



**WISCONSIN HOSPITAL  
ASSOCIATION**

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**SUMMARY OF THE  
FFY 2009 FINAL RULE  
FOR THE MEDICARE PROSPECTIVE  
PAYMENT SYSTEM AND  
CONSOLIDATED BILLING FOR SKILLED  
NURSING FACILITIES**

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# TABLE OF CONTENTS

I.	Overview .....	3
II.	Payment Rate .....	3
	- Marketbasket Update .....	3
	- Case-Mix Refinements .....	3
	- Forecast Error Adjustment.....	4
	- AIDS Add-on.....	4
	- Wage Index.....	4
	- Multi-Campus Hospital Wage Index Data .....	5
	- Unadjusted Per Diem Federal Rates .....	5
	- Calculation of Payment Amount .....	6
III.	Consolidated Billing .....	6
IV.	Future Proposals .....	7
	- Staff Time and Resource Intensity Verification (STRIVE) Project .....	7
	- Minimum Data Set (MDS) 3.0 .....	7
	- Integrated Post-Acute Care Payment.....	8

# 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 2009, which will be effective for services beginning October 1, 2008, in the August 8, 2008 *Federal Register*. All provisions of the proposed rule will also apply to SNF PPS payments for all non-Critical Access Hospital (CAH) swing bed services in rural hospitals.

**Note:** Text in italics is extracted from either the May 7, 2008 *Federal Register* or the August 8, 2008 *Federal Register*.

Major provisions of the rule include:

- **Marketbasket Update:** CMS will apply a full marketbasket update of 3.4% for FFY 2009.
- **Recalibration of SNF Rates:** CMS did not adopt their proposal, which would have reduced SNF payments by 3.3% in FFY 2009 to account for changes in coding behavior due to the expansion of the Resource Utilization Groups (RUGs) implemented in FFY 2006.

## II. PAYMENT RATE

### Marketbasket Update

*Federal Register* pages 46418 - 46419

**Background:** 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. In FFY 2008, CMS revised and rebased the marketbasket, updating the base year from FFY 1997 to FFY 2004.

**CMS' Proposal:** For FFY 2009, CMS proposed “. . . a marketbasket increase of 3.1 percent.”

**CMS' Final Rule:** For FFY 2009, the “. . . market basket increase is 3.4 percent.” This marketbasket update is based on Global Insight's second quarter 2008 forecast.

*“The final budget neutrality factor for this year is 1.0009.”*

Based on the relative weights from the SNF marketbasket, CMS is decreasing the labor-related share of the federal rates from 70.249% in FFY 2008 to 69.783% in FFY 2009.

### Case-Mix Refinements

*Federal Register* pages 46421 - 46426

**Background:** The FFY 2006 SNF PPS final rule expanded the original 44-group RUG-III model to include nine additional case-mix groups, called the 53-group RUG-III model. The additional groups had higher case-mix weights, reflecting the resource needs for patients requiring extensive medical and rehabilitation services. The case-mix indexes (CMIs) for the 53 new RUGs were developed using 2001 claims data and resulted in lower case-mix weights for some of the older RUGs categories. To maintain budget-neutrality, CMS compared estimated payments under the old 44-group RUGs to payments under the new 53-group RUGs and,

based on that comparison, adjusted the 53-group RUG weights upward by 17.9%.

**CMS' Proposal:** For FFY 2009, CMS reviewed 2006 claims data and observed that actual utilization of the nine new, higher weighted RUGs was significantly higher than projections, which were based on 2001 data. Therefore, the FFY 2009 RUGs CMI will be decreased to recoup the overpayments that the program made in excess of budget neutrality—CMS states that the FFY budget neutrality adjustment should have been 9.68%.

**CMS' Final Rule:** For FFY 2009 CMS is “... *not proceeding with the proposed recalibration at this time, pending further analysis.*” Due to the potential ramifications of the above proposal and the complexity of the issues involved, CMS believes “...*that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it.*”

## **Forecast Error Adjustment**

*Federal Register* pages 46434 - 46435

**Background:** CMS is required to provide a marketbasket forecast error adjustment to SNF providers whenever the actual marketbasket increase differs from CMS' projection by a certain threshold. This adjustment measures the difference between the forecast and actual marketbasket increase against a specified threshold each year. Originally, as established in the FFY 2004 final rule, the threshold was defined by a cost differential of 0.25% or more. Effective FFY 2008, the SNF marketbasket forecast error threshold was set at 0.50%.

**CMS' Proposal:** For FFY 2009, CMS proposed that, “... *payment rates . . . do not include a forecast error adjustment.*” Based on the most recent data available, CMS concluded that “... *the estimated increase in the market basket index was 3.1 percentage points, while the actual increase was 3.1 percentage points, resulting in no difference. Accordingly, as the difference between the estimated and actual amount of change does not exceed the 0.5 percentage point threshold . . . .*”

**CMS' Final Rule:** “. . . *the payment rates for FY 2009 do not include a forecast error adjustment.*”

## **AIDS Add-on**

*Federal Register* pages 46420 - 46421

**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 of Health and Human Services certifies there is an appropriate adjustment in the case mix to account for the cost of care provided to these residents. This provision was effective for services beginning on or after October 1, 2004.

**CMS' Proposal:** For FFY 2009, CMS proposed “. . . *the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA, remains in effect.*”

**CMS' Final Rule:** For FFY 2009, CMS is adopting the above proposal without modification.

## **Wage Index**

*Federal Register* pages 46426 - 46430

**Background:** The SNF PPS adjusts the federal rates to account for differences in area wage levels. In the absence of SNF-specific wage data, CMS uses the pre-reclassified, pre-rural floor inpatient acute care hospital

wage indexes for the SNF PPS. CMS believes the actual location of the SNF is most appropriate for determining the wage adjustment; hospitals that are geographically reclassified for an inpatient acute payment do not receive the reclassified wage index for a SNF payment and there is no provision for a rural floor. In addition, CMS does not apply the out-migration adjustment to the SNF PPS wage index because this policy only pertains to the Inpatient PPS.

**CMS’s Final Rule:** For FFY 2009, CMS has adopted no change to the current wage index methodology. “...the final budget neutrality factor...is 1.0009.”

## Multi-Campus Hospital Wage Index Data

*Federal Register* pages 46427 - 46430

**Background:** A multi-campus hospital is a single, integrated institution that has one provider number and submits a single cost report that combines the entire institution’s total wages and hours for each of its campuses, which is included in the calculation of the wage index for that labor market area. However, in FFY 2005, CMS implemented revised wage areas based on Core-based Statistical Areas (CBSAs), which caused some multi-campus hospitals to be located in more than one CBSA, rather than in a single labor market area. Multi-campus hospitals were still required to report wage data in the labor market area of the hospital campus associated with the provider number, even though some of the hospital’s staff were working at different campuses in more than one labor market area.

In FFY 2008, CMS implemented the use of FTEs or Medicare discharge data to allocate salaries and hours to the campuses of multi-campus hospitals that are located in different labor markets. CMS will continue to use this method until revisions are made to Worksheet S-3 of the Medicare cost report that would require the reporting of FTE data by campus.

**CMS’ Final Rule:** For FFY 2009, CMS will continue to allow hospitals the option of allocating their wages and hours based on either FTEs or discharge data.

## Unadjusted Per Diem Federal Rates

*Federal Register* page 46421

The final unadjusted per diem federal rates for FFY 2009 are as follows:

Area	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non-Case Mix
<b>Urban</b>	<b>\$151.74</b>	<b>\$114.30</b>	<b>\$15.05</b>	<b>\$77.44</b>
<b>Rural</b>	<b>\$144.97</b>	<b>\$131.80</b>	<b>\$16.08</b>	<b>\$78.87</b>

*All components reflect the 3.4% 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 in a hypothetical CBSA, effective October 1, 2008.

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)	\$329.57	0.8919	\$293.94	\$142.71	\$436.65	N/A	\$436.65	14	\$6,113
Rehabilitation High Category (RHA)	\$228.55	0.8919	\$203.84	\$98.97	\$302.81	N/A	\$302.81	16	\$4,845
Clinically Complex 2 Category (CC2)	\$193.72	0.8919	\$172.78	\$83.89	\$256.67	128%*	\$585.21	10	\$5,852
Rehabilitation Low Plus Extensive Services Category (RLX)	\$227.05	0.8919	\$202.51	\$98.32	\$300.83	N/A	\$300.83	30	\$9,025
Impaired Cognition 2 Category (IA2)	\$129.13	0.8919	\$115.17	\$55.92	\$171.09	N/A	\$171.09	30	\$5,133
<b>TOTAL</b>								<b>100</b>	<b>\$30,968</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 46424 - 46426.

## III. CONSOLIDATED BILLING

*Federal Register* pages 46435 - 46437

**Background:** The Balanced Budget Act of 1997 (BBA), which implemented the SNF PPS, required a SNF to submit consolidated Medicare bills to its fiscal intermediary for nearly all of the services that its residents received during the course of a covered Part A stay. Subsequent to the BBA a number of modifications were enacted by legislation and implemented.

Specifically, the Balanced Budget Refinement Act of 1999 (BBRA) identified service codes within four specified categories (chemotherapy items, chemotherapy administration services, radioisotope services, and

customized prosthetic devices) as exclusions from consolidated billing.

In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) excluded certain practitioners and other services furnished to SNF residents by rural health clinics and federally qualified health centers.

**CMS' Final Rule:** For FFY 2009, CMS has adopted no change to the current consolidated billing provision.

## IV. FUTURE PROPOSALS

### Staff Time and Resource Intensity Verification (STRIVE) Project

*Federal Register* pages 46430 - 46431

**Background:** The inception of the SNF PPS included the development of the RUG-III case-mix classification system. Staff time measurement (STM) studies were used to establish resource use, patient characteristics, and case-mix indexes. Subsequently, CMS became concerned that changes in provider practices, technology, and population mix have affected the nursing resources required to treat different types of patients. In 2005, CMS sponsored a national nursing home time study called STRIVE. CMS' preliminary analyses of RUG-III resource times and payment rates indicated that SNF care patterns have changed significantly over the past decade.

**CMS' Proposal:** *"It is our intention to introduce new case-mix weights in FY 2010 that reflect the results of the STRIVE analysis and any changes to the RUG classification structure."*

**CMS' Final Rule:** CMS will continue to analyze the STRIVE data and intends to create an updated RUG classification structure that will more accurately reflect current care practices and resource use.

More information about STRIVE is available at <https://www.qtso.com/strive.html>.

### Minimum Data Set (MDS) 3.0

*Federal Register* page 46431

**Background:** The Omnibus Budget Reconciliation Act of 1987 requires the Secretary of Health and Human Services to specify a minimum data set of core elements to be used in performing comprehensive assessments of nursing home patients.

**CMS' Proposal:** *"We intend to develop ways to adapt the RUG system to the MDS 3.0 assessment instrument as part of the STRIVE study. We would then finalize changes to the MDS 3.0 and any necessary adaptations to the RUG classification system."*

**CMS' Final Rule:** CMS will continue to develop a new version of the MDS, with implementation in FFY 2010. The MDS 3.0 will more accurately reflect residents' clinical, cognitive, and functional status.

### Integrated Post-Acute Care Payment

*Federal Register* pages 46431 - 46432

**Background:** Post-acute care (PAC) services are provided in multiple settings, including SNFs, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities. Each of these provider types has separate Medicare payment systems and patient assessment tools. In the FFY 2007 SNF PPS update notice, CMS introduced its plans to refine the PAC payment system in order to create a more seamless delivery of PAC: *“The new model will focus on beneficiary needs rather than provider type and will be characterized by more consistent payments for the same type of care across different sites of service, quality-driven pay-for-performance incentives, and collection of uniform clinical assessment information to support quality and discharge planning.”* CMS implemented the PAC Payment Reform Demonstration (PAC-PRD), which developed a standardized patient assessment tool, the Continuity Assessment Record and Evaluation (CARE) tool, to be used among all PAC providers.

**CMS’ Final Rule:** *“We will continue to evaluate the CARE tool closely during the remainder of the current demonstration, . . .”*

*“. . .we would expect to work closely with stakeholders to determine which conditions could reasonably be prevented through the application of evidence-based guidelines. With regard to the comments that questioned the existing legal authority for expanding the HAC payment provision beyond the IPPS hospital setting, we note that in this final rule, we are not establishing any new Medicare policies in this area.”*