



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE
FFY 2010 FINAL RULE
FOR THE MEDICARE PROSPECTIVE
PAYMENT SYSTEM AND
CONSOLIDATED BILLING FOR SKILLED
NURSING FACILITIES**

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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 2010 in the August 11, 2009 *Federal Register*. It will be effective for services beginning October 1, 2009. All provisions of the final 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 12 *Federal Register* (proposed rule) or August 11, 2009 *Federal Register* (final rule).

Major provisions of the rule include:

- **Marketbasket Update:** CMS will provide a full marketbasket update of 2.2% for FFY 2010.
- **Recalibration of SNF Rates:** CMS has adopted its proposal to apply a 3.3% reduction to SNF PPS payments for FFY 2010 due to recalibrating the case-mix index because of unexpected increases that occurred when CMS expanded the Resource Utilization Groups (RUGs) in 2006.
- **Parity Adjustment:** CMS is adopting its proposal to apply a 59.4% “parity adjustment” to account for utilization changes caused by the shift when moving to a RUG-IV model from a RUG-III model, with implementation in FFY 2011.

II. PAYMENT RATE

Marketbasket Update

Federal Register page 40351 - 40352

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’ Final Rule: For FFY 2010, CMS will provide a “. . . marketbasket increase . . . 2.2 percent, which is based on IHS Global Insight, Inc. second quarter 2009 forecast . . .”

Recalibration of Case Mix

Federal Register pages 40294 - 40300

Background: The FFY 2006 SNF PPS final rule expanded the original 44-group RUG-III model to include nine additional Rehabilitation Plus Extensive Services RUGs, for a total of 53 groups. 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 estimated payments made under the 44-group RUGs to what CMS anticipated would be made under the 53-group RUGs, and adjusted the 53-group RUG weights upward by 17.9% to neutralize the CMIs.

In the FFY 2009 proposed rule, CMS indicated that actual patterns under the refined case-mix system differed significantly from what CMS had projected. Therefore, CMS proposed, but never adopted, the provision to recalibrate the parity adjustment to restore the intended budget neutrality to the 2006 case-mix refinements. CMS determined that the 17.9% increase, intended to create budget neutrality, actually increased overall payments under the 53-group model, resulting in overpayments to SNFs.

CMS' Proposal: For FFY 2010, CMS proposed “. . . to proceed with the recalibration using the methodology described in the FFY 2009 proposed and final rules.” Instead of the original 17.9% increase, “. . . this proposed recalibration, the parity and NTA [non-therapy ancillary] adjustments to the CMI, would instead result in an overall 9.68% increase for FFY 2010. Thus, for FFY 2010, the aggregate impact of this proposed recalibration of the CMIs would be the difference between payments calculated using the original FFY 2006 total CMI increase of 17.9% and payments calculated using the recalibrated total CMI increase of 9.6%. The difference is a decrease of \$1.05 billion in payments for 2010.”

CMS' Final Rule: For FFY 2010, CMS has adopted the above proposal as final.

Forecast Error Adjustment

Federal Register page 40352

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. For FFY 2008 and subsequent years, CMS has set the SNF marketbasket forecast error threshold at 0.50%.

CMS' Final Rule: For FFY 2010, CMS will “. . . not include a forecast error adjustment.”

AIDS Add-on

Federal Register pages 40290 - 40291

Background: Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 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 (HHS) 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' Final Rule: For FFY 2010, CMS has adopted no change to the AIDS add-on of 128%. CMS will continue to study this issue to develop an alternative to this add-on payment.

Wage Index

Federal Register pages 40300- 40304

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' Proposal: For FFY 2010, CMS proposed “. . . that in the absence of SNF-specific wage data, using the hospital inpatient wage index is appropriate and reasonable for the SNF PPS”

CMS' Final Rule: For FFY 2010, CMS has adopted the above proposal as final. In addition, “. . . the budget neutrality factor for this year is 1.0010.”

Based on the relative weights from the SNF marketbasket, CMS is increasing the labor-related share of the

federal rates from 69.783% in FFY 2009 to 69.840% in FFY 2010.

Unadjusted Per Diem Federal Rates

Federal Register page 40293

The final unadjusted per diem federal rates for FFY 2010 are as follows:

| Area | Nursing Case Mix | Therapy Case Mix | Therapy Non-Case Mix | Non-Case Mix |
|--------------|------------------|------------------|----------------------|----------------|
| Urban | \$155.23 | \$116.93 | \$15.40 | \$79.22 |
| Rural | \$148.31 | \$134.83 | \$16.45 | \$80.69 |

All components reflect the 2.2% 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 Core-based Statistical Area (CBSA), effective October 1, 2009.

| 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) | \$327.11 | 0.8790 | \$287.53 | \$140.08 | \$427.61 | N/A | \$427.61 | 14 | \$5,987 |
| Rehabilitation High Category (RHA) | \$227.86 | 0.8790 | \$200.29 | \$97.57 | \$297.86 | N/A | \$297.86 | 16 | \$4,766 |
| Clinically Complex 2 Category (CC2) | \$188.89 | 0.8790 | \$166.03 | \$80.89 | \$246.92 | 128%* | \$562.98 | 10 | \$5,630 |
| TOTAL | | | | | | | | 100 | \$16,383 |

** 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 40298 - 40300.

III. CONSOLIDATED BILLING

Federal Register pages 40352 - 40356

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

Specifically, the Balanced Budget Refinement Act (BBRA) of 1999 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, 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 2010, CMS has adopted no change to the consolidated billing provision.

IV. FFY 2011 PROPOSALS

RUG-IV Classification System

Federal Register pages 40304 - 40342

Background: The inception of the SNF PPS included the development of the RUG-III case-mix classification system. Staff time measurement 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 had affected the nursing resources required to treat different types of patients. In 2005, CMS sponsored a national nursing home time study called the Staff Time and Resource Intensity Verification (STRIVE) Project. Information collected via STRIVE includes the amount of time that staff members spend on residents, information on residents' physical and clinical status derived from Minimum Data Set (MDS) assessment data, and the resources used to deliver services to residents. CMS' preliminary analyses of RUG-III resource times and payment rates indicated that SNF care patterns have changed significantly over the past decade.

The STRIVE analyses have indicated that the RUG-III model is still effective in determining relative nursing resource use across a broad range of conditions. However, the resources and staff times associated with specific conditions and treatments, such as diabetes, the use of intravenous fluids or medications, and the increased use of concurrent therapy, has changed significantly.

RUG-IV Model

CMS' Proposal: For FFY 2011, CMS proposed to move from a RUG-III model to a RUG-IV model. CMS states: *"In the RUG-IV model, we propose modifying the eight levels of the hierarchy and increasing the number of case-mix groups from 53 to 66."*

CMS' Final Rule: For FFY 2010, CMS will continue to use the same RUG III classification structure. However, for FFY 2011 CMS will move from the RUG-III model to a RUG-IV model with some modifications as shown below.

Administrative Presumption of Skilled Level of Care

CMS' Final Rule: CMS will continue this existing policy with implementation of RUGs IV. All residents classified into one of the upper 52 groups in the following RUGs IV categories, by completion of the required Medicare five-day MDS assessment, will be presumed to meet SNF coverage requirements at the beginning of their stay. The categories include Rehabilitation Plus Extensive Services, Ultra High Rehabilitation, Very High Rehabilitation, Low Rehabilitation, Extensive Services, Special Care High, Special Care Low, and Clinically Complex.

Special Qualifying Conditions

CMS' Final Rule: In CMS' analysis of STRIVE data, the agency examined the documentation of special

clinical qualifiers on classifying a resident into a particular category. CMS determined from that review that previous assumptions about clinical qualifiers being a proxy for higher resource use and costs have not been proven by the data. Therefore, CMS is making several changes to the use of some clinical qualifiers in selected RUGs IV categories.

- “Removal of suctioning as an independent qualifier” in the Extensive Services Category;
- “Dropping Aphasia;
- Fever with feeding tube has been added to Special Care High; Dehydration has been deleted as a qualifier in any category, including the Special Care and Clinically Complex categories;
- Eliminating the physician orders” and “internal bleeding” qualifiers from the Clinically Complex category, but retaining transfusions;
- “Respiratory failure in combination with oxygen therapy classifies a resident in the Special Care Low category, while oxygen therapy alone will qualify a resident into Clinically Complex; and
- A patient will also qualify in the Special Care Low category if one of the following is present along with two or more skin treatments:
 - 2 or more venous/arterial ulcers; or
 - one Stage 2 pressure ulcer and one venous/arterial ulcer.”

Non-Therapy Ancillaries

CMS’ Final Rule: CMS received several comments on the ongoing changes in the standards of care in long-term care that result from its role in the health care continuum. These changes in care standards impose increasing non-reimbursed costs on nursing homes. CMS states a need for “. . . a separate method to reimburse for non-therapy ancillaries (NTAs), such as IV medications and pharmaceutical We are committed to developing an NTA classification system as quickly as possible to recognize these higher costs.”

Parity Adjustment

CMS projects future utilization patterns under RUG-IV would produce lower overall payments than it would under the RUG-III model.

CMS’ Proposal: To maintain budget neutrality when moving from RUG-III to RUG-IV, CMS proposed a “parity” adjustment, stating, “The adjustment to the nursing weights necessary to achieve ‘parity’ is an upward adjustment of 52.6 percent.”

CMS’ Final Rule: For FFY 2011, CMS is adopting its proposal to adjust the nursing CMIs to achieve parity when the RUG-IV model is implemented. However, based upon updated data analysis, the adjustment necessary to achieve parity will be an upward adjustment of 59.4%.

Concurrent Therapy

Concurrent therapy is the practice of one professional therapist treating multiple patients at the same time while the patients are performing different activities.

CMS’ Proposal: CMS proposed changes to the current reporting and allocation of concurrent therapy time. CMS proposed “. . . to use allocated concurrent therapy minutes in developing the RUG-IV therapy model.”

As a result, “. . . a therapist who is treating patients concurrently would allocate the total minutes among the patients based on the therapist’s clinical judgment of how much therapist time was actually provided to each patient.”

“. . . we are proposing that we calculate the appropriate therapy level by using items that will be reported on the MDS 3.0: the actual number of therapy minutes provided, the date of admission, the date therapy started, the patient’s ADL level, and the assessment reference date (ARD), to assign a therapy group.”

CMS' Final Rule: For FFY 2011, CMS is adopting the above proposal on concurrent therapy treatments and states “. . . *delivery of therapy services should be based on the therapist's professional and clinical judgment solely according to the individual needs of each patient.*”

In addition, CMS “. . . *believes the clinical knowledge and expertise of the therapy associations is a proper benchmark for determining the allowable number of patients during a concurrent session, and we agree that a therapist (or assistant) should treat no more than two patients concurrently.*” CMS is not imposing a specific cap on the amount of concurrent therapy that can be coded on the MDS at this time. However, CMS “. . . *will require the therapist to track and report the three different delivery modes of therapy (individual, concurrent, and group) on the MDS 3.0.*” and states that they will evaluate this issue for future years' rulemakings based on their review of these new data.

Minimum Data Set 3.0

Federal Register pages 40342 - 40349

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

In STRIVE, CMS collected updated assessment, staff time, and resource utilization data and tested new MDS data elements to refine the RUG reimbursement system. CMS' goal in updating the MDS model is to introduce advances in assessment measures, increase relevance of items, improve accuracy and validity of the tool, and increase knowledge of residents' experience of care by introducing more residents' interview items.

MDS 3.0

CMS' Proposal: “*Effective October 1, 2010, MDS 3.0 will become the required version of the MDS for all Medicare SNFs and Medicaid-certified nursing facilities (NFs).*” CMS has developed the MDS 3.0 to more accurately reflect each resident's status and the care the nursing home provides the resident.

CMS also proposed “. . . *to require LTC facilities to transmit MDS data to the national CMS System, instead of the states, within 14 days after the facility completes a resident's assessment.*”

CMS' Final Rule: CMS is adopting the above proposals as final.

Look-Back Period

CMS' Proposal: CMS proposed “. . . *to modify the look-back period under RUG-IV for those items in Section P1a of the MDS 2.0, to include only these services that are provided after admission (or readmission) to the SNF.*”

CMS' Final Rule: CMS believes “. . . *it is appropriate to eliminate the look-back to the hospital stay for P1a services, rather than adopt a shorter look-back period.*”

Section T of the RAI

CMS' Proposal: CMS proposed “. . . *to eliminate Section T of the RAI. In addition . . . proposed (a) to revise the therapy reporting procedures related to short-stay patients so that the appropriate therapy level is calculated using items that will be reported on the MDS 3.0 (using the procedures set forth in the proposed rule); (b) to provide SNFs with the option to use the Other Medicare Required Assessment (OMRA) to signal the start of therapy; and (c) to require SNFs to complete an OMRA with an ARD that is set one to three days (rather than eight to ten days) from the last day therapy services were provided.*”

CMS' Final Rule: Effective October 1, 2010, CMS “. . . *will eliminate section T of the MDS and revise the therapy reporting procedures as proposed. . . . (that is, reporting procedures for short-stay patients,*

implementation of an optional start-of-therapy OMRA, and revised ARD for the end-of-therapy OMRA) . . .
.”

V. OTHER PROPOSALS

Integrated Post-Acute Care Payment

Federal Register pages 40292 - 40293

Background: Post-acute care (PAC) services are provided in multiple settings, including SNFs, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities (IRFs). 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 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: CMS is currently collecting data from SNFs, IRFs, home health agencies, and long-term care hospitals to help predict the need for post-hospital care across the four settings.

Quarterly Reporting of Nursing Home Staffing Data

Federal Register pages 40349 - 40351

Background: Nursing staffing data and census data are used to rate nursing homes on quality. Nursing staffing data for each facility are adjusted for the case mix of the residents in the nursing home and then divided by the nursing home census to calculate the average number of hours of care per day provided by the different types of nursing staff. Optimal hours of care and average hours of care for each case-mix group are used as a basis for rating the staffing in the nursing home. Currently, this information is collected once a year and there are concerns about the accuracy and reliability of the data.

CMS’ Proposal: CMS is considering requiring “. . . nursing homes to report nursing staffing data to CMS on a quarterly basis. The data would be reported through an electronic system and would be based on nursing home payroll data”

CMS’ Final Rule: CMS received numerous comments regarding the submission of nursing staffing data, and will consider them when developing the final system.

Application of SNF PPS and Quality Monitoring to Swing Bed Units

Federal Register pages 40356 - 40357

Background: Under BBA, swing bed facilities were to be incorporated into the SNF PPS by June 30, 2002. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed services in rural, non-CAHs were paid based on the SNF PPS.

The SNF PPS covers all non-CAH swing bed costs (ancillary, routine, and capital) related to covered services

furnished to beneficiaries under Medicare Part A. The SNF PPS relies on information from a resident assessment instrument to classify residents into one of 53 RUGs categories for payment purposes. Swing bed hospitals are required to use a special two-page assessment form to meet this requirement, known as the Swing Bed MDS.

Under the RUG-III payment model, swing bed hospitals have not been comprehensively monitored for quality of care, but have been required to submit four types of abbreviated MDS assessments, used to determine payment under the SNF PPS, entry and discharge tracking assessments, the clinical change assessments, and the Other Medicare Required Assessments. The limited use of the MDS for quality monitoring was established because CMS believed that swing bed units, as parts of rural hospitals, were already subject to the hospital quality review process.

Moreover, CMS' analyses showed that the average length of stay in swing bed facilities was significantly lower than in either hospital-based or freestanding SNFs, and that the existing SNF PPS quality measures might be unable to evaluate short-stay patient care accurately. In the FFY 2002 final rule, CMS did not *"require swing-bed facilities to perform the care planning and quality monitoring components included in the full MDS . . ."* However, CMS did indicate it would include swing bed requirements in any future analysis and comprehensive evaluation *"of all post-acute data needs, and in the design of any future assessment and data collection tools."* Effective June 30, 2003, all non-CAH swing-bed rural hospitals were paid under the SNF PPS.

A complete discussion of assessment schedules, MDS, and the transmission software (RAVEN-SB for Swing Beds) appears in the final rule for FFY 2002. The latest changes in the MDS for swing bed rural hospitals appear on the SNF PPS Web site at <http://www.cms.hhs.gov/snfpps>.

CMS' Proposal: For FFY 2011, CMS proposed *" . . . to eliminate the SB-MDS, and replace it with the MDS 3.0 equivalent of the Medicare Payment Assessment Form (MPAF) that captures all of the items used in determining quality measures Therefore, all rates and wage indexes outlined in . . . this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals."*

CMS' Final Rule: CMS does not require non-CAH swing beds to meet quality measures in this final rule; however, CMS will begin a focused data collection and review process on swing bed services, stating, *"We will not be able to make a sound decision unless we first gather the data to determine the best avenue for measuring quality similar to SNFs."*

Beginning October 1, 2010 (FFY 2011), CMS *" . . . will limit the items to be collected in the MDS 3.0 swing-bed assessment to the required demographic, payment, and quality items. The MDS 3.0 swing-bed assessment will be similar to the MDS 3.0 MPAF; however, it will contain fewer items, as the MPAF includes clinical items that are not required for payment of quality measures."*

CMS will use the data collected to perform an analysis to determine:

- *"Whether the length of stay in swing beds is adequate to measure changes (or outcomes) in patient care;*
- *Whether these changes are measurable and attainable; and*
- *Which quality measures are appropriate?*

Because CAHs are not subject to SNF PPS and MDS requirements at this time, they will not be required to complete the MDS 3.0 and, thus, are not affected by the policy to collect quality data from swing beds based on MDS data."