



**WISCONSIN HOSPITAL  
ASSOCIATION**

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**SUMMARY OF THE  
FFY 2008 FINAL RULE  
FOR THE MEDICARE PROSPECTIVE  
PAYMENT SYSTEM AND CONSOLIDATED  
BILLING FOR SKILLED NURSING FACILITIES**

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# PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED BILLING FOR SKILLED NURSING FACILITIES

## I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the final Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) rule for FFY 2008 in the August 3, 2007 *Federal Register*, which will be effective for services beginning October 1, 2007. All provisions of the final rule will also apply to SNF PPS payments for swing bed services in rural hospitals.

**Note:** Text in italics is extracted from either the May 4 or August 3, 2007 *Federal Register*.

## II. PAYMENT RATE

### Marketbasket Update for FFY 2008

*Federal Register* pages 43415 - 43416

CMS is required by law to provide a SNF marketbasket index that reflects changes over time in the prices of the appropriate mix of goods and services included in covered SNF services. Therefore, CMS in the final rule will provide a 3.3% marketbasket update for FFY 2008 based on Global Insight's second quarter 2007 forecast.

However, the Children's Health and Medicare Protection (CHAMP) Act of 2007, which has been introduced by the U.S House of Representatives, would eliminate the SNF marketbasket update for the period January 1, 2008 through September 30, 2008. It is uncertain whether this proposal will be included in any final legislative package that passes both chambers and is signed by the President.

### Revising and Rebased the SNF Facility Marketbasket Index

*Federal Register* pages 43425 - 43430

**Background:** Currently, the SNF marketbasket is based on fiscal year 1997 total facility costs, which includes costs not reimbursed under the SNF PPS (such as nursing facility, long-term care, home health agency, and intermediate care facility costs) for 21 cost categories. The data used for the 1997 based SNF marketbasket did not allow CMS to separate Medicare allowable costs from total facility costs, due to insufficient data.

CMS uses only freestanding SNF data to determine true costs for the marketbasket update each year since hospital-based SNF data would skew the marketbasket index due to allocations for overhead.

**CMS Proposal:** For FFY 2008, CMS proposed “. . . both to rebase and revise the SNF market basket to reflect 2004 Medicare allowable total cost data (routine, ancillary, and capital-related).” CMS' proposal was based on the most recent available Medicare cost report data, compared to the current methodology based on total facility costs, which resulted in similar cost weights. Therefore, CMS believes that “. . . using only Medicare allowable costs better reflects the cost structure of SNFs serving Medicare beneficiaries.”

In addition, CMS proposed to add two new cost categories; postage and professional liability insurance, to the current 21 cost categories. CMS also proposed new price proxies to replace current price proxies within some of the existing 21 cost categories.

**CMS Final Rule:** For FFY 2008 CMS will. “. . .rebase the market basket to reflect the changes in the average SNF’s cost structure from 1997 to 2004, as well as to revise the market basket to reflect more appropriate, industry-specific price proxies. . .” In addition, CMS has adopted the proposed cost categories; postage and professional liability insurance.

CMS received several comments regarding the proposed methodology to develop pharmaceutical cost-weights. Commenters were concerned that CMS’ methodology did not represent Medicaid drug expenses in the Medicare-allowable drug costs weights as proposed. According to comments received, nursing facilities that consist of dual-eligible beneficiaries, have drug costs directly reimbursed by Medicaid which are not reflected in the claims data. Therefore, these nursing facilities would not have submitted Medicaid claims for these pharmaceuticals because such claims would have been submitted by the dispensing local pharmacies instead. With the exception of drug expense, all other cost category weights reflect all payers, including Medicaid. As a result, CMS in the final rule included an estimate of Medicaid drug costs for purposes of recalculating the marketbasket weights.

*“We believe our current Medicare-allowable methodology, now adjusted to include an estimate of Medicaid drug expenses. . . , represents the best available technical methodology at this time.”*

For more details on CMS’ adopted weight methodologies refer to the pages referenced in the heading above.

CMS states that they will continue to work with industry stakeholders to further refine and rebase the marketbasket methodology. In addition, CMS seeks suggestions from the SNF community on how the SNF Medicare cost report forms can be improved to better capture data needed for marketbasket rebasing and revising.

## **Forecast Error Adjustment**

*Federal Register* pages 43424 – 43425

**Background:** Under current regulations, CMS is required to provide a marketbasket forecast error adjustment whenever the error exceeds a threshold of 0.25 percentage points. This threshold was established in the FFY 2004 final rule. This adjustment measures the difference between the forecasted and actual marketbasket increase against a specified threshold each year. For FFY 2007, the current SNF marketbasket forecast error threshold is set at 0.25 percentage points.

**CMS Proposal:** “. . . we are proposing to raise the 0.25 percentage point threshold for forecast error adjustments under the SNF PPS to 0.5 percentage point effective with FY 2008 . . . . The payment rates for FY 2008 do not include a forecast error adjustment, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2006 (the most recently available fiscal year for which there is final data) does not exceed the proposed 0.5 percentage point threshold.”

**CMS Final Rule:** “. . . we will use the 0.5 percentage point threshold to determine whether a forecast error adjustment is appropriate, effective for FY 2008 and subsequent years.” “We believe that a threshold of 0.5 percent represents an appropriate amount to draw a distinction between the kind of exceptional, unanticipated major increases in wages and benefits that initially gave rise to this policy, and the more typical minor variances that are inherent in statistical measurements.”

WHA strongly objected to this proposal since FFY 2006 is the first year subsequent to the establishment of the 0.25 percentage point threshold that the error of 0.3 percentage points exceeded and would result in a FFY 2008 rate increase. However, CMS in the final rule has adopted the 0.50 percentage point threshold for FFY 2008. Therefore, no forecast error adjustment is provided in FFY 2008.

## **AIDS Add-on**

*Federal Register* page 43416

**Background:** 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), as indicated by a diagnosis code 042 on the claim. This add-on is intended to remain in effect until the Secretary certifies there is an appropriate adjustment in the case mix that accounts for the costs of care provided to these residents. This provision was effective for services beginning on or after October 1, 2004.

**CMS Proposal:** CMS proposed to retain the AIDS add-on for FFY 2008, since no changes were proposed for the Resource Utilization Groups (RUGS) III.

**CMS Final Rule:** For FFY 2008 “. . . *the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, ... remains in effect.*”

## **Wage Index**

*Federal Register* pages 43420 - 43423

**Background:** In FFY 2006, CMS implemented redefined labor market areas, called Core-based Statistical Areas (CBSAs). CMS provided a phase-in to the SNF PPS for FFY 2006 using a blend of 50% of wage index values under the FFY 2006 Metropolitan Statistical Area and 50% of wage index values under the FFY 2006 CBSAs. In FFY 2007, CMS fully implemented the new labor market definitions using the CBSA-based wage index values.

**CMS Proposal:** “*Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. We propose to continue that practice for FY 2008, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage data is appropriate and reasonable for the SNF PPS.*”

**CMS Final Rule:** “*We are finalizing the wage index and associated policies as proposed for the SNF PPS for FY 2008. In addition, we note that we plan to evaluate any policies adopted in the FY 2008 IPPS final rule that affect the wage index, . . .*”

Under the SNF PPS, wage index values do not include the occupational mix adjustment, since that adjustment was designed to reflect occupational categories within the hospital setting only. For FFY 2008, based on the new marketbasket methodology, CMS has finalized the labor-related portion of the federal rate to be 70.152%.

In addition, the FFY 2008 budget neutrality factor will be 0.9993.

## Unadjusted Per Diem Federal Rates

*Federal Register* page 43416

CMS will provide the following unadjusted per diem federal rates for FFY 2008:

Area	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non-Case Mix
<b>Urban</b>	<b>\$146.62</b>	<b>\$110.44</b>	<b>\$14.54</b>	<b>\$74.83</b>
<b>Rural</b>	<b>\$140.08</b>	<b>\$127.35</b>	<b>\$15.54</b>	<b>\$76.21</b>

*All components reflect the 3.3% marketbasket.*

## Calculation of Payment Amount

The following table provides an example of the computation of the 53 RUGs III-adjusted PPS rates for a SNF with a wage index of 0.8588, effective October 1, 2007.

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)	<b>320.14</b>	<b>0.8588</b>	<b>274.94</b>	<b>136.21</b>	<b>411.14</b>	<b>N/A</b>	<b>411.14</b>	<b>30</b>	<b>\$12,334</b>
Rehabilitation High Category (RHA)	<b>222.01</b>	<b>0.8588</b>	<b>190.66</b>	<b>94.46</b>	<b>285.12</b>	<b>N/A</b>	<b>285.12</b>	<b>30</b>	<b>\$8,554</b>
Clinically Complex 2 Category (CC2)	<b>188.18</b>	<b>0.8588</b>	<b>161.61</b>	<b>80.07</b>	<b>241.68</b>	<b>128%*</b>	<b>551.03</b>	<b>30</b>	<b>\$16,531</b>
Rehabilitation Low Plus Extensive Services Category (RLX)	<b>220.55</b>	<b>0.8588</b>	<b>189.41</b>	<b>93.84</b>	<b>283.25</b>	<b>N/A</b>	<b>283.25</b>	<b>30</b>	<b>\$8,498</b>
Impaired Cognition 2 Category (IA2)	<b>125.44</b>	<b>0.8588</b>	<b>107.73</b>	<b>53.37</b>	<b>161.10</b>	<b>N/A</b>	<b>161.10</b>	<b>30</b>	<b>\$4,833</b>
<b>TOTAL</b>								<b>150</b>	<b>\$50,750</b>

\* Represents 128% add-on for AIDS residents as mandated by section 511 of the MMA.

A complete listing of the RUG-53 case-mix adjusted federal rates and associated indexes for urban and rural providers can be found in the *Federal Register* on pages 43418 – 43419.

### III. Consolidated Billing

*Federal Register* pages 43430 - 43432

**Background:** The Balanced Budget Act (BBA), which implemented the SNF PPS, included a provision for consolidated billing that required a SNF to submit consolidated Medicare bills to its fiscal intermediary for almost all of the services that its residents received during the course of a covered Part A stay. However, since the BBA a number of modifications have been enacted by legislation and implemented.

More specifically, the Balanced Budget Refinement Act of 1999 (BBRA) identified for exclusion from consolidated billing a number of service codes within four specified categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices).

In addition, the MMA excluded certain practitioner and other services furnished to SNF residents by rural health clinics and federally-qualified health centers.

**CMS Proposal:** Even though CMS proposed no new changes to consolidated billing requirements, they invited comments on codes in any of the four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) which represent recent medical advances that might meet exclusion from the SNF consolidated billing.

**CMS Final Rule:** “. . .the BBRA authorizes us to identify additional services for exclusion only within those particular service categories—chemotherapy and its administration; radioisotope services; and, customized prosthetic devices— that it has designated for this purpose, and does not give us the authority to create additional categories of excluded services beyond those specified in the law.” “To date, the Congress has enacted no further legislation affecting the consolidated billing provision.”

The recommendations received for additional exclusions do not fall within one of the specific service categories designated for this purpose in the statute itself. Therefore, these services remain subject to consolidated billing for FFY 2008.

### IV. OTHER ISSUES

#### Skilled Level of Care

*Federal Register* pages 43423 - 43424

**Background:** Currently, CMS uses the upper 35 groups of the RUG-53 classification system to represent the required SNF level of care. More specifically, for purposes of an administrative presumption CMS refers to the following RUG-53 classifications: “. . . All groups within the Rehabilitation plus Extensive Services category; all groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; all groups within the Special Care category; and, all groups within the Clinically Complex category.”

An administrative presumption will to be applied to a beneficiary who is correctly assigned to one of the upper 35 RUG-53 groups upon completion of the initial five-day, Medicare required Minimum Data Set assessment.

**CMS Final Rule:** “In this final rule, we continue the designation of the upper 35 groups for purposes of this administrative presumption. . .”