



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

FEDERAL FISCAL YEAR 2006 UPDATE

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OVERVIEW OF PROPOSED CHANGES—SNF PROSPECTIVE PAYMENT SYSTEM

On May 19, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule updating the Skilled Nursing Facility Prospective Payment System (SNF PPS) and consolidated billing provisions. The proposed 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. The provisions in the notice will result in essentially no increase in payment compared to FFY 2005. In addition, it will cause a redistribution of payments among providers. This is attributable to the increase in payments from the 3.0% marketbasket-based update and the Resource Utilization Groups (RUGs) case-mix refinements being offset by the elimination of the temporary rate add-ons.

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 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. CMS is proposing revisions to the case-mix classification system for FFY 2006; therefore, CMS is proposing to eliminate the temporary add-ons.

Case-Mix Refinements

Section 101 of the BBRA mandated that CMS implement case-mix refinements to better account for medically complex residents. In FFY 2001, CMS attempted to implement case-mix refinements. However, in validating its refinement, CMS concluded that the refinement explained an extremely low percentage of cost variation. Accordingly, CMS decided not to adopt the proposed case-mix refinement.

In this proposed rule, CMS has proposed another set of refinements:

Creation of Nine Additional RUGs Categories

In researching a case-mix refinement that would better account for medically-complex residents, CMS verified that non-therapy ancillary costs are higher for Medicare residents who classify into the Extensive Services category as opposed to the other categories. These high non-therapy ancillary costs are an indication of the complex clinical needs of these patients. However, many of these residents who would normally qualify into the Extensive Services category are instead classified into the Rehabilitation category because they also receive rehabilitation services. Identifying this subset of residents as medically complex, CMS eventually concluded that the addition of a combined group that includes Rehabilitation Services and Extensive Services would provide for an improvement in the accuracy of payments based on clinical needs and appropriate services rendered. CMS determined that the most practical refinement methodology would involve the addition of nine RUGs groups 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 addition, currently the upper 26 RUGs categories meet the administrative presumption of skilled-level care. CMS has determined 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 proposed new 53-group hierarchy are presumed to meet the SNF level of care. A crosswalk between the existing Rehabilitation Services group and the proposed Extensive plus Rehabilitation group can be found on page 29077 of the May 19 *Federal Register*.

Case-Mix Index Adjustments

CMS noted significant variability in non-therapy ancillary utilization both within and across RUGs groups. In addition, even with the addition of nine RUGs, CMS believed that non-therapy ancillary services were still not adequately accounted for. CMS further noted that the SNF PPS does not have an outlier policy to account for high variability in resource utilization. Therefore, as part of the case-mix refinement, CMS proposed to increase the case-mix index of all 53 RUGs III groups. In determining an appropriate 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. In order to reflect a proportionally similar amount for SNF PPS, CMS determined that an increase of 8.4% of the nursing component of the case-mix weights (which included non-therapy ancillaries) would be appropriate as this is estimated to increase SNF PPS payments by 3%.

Marketbasket Update

CMS has proposed to update to unadjusted federal rates by 3.0%, which represents the full marketbasket increase. This will be effective October 1, 2005.

Last year, CMS implemented an adjustment for forecast error in the calculation of the update factor. In reviewing the most recent year with final marketbasket data—2004—the actual increase in the marketbasket from 2003 was determined to be 3.1%. The estimated increase that CMS used in updating the rates previously was 3.0%. Since the change is under the threshold of 0.25 percentage points, there will not be a marketbasket forecast error adjustment included in the proposed FFY 2006 rates.

AIDS add-on

Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) implemented a 128% increase in residents with acquired immunodeficiency syndrome (AIDS) whose claims have diagnosis code 042. This 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 proposed rule address this problem and therefore, proposes to retain the AIDS add-on for FFY 2006.

SNF Wage Index

CMS will continue to base its SNF wage index on hospital-wage data and has determined the labor-related portion of the federal rate to be 76.087%. In the prior year SNF PPS update, CMS noted that the Inpatient Prospective Payment System (IPPS) redefined labor market areas; however, CMS refrained from applying this to the SNF PPS. In this proposed rule, CMS is proposing to use these redefined labor market areas, called core-based statistical areas (CBSAs), for FFY 2006. Unlike in the IPPS, CMS is not proposing a transition period or a hold-harmless provision.

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	\$137.44	\$103.53	\$13.63	\$70.15
Rural	\$131.30	\$119.38	\$14.56	\$71.45

All components reflect the 3.0% marketbasket.

Calculation of Payment Amount

The following table provides an example of the computation of the 44 RUGs III adjusted PPS rates for a SNF with a Wage Index of .8545, 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)	282.62	0.8545	241.50	88.82	330.32	6.7%*	352.45	30	\$10,574
Rehabilitation High Category (RHA)	218.40	0.8545	186.62	68.64	255.26	6.7%*	272.37	30	\$8,171
Clinically Complex 2 Category (CC2)	180.87	0.8545	154.55	56.84	211.39	128%**	481.98	30	\$14,459
Extensive Services 3 Category (SE3)	241.52	0.8545	206.38	75.91	282.29	20%***	338.74	30	\$10,162
Impaired Cognition 2 Category (IA2)	123.35	0.8545	105.40	38.77	144.17	N/A	144.17	30	\$4,325
TOTAL								150	\$47,691

* 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 53 group RUGs III adjusted PPS rate for a SNF **with a Wage Index of .8545**, 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)	310.03	0.8545	264.92	97.44	362.36	N/A	362.45	30	\$10,871
Rehabilitation High Category (RHA)	233.09	0.8545	199.18	73.26	272.44	N/A	272.44	30	\$8,173
Clinically Complex 2 Category (CC2)	184.01	0.8545	157.24	57.83	215.07	128%*	490.35	30	\$14,711
Rehabilitation Low Plus Extensive Services Category (RLX)	246.32	0.8545	210.48	77.42	287.90	N/A	287.90	30	\$8,637
Impaired Cognition 2 Category (IA2)	125.44	0.8545	107.19	39.43	146.62	N/A	146.62	30	\$4,399
TOTAL								150	\$46,790
* Represents add-on for AIDS residents as mandated by section 511 of the MMA.									

ADMINISTRATIVE AND IMPLEMENTATION POLICIES

CMS also seeks comment on several proposed changes to SNF PPS administrative and implementation policies that could provide additional Medicare savings.

Qualifying Three-day Inpatient Hospital Stay

CMS states that the SNF Medicare benefit was never intended to cover long-term, low-level custodial care. Rather, it was to serve as a less expensive alternative to the otherwise final, convalescent portion of an acute inpatient hospital stay lasting only several days. In keeping with this intent, Congress established the prerequisite of a prior inpatient hospital stay of no less than three days for SNF coverage. Since the enactment of this provision in 1965, hospital admission practices and policies have changed considerably, particularly in the area of emergency room admissions and observation stays. CMS seeks comment if it is appropriate to modify this provision to include counting the time a patient spends in the hospital in an observation status

towards the qualifying hospital stay requirement for SNF coverage. In this proposed rule, CMS also seeks comment on the need to differentiate between emergency room stays and observation status for purposes of this requirement.

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

CMS analyzed the Minimum Data Set (MDS) focusing on four items in the Special Services section that classify residents into the Extensive Care RUGs category and that have a 14-day look-back period: intravenous (IV) medications, suctioning, tracheostomy care, and the use of a ventilator or respirator. CMS noted in its analysis that many residents are classified into Extensive Services solely because of the receipt of such services in the acute setting prior to SNF admission and within the look-back period. CMS is seeking comment on the revision of MDS Manual instructions to include only those special care services furnished after a SNF admission or re-admission. Such a provision could result in reduced payments. In addition, CMS is seeking 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 are 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.

Assessment Timeframes

CMS clarifies in this proposed rule the reasons for and calculation of the appropriate Assessment Reference Date (ARD) for an “Other Medicare Required Assessment” (OMRA). OMRA 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 clarifies 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. Moreover, when calculating the eight to ten days for the ARD following the “last day of therapy,” staff must count calendar days, not business days. Finally, 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.

SNF Certifications And Recertifications Performed By Nurse Practitioners (NPs) And Clinical Nurse Specialists (CNSs)

There has been confusion about CMS’ policy on NPs and CNSs signing orders for the certification and/or recertification of a resident’s need for a skilled level of care. The confusion exists with the lack of clarity about an “indirect employment” relationship between NPs and CNSs and nursing homes in which they see residents. In this proposed rule, CMS restates that an indirect relationship exists whenever the NP or CNS performs designated physician tasks and provides other nursing services, such as those within the Part A SNF benefit. NPs and CNSs considered to be in a direct or indirect employment relationship with the nursing home cannot sign orders for certification or recertification.

Concurrent Therapy

CMS states it continues to receive reports of therapists being coerced by providers into conducting inappropriate concurrent therapy sessions to be more productive. Concurrent therapy sessions may be valid treatment tools when they are initiated by therapists due to valid clinical considerations. CMS is seeking comment on how to best prevent abuse of this therapeutic tool when it is not clinically justified.

PAY FOR PERFORMANCE

CMS notes that it has collaborated with nursing home providers on several broader initiatives that have produced significant improvements in quality of care and resident outcomes and indicates that pay for performance is yet another tool that could support further advancements in quality of care. CMS acknowledges that Medicare Part A pays for only a small portion of the nursing home care (approximately 10%), that short-term rehabilitation and traditional long-term care residents require a differing focus of care, and that quality measures that apply appropriately to these differing populations are very difficult to construct. CMS also wishes to move toward a

performance measurement model that coordinates an approach to payment for post-acute services that reach across settings and focuses on quality of care for the overall post acute episode, regardless of provider. Therefore, CMS is looking to pay for performance as a means to promote future quality of care for beneficiaries that spans the continuum of post-acute providers.

CMS is searching for strategies for developing payment policies that are budget-neutral regarding provider and setting but pay for quality care in the most appropriate setting throughout the duration of a post-acute care episode. This will require the comparison of clinical data across settings, which demands standardized electronic health records and an integrated assessment tool. This strategy also calls for CMS to transition from provider-centric payment approaches to patient-centric approaches based on patient characteristics and outcomes. Therefore, CMS seeks comments on payment reforms, both short- and long-term, that promote continuity of post-acute care and reward the avoidance of medical complications and additional costs of re-hospitalizations.

CONCLUSION

CMS is providing a comment period on this proposed rule. **Comments must be received by CMS by 5 p.m. on July 12, 2005.**

In addition, as stated above, CMS has indicated in the proposed rule that it considers the proposed RUGs III refinements to fulfill the mandate set forth by section 101 of the BBRA. However, it is CMS' belief that section 311(e) of the BIPA mandates CMS to implement changes to the SNF PPS of a more comprehensive and substantial nature than what CMS believes is the narrowly focused nature of the BBRA mandated changes. Section 311(e) of the BIPA states that:

“The Secretary of Health and Human Services shall conduct a study of the different systems for categorizing patients in Medicare skilled nursing facilities in a manner that accounts for the relative resource utilization of different patient types Not later than January 1, 2005, the Secretary shall submit to Congress a report Such report shall include such recommendations regarding changes in law as may be appropriate.”

In the proposed rule, CMS remarks that the report to Congress is forthcoming and that it will describe next steps with regard to a framework for future progress.