirement for SNF coverage. CMS also sought comments on the need to differentiate between emergency room stays and observation status for purposes of this requirement. In the final rule, CMS noted that it is still reviewing these issues and is not ready to make a final determination.

14-Day Look-Back and Five-Day Grace Period Provisions

With regard to the 14-day look-back period, CMS asked for comments on the revision of the Minimum Data Set (MDS) Manual instructions to include only those special care services furnished after an SNF admission or re-admission. Such a provision could result in reduced payments. Also, CMS sought comments on policy options that could improve the accuracy of payments and the quality of care provided, without limiting access to post-acute care. Two examples provided by CMS were the use of the five-day grace period for PPS MDS assessments and the value of projecting anticipated therapy services during that five-day period.

CMS believes that all of these issues should be addressed as part of the forthcoming comprehensive examination of both the MDS 3.0 design initiative and the case-mix classification system.

Assessment Timeframes

In the proposed rule, CMS clarified the reasons for and calculation of the appropriate Assessment Reference Date (ARD) for an “Other Medicare Required Assessment” (OMRA). OMRAs are due eight to ten calendar days after cessation of all therapy services in all situations where the resident was assigned to a rehabilitation RUGs category on the previous assessment. CMS clarified that the “last day of therapy” is the last day on which therapy services were delivered and not the date the discharge order was written or received. When calculating the eight to ten days for the ARD following the “last day of therapy,” staff must count calendar days, not business days. In addition, when a resident goes on a therapeutic leave following the “last day of therapy,” those therapeutic leave days are included in the calendar days counted for determining the OMRA ARD.

The only further clarification made by CMS in the final rule is that the “due date” to which CMS refers is the ARD; it is the ARD of the OMRA that must be set eight to ten days after the cessation of the above mentioned activities.

SNF Certifications and Recertifications Performed by Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

NPs and CNSs involved in a direct or indirect relationship with a nursing home cannot perform the level of care certifications and recertifications of residents in that nursing home. CMS, in the proposed rule, clarified the definition of an “indirect” employment relationship as it pertains to an NP or CNS. Specifically, CMS identified the existence of an indirect employment relationship in terms of type of service performed by the practitioner. In response to comments, CMS has further clarified this provision as follows:

“an indirect employment relationship exists in situations where an NP or CNS meets both of the following conditions: 1) The NP or CNS has a direct employment relationship with an entity other than the SNF itself; and 2) The NP’s or CNS’s employer enters into an agreement with the SNF for the provision of bundled general nursing services to the SNF’s residents. Under this definition, an NP or CNS who is employed by an entity other than the SNF can still perform SNF certifications and recertifications, as long as his or her employer has not entered into such an agreement with the SNF.”

Concurrent Therapy

CMS sought comment on how to best prevent abuse of this therapeutic tool when it is not clinically justified. CMS will continue to monitor this issue and intends to address it during the forthcoming Staff Time Measurement study.

PAY FOR PERFORMANCE

In the proposed rule, CMS sought comment on various long-term payment and quality incentives. Regarding pay-for-performance initiatives, CMS agreed with the consensus among the commenters that a collaborative effort between CMS and health care community representatives and stakeholders is the key to the development of a viable program. CMS has had informal contact with stakeholders and has begun work on a pay- for-

performance model. CMS has contracted with Abt Associates to design a demonstration model.

CONCLUSION

In this final rule, CMS has reiterated what it stated in the proposed rule regarding the RUGs refinements. CMS believes that, while the BBRA had required revisions to the case-mix system, the BBRA revisions were incremental in nature and that the BIPA mandates CMS to implement changes to the SNF PPS of a more comprehensive and substantial nature. CMS indicates that a mandated report to Congress is forthcoming and that it will describe next steps with regard to a framework for future progress.