



WISCONSIN HOSPITAL  
ASSOCIATION, INC.

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**SUMMARY OF THE FFY 2007  
MEDICARE SKILLED NURSING  
FACILITY PROSPECTIVE PAYMENT  
SYSTEM UPDATE NOTICE**

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**August 2006**

## SUBMISSION OF COMMENTS

This document provides an overview of the Medicare update notice for the Skilled Nursing Facility Prospective Payment System (SNF PPS) for federal fiscal year (FFY) 2007. Additional information regarding the Skilled Nursing Facility PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/center/snf.asp>.

CMS normally provides for a period of public comment before provisions in a notice take effect. However, the notice does not enact any policy change within the SNF PPS. The notice only reflects the application of previously established methodologies that already have been subject to public comment. Therefore, CMS has waived a public comment period for this notice.

### I. OVERVIEW

In the July 31 *Federal Register*, CMS issued a notice updating the SNF PPS and consolidated billing provisions. The notice updates the payment rules under the SNF PPS for FFY 2007, which will be effective for services beginning October 1, 2006. All provisions of the final rule will also apply to SNF PPS payments for swing bed services in rural hospitals. The provisions in the notice will result in a nationwide increase of \$560 million in payment compared to FFY 2006.

### II. PAYMENT RATE

**Marketbasket Update** (*Federal Register* pages 43161-43162, 43171)

CMS will update the unadjusted federal rates by 3.1%, which represents the full marketbasket increase. This will be effective October 1, 2006.

In computing the update factor, CMS is required to adjust for forecast error. In reviewing the most recent year with final marketbasket data—2005—the actual increase in the marketbasket was determined to be 2.9%. The estimated increase that CMS used in updating the rates for FFY 2005 was 2.8%. Since the change is under the threshold of 0.25 percentage points, there will not be a marketbasket forecast error adjustment included in the FFY 2007 rates.

In constructing the SNF marketbasket, CMS relies on Bureau of Labor Statistics (BLS) data to obtain price proxies. The three categories of price proxies used are the Producer Price Index, Consumer Price Index, and Employment Cost Index (ECI). In 2006, the BLS' ECI switched from the Industrial Classification System, which no longer exists, to the North American Industrial Classification System. In light of this change, CMS welcomes input with regard to the continued use of the BLS ECI data. Comments can be directed to CMS via Jeanette Kranacs at (410) 786-9385 or Bill Ullman at (410) 786-5667.

**Wage Index** (*Federal Register* pages 43166, 43169-43170)

CMS will continue to base its SNF wage index on hospital wage data; however, the SNF PPS does not reflect the hospital area wage index's occupational mix adjustment, since that adjustment was designed to reflect occupational categories more clearly only within the hospital setting. In addition, CMS has determined the labor-related portion of the federal rate to be 75.839%.

In FFY 2006, CMS implemented redefined labor market areas, called Core-based Statistical Areas (CBSAs). They were phased in to the SNF PPS for FFY 2006 using a blend of 50% of the FFY 2006 Metropolitan Statistical Area-based wage index and 50% of the FFY 2006 CBSA-based wage index. For FFY 2007, CMS will use the full 2007 CBSA-based wage index values.

In applying the CBSAs along with their proper wage indices, the resulting aggregate nationwide payment is estimated to be less in FFY 2007 than the aggregate nationwide payments made last year. As a result, to fulfill the budget neutrality provision required by law in this instance, CMS is applying a budget neutrality adjustment to increase the payment rates by a factor of 1.0013. Added to the 3.1% marketbasket adjustment, this produces an increase in the payment rate of 3.23%. However, as indicated previously, once the decrease in payments resulting from application of the new wage index is factored in, the overall payment increase nationwide is 3.1%.

**AIDS add-on** (*Federal Register* pages 43160-43161, 43162)

Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) implemented a 128% increase in payment rates to 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 notice address this problem and therefore, retains the AIDS add-on for FFY 2007.

**Unadjusted Federal Rates** (*Federal Register* page 43162)

The unadjusted federal rates are as follows:

Area	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non-Case Mix
<b>Urban</b>	<b>\$142.04</b>	<b>\$106.99</b>	<b>\$14.09</b>	<b>\$72.49</b>
<b>Rural</b>	<b>\$135.70</b>	<b>\$123.37</b>	<b>\$15.05</b>	<b>\$73.83</b>
<i>All components reflect the 3.1% marketbasket.</i>				

**Calculation of Payment Amount** (*Federal Register* page 43170)

The following table provides an example of the computation of the 53 RUGs III categories' adjusted PPS rates for a SNF in a hypothetical CBSA, effective October 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)	335.28	0.8720	292.36	106.81	399.17	N/A	399.17	30	\$11,975
Rehabilitation High Category (RHA)	232.51	0.8720	202.75	74.07	276.82	N/A	276.82	30	\$8,305
Clinically Complex 2 Category (CC2)	197.08	0.8720	171.85	62.79	234.64	128%*	534.98	30	\$16,049
Rehabilitation Low Plus Extensive Services Category (RLX)	230.98	0.8720	201.41	73.59	275.00	N/A	275.00	30	\$8,250
Impaired Cognition 2 Category (IA2)	131.37	0.8720	114.56	41.85	156.41	N/A	156.41	30	\$4,692
<b>TOTAL</b>								<b>150</b>	<b>\$49,271</b>
* Represents 128% add-on for AIDS residents as mandated by section 511 of the MMA.									

### III. OTHER ISSUES

#### Post-Acute and Residential-Based Services (Federal Register page 43172)

CMS reiterates its desire to establish a payment model that provides for a more seamless system as it pertains to post-acute (SNF, inpatient rehabilitation, long-term care hospitals) and residential-based (home health, outpatient) services. CMS outlines major features of this more seamless system to include more consistent payments for the same type of care delivered in different settings, Value Based Purchasing incentives for providers, and a uniform patient assessment tool to support quality and discharge planning across settings.

One step toward that end is provided by Section 508 of the Deficit Reduction Act of 2005 (DRA). Specifically, a three-year demonstration project is slated to begin on January 1, 2008 that pertains to uniform assessment and data collection across different care settings. The ultimate goal is to “. . . create a discharge assessment tool that can serve to: facilitate post-hospital placement decision making; enhance the safety and quality of care during patient transfers through transmission of core information to a receiving provider; and provide baseline information for longitudinal follow-up of health and function.”

**Nursing Home Quality Campaign** (*Federal Register* page 43173)

This new program will build upon the Nursing Home Quality Initiative that was created in 2002. It will launch this fall of 2006 and will last through 2008. Its objective is to make a “. . . *difference in the quality of life and efficiency of care delivery in nursing homes, by accelerating progress in identifying and treating pain and pressure ulcers, by virtually eliminating the use of physical restraints, and by transforming the nursing home work environment to attract and retain nursing and other staff.*”

**Nursing Home Value-Based Purchasing Demonstration** (*Federal Register* page 43172)

CMS is developing a nursing home value-based purchasing demonstration project. This is connected to a comprehensive effort by CMS to “. . . *eliminate wasteful Medicare spending and improve quality of care*” in which nursing homes would be eligible for additional payment based upon performance in various quality measures.

**Skilled Level of Care**

In this notice, CMS is continuing its designation of the upper 35 groups of the RUG III 53 classifications as administrative presumption of the SNF level of care. Administrative presumption will continue to be applied to a beneficiary who is correctly assigned to one of the upper 35 RUG III groups upon completion of the initial five-day, Medicare required Minimum Data Set assessment.

**Consolidated Billing**

A number of modifications to consolidated billing requirements for SNFs have been enacted by legislation and implemented since the BBA established consolidated billing. Consolidated billing was most recently amended by section 410 of the MMA that excluded certain practitioner and other services furnished to SNF residents by rural health clinics and federally qualified health centers. Since CMS’ update notice for FY 2005 and the issuance of Program Transmittal #390 (Change Request #3575) in 2004 outlining that change, Congress has enacted no further legislation addressing consolidated billing requirements for SNFs. Therefore there are no new changes to consolidated billing requirements proposed in this update.