



WISCONSIN HOSPITAL  
ASSOCIATION

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

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**May 2009**

## SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Skilled Nursing Facility Prospective Payment System (SNF PPS) for federal fiscal year (FFY) 2010. Additional information regarding the SNF PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/SNFPPS>.

CMS must receive comments on the proposal by June 30 at 5 p.m. CMS requests that comments reference the file code CMS-1410-P.

Comments on the proposed rule can be:

Submitted electronically at <http://www.regulations.gov>. Follow the instructions under the “More Search Options” tab.

**-OR-**

Regular Mail (an original and two copies):

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1410-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Express/Overnight Mail (an original and two copies):

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1410-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**-OR-**

Hand-delivered to (an original and two copies):

Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**OR**

7500 Security Boulevard  
Baltimore, MD 21244 -1850  
Note: Call (410) 786-7195 to  
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# I. OVERVIEW

CMS published the proposed Medicare SNF PPS rule for FFY 2010, which will be effective for services beginning October 1, 2009, in the May 12, 2009 *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 the May 12, 2009 *Federal Register*.

Major provisions of the rule include:

- **Marketbasket Update:** CMS is proposing to apply a full marketbasket update of 2.1% for FFY 2010.
- **Recalibration of SNF Rates:** CMS is proposing to apply an overall 3.3% reduction to SNF PPS payments for FFY 2010 to “recalibrate” the case-mix indexes due to unexpected increases that occurred when CMS expanded the Resource Utilization Groups (RUGs) in 2006.
- **RUGs Version IV Classification:** CMS is proposing to revise the case-mix classification system from RUG-III to RUG-IV in FFY 2011.
- **Parity Adjustment:** CMS is proposing an upward parity adjustment of 52.6% to account for the utilization changes due to the switch from RUG-III to RUG-IV, with implementation in FFY 2011.

## II. PAYMENT RATE

### Marketbasket Update

*Federal Register* page 22212

**Background:** CMS is required by law to provide a SNF marketbasket index that measures the price changes for the goods and services purchased by SNFs in order to provide care. Since FFY 2008, CMS has used a FFY 2008 base year to establish the component weights in the SNF marketbasket.

**CMS’ Proposal:** For FFY 2010, CMS is proposing to apply a full marketbasket update factor of 2.1%.

### Recalibration of Case Mix

*Federal Register* pages 22214 - 22217

**Background:** The final FFY 2006 SNF PPS rule expanded the original, 44-group RUG-III model to include nine new Rehabilitation Plus Extensive Services RUGs, resulting in a total of 53 RUGs categories. 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 and higher case-mix weights for the nine new categories, (to reflect the resource needs for patients requiring extensive medical and rehabilitation services). Based on CMS’s estimates that payments under the 44 RUGs categories would have been higher than under the new 53 categories, CMS adjusted the 53 RUGs weights upward by 17.9% to maintain budget neutrality.

In the FFY 2009 SNF PPS proposed rule, CMS indicated that the actual payment distribution under the refined case-mix system differed significantly from what CMS had projected. 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 proposed, but did not adopt, a provision to recalibrate the RUGs weights to restore the intended budget neutrality for the 2006 case-mix refinements.

**CMS' Proposal:** For FFY 2010, CMS is “. . . proposing 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 percent 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.”

## **Forecast Error Adjustment**

*Federal Register* pages 22247 - 22248

**Background:** CMS is required to provide a forecast error adjustment to SNFs whenever the actual marketbasket increase differs from CMS' projection by a certain threshold. Originally, as established in the FFY 2004 final rule, the threshold was set at 0.25%; meaning that the actual marketbasket increase must be at least 0.25% different from the forecast in order to trigger the error adjustment. For FFY 2008 and subsequent years, CMS set the SNF marketbasket forecast error threshold at 0.50%.

**CMS' Proposal:** For FFY 2010, CMS is proposing to “. . . not include a forecast error adjustment.”

## **AIDS Add-on**

*Federal Register* pages 22240 - 22241

**Background:** Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 implemented a 128% increase in payment rates for SNF residents with acquired immunodeficiency syndrome (AIDS); this provision was effective for services beginning on or after October 1, 2004. The add-on is intended to remain in effect until the Secretary of Health and Human Services certifies there is an appropriate adjustment in the RUGs case-mix to account for the cost of care provided to these residents.

**CMS' Proposal:** For FFY 2010, CMS is proposing no changes 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 22217 - 22219

**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 payment rates. 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 is proposing “. . . that in the absence of SNF-specific wage data, using the hospital inpatient wage index is appropriate and reasonable for the SNF PPS. . . .” In addition, “. . . the proposed 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 70.017% in FFY 2010.

## **Unadjusted Per Diem Federal Rates**

*Federal Register* page 22213

The proposed 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
<b>Urban</b>	<b>\$155.08</b>	<b>\$116.82</b>	<b>\$15.38</b>	<b>\$79.15</b>
<b>Rural</b>	<b>\$148.16</b>	<b>\$134.70</b>	<b>\$16.43</b>	<b>\$80.61</b>

*All components reflect the 2.1% marketbasket.*

## Calculation of Payment Amount

The following table provides an example of the computation of SNF PPS payments 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	0.8992	\$294.14	\$140.08	\$434.22	N/A	\$434.22	14	\$6,079
Rehabilitation High Category (RHA)	\$227.86	0.8992	\$204.89	\$97.57	\$302.46	N/A	\$302.46	16	\$4,839
Clinically Complex 2 Category (CC2)	\$188.88	0.8992	\$169.84	\$80.89	\$250.73	128%*	\$571.67	10	\$5,717
Rehabilitation Low Plus Extensive Services Category (RLX)	\$223.06	0.8992	\$200.58	\$95.52	\$296.10	N/A	\$296.10	30	\$8,883
Impaired Cognition 2 Category (IA2)	\$128.08	0.8992	\$115.17	\$54.85	\$170.02	N/A	\$170.02	30	\$5,101
<b>TOTAL</b>								<b>100</b>	<b>\$30,619</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 22215 - 22217.

## III. CONSOLIDATED BILLING

*Federal Register* pages 22248 - 22249

**Background:** The Balanced Budget Act (BBA) of 1997, which implemented 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. 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' Proposal:** For FFY 2010, CMS is not proposing any changes to the consolidated billing provision. However, CMS does seek “. . . *public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing.*”

## IV. FFY 2011 PROPOSALS

### RUG-IV Classification System

*Federal Register* pages 22229 - 22238

**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 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 (STRIVE) Project. Information collected via STRIVE includes the amount of time that staff members spend on residents and information on residents' physical and clinical status derived from Minimum Data Set (MDS) assessment data. 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 resource times associated with specific conditions and treatments, such as diabetes, the use of intravenous fluids or medications, and the increased use of concurrent therapy, have changed significantly.

**CMS' Proposal:** For FFY 2010, CMS is proposing no changes to the RUG classification structure. However, for FFY 2011, CMS is proposing to move from a RUG-III model to a RUG-IV model. CMS stated: *“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 is proposing changes to the current reporting and allocation of concurrent therapy time. CMS proposes *“. . . 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.”* CMS is also seeking comments *“on whether there should be other restrictions relating to concurrent therapy such as a limit to the percentage of concurrent therapy minutes that may be counted on the MDS for any individual or to the number of people that can be treated concurrently by the same therapist.”*

CMS projects future utilization patterns under RUG-IV would produce lower overall payments than it would under the RUG-III model. To maintain budget neutrality when moving from RUG-III to RUG-IV, CMS is proposing a “parity” adjustment, stating: *“The adjustment to the nursing weights necessary to achieve ‘parity’ is an upward adjustment of 52.6 percent.”*

## Minimum Data Set 3.0

*Federal Register* page 22241 - 22245

**Background:** The Consolidated 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.

In STRIVE, CMS collected updated assessment, staff time, and resource utilization data and tested new MDS data elements to refine the RUG reimbursement system. Many of CMS' proposals in this rule implement refinements to SNF PPS and MDS generated from STRIVE, including implementation of MDS 3.0, including changed scoring of Special Treatments and Procedures and "look-back" periods.

**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 is also proposing ". . . 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 is seeking comments on the implications of changing the submission time from 30 days to 14 days after assessment.

In addition, for FFY 2011, ". . . 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."

For Special Treatments and Procedures, CMS proposes ". . . 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."

## V. OTHER PROPOSALS

### Integrated Post-Acute Care Payment

No *Federal Register* pages identified for this topic area.

**Background:** Post-acute care (PAC) services are provided in/by multiple settings, including SNFs, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities (IRFs). Each of these provider types is paid according to its own, separate Medicare prospective payment system and requires its own patient assessment tools. In the FFY 2007 SNF PPS update notice, CMS introduced its plans to refine the PAC payment systems 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' Proposal:** CMS is currently collecting data from SNFs, IRFs, home health agencies, and long-term care hospitals that are intended to help predict the need for post-hospital care across the four settings.

### Quarterly Reporting of Nursing Home Staffing Data

**Background:** Nurse staffing data and census data are used to rate nursing homes on quality. Nurse 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 is soliciting comment on this potential requirement.

## **Application of SNF PPS and Quality Monitoring of Swing-Bed Units**

Federal Register pages 22249 - 22250

**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-critical access hospitals (non-CAHs) no longer were paid based on the cost-related method, but rather based on the SNF PPS.

The SNF PPS covers all non-CAH swing bed costs (ancillary, routine, and capital) for covered services furnished to beneficiaries under Medicare Part A. While 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 (SB) MDS.

Swing bed hospitals have not been comprehensively monitored for quality of care, but have been required to submit four types of abbreviated MDS assessments: entry and discharge tracking assessments, the clinical change assessments, and the Other Medicare Required Assessments (OMRAs). The limited use of the MDS for quality monitoring is based on the CMS belief that swing bed units, as parts of rural hospitals, are already subject to the hospital quality review process.

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.*”

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 is proposing “. . . 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.”

In addition CMS is seeking comments on “. . . expanding swing bed MDS reporting requirements to apply the quality monitoring mechanism in place for all other SNF PPS facilities to rural swing bed hospitals.”

