American Hospital Association

Regulatory Advisory

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Skilled Nursing Facilities
Proposed PPS Changes for 2006

A Message to AHA Members:

On May 14, 2005, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule on the skilled nursing facility prospective payment system (SNF PPS). This rule contains CMS' long-awaited proposal for refining the payment system to correct widely recognized problems related to under-reimbursement of non-therapy ancillary services. The proposed changes, other than the payment system refinements, would take effect October 1, 2005. The proposed refinements would take effect on a delayed basis, beginning January 1, 2006. The proposed rule is available online at http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-9934.pdf. American Hospital Association (AHA) documents on SNF-related topics and other post-acute issues are available at www.aha.org/postacute.

Please review this advisory and share it with key hospital and SNF staff to assess its impact on your organization. We also encourage you to develop written comments on any issues of concern in the SNF PPS proposed rule. Comments must be received by July 12, 2005, and may be submitted by mail or online at: http://www.cms.hhs.gov/regulations/ecomments. If mailing written comments, send one original and two copies to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS—1282—P
P.O. Box 8011
Baltimore, MD 21244-8011

AHA will be commenting on the proposed rule and will distribute comments for review prior to the July 12 deadline. We will also continue working with CMS to help secure a final rule that is appropriate and fair for hospital-based SNFs and the patients they serve. To discuss any questions or concerns about the proposed SNF provisions, contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President

June 23, 2005

American Hospital Association

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Skilled Nursing Facilities
Proposed PPS Changes for 2006

On May 14, 2005, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* a proposed rule concerning skilled nursing facility (SNF) payments under Medicare for fiscal year (FY) 2006 and the long-awaited refinement of the SNF prospective payment system (SNF PPS). The proposed changes, other than the payment system refinements, would take effect October 1, 2005. The proposed refinements would take effect on a delayed basis beginning January 1, 2006.

Background

The SNF PPS was implemented in 1998 and replaced a cost-based payment system. Under the SNF PPS, providers receive a per diem payment from Medicare if a SNF patient admission was immediately preceded by a hospital stay of at least three days. Payments are based on 44 payment categories called resource utilization groups (RUGs) and cover all costs of providing care to patients in each RUG (with exceptions), including therapy and other ancillary services, such as diagnostic tests, supplies and pharmacy expenses.

The SNF PPS has been widely criticized for under-reimbursing providers for costly non-therapy ancillary services, such as dialysis, intravenous feeding and medications, ventilator care and prescription drugs. These services are frequently used by medically complex Medicare patients who are most commonly treated in hospital-based SNFs. Since 1998, this pattern of under-reimbursement has caused one in three hospital-based SNFs to close, resulting in reduced access to care for many medically complex Medicare patients.

In recognition of this problem, Congress initiated several temporary payment adjustments. Two of these payment adjustments, which were authorized under the Balanced Budget Reconciliation Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000, CMS proposes to keep in effect until they comprehensively refine the SNF PPS. Under the proposed rule, CMS calls for such a refinement which would terminate the remaining payment add-ons. These include a 20 percent add-on for medically complex RUGs and a 6.7 percent add-on for rehabilitation RUGs.

Major Provisions in the Proposed Rule

Market Basket Increase

The proposed rule includes the statutorily required market basket update of 3.0 percent, which would take effect Oct. 1 and would increase Medicare payments to SNFs by an estimated $510 million. When the difference between the estimated and actual market basket increase for a prior fiscal year exceeds 0.25 percent, an adjustment is made to account for the error. The proposed payment rate does not include an adjustment because the difference between FY 2004's *estimated* market basket (3.0 percent) and *actual* market basket (3.1 percent) did not exceed the 0.25 percentage point threshold.

SNF PPS Refinement

CMS proposes to refine the SNF PPS by maintaining the general structure of the current payment system, while adding new payment categories to capture the most clinically complex and costly patients who presently receive both extensive services and rehabilitation therapy. Unlike the other provisions in the proposed rule, the proposed payment system refinements would take effect on a delayed basis, beginning January 1, 2006. Patients in the extensive services RUGs are targeted in the refinement because they use the greatest quantities of non-therapy ancillary services as the result of their advanced medical needs. Currently, the extensive service RUGs poorly predict the actual costs of caring for these sicker patients, especially for those patients who require non-therapy ancillary services. As a result, providers treating these patients are often under-reimbursed for the care they provide. The proposed rule does not quantify the fiscal impact of Medicare's under-reimbursement of non-therapy ancillary services. As noted, hospital-based SNFs treat a greater proportion of extensive service patients and have struggled under the resulting financial difficulties.

Research by the Urban Institute found that combining the extensive service RUGs with the rehabilitation RUGs produces a stronger correlation between Medicare payments and the actual cost of delivering care. The Institute recommended adding a new RUG category that captures patients in these two existing RUG categories to help mitigate a major problem of the current PPS – a weak relationship between actual costs and Medicare payments for medically complex patients using non-therapy ancillary services. Heeding this suggestion, the proposed rule would create a new RUG category – Combined Rehabilitation and Extensive Care – to consist of nine new RUGs. The new category of RUGs would have the highest relative weights within the SNF PPS while other RUG weights would be decreased proportionally. CMS predicts that by removing the most clinically complex cases and accounting for them in a group of their own, both the new and remaining RUG categories would be more homogeneous.

CMS has found wide variability in non-therapy ancillary utilization within each RUG and across all 44 RUGs. Data show great variability in ancillary services utilized by different SNF residents grouped within the same RUG. CMS also found that patients classified into a less-intensive RUG may still receive significantly more expensive non-therapy ancillary services than patients in a more intensive RUG. The proposed rule recognizes that CMS cannot adequately explain these discrepancies within and across RUGs and that the addition of nine new RUGs does not eliminate or compensate for the discrepancies. The regulation further notes that the SNF PPS is

the only Medicare prospective payment system that lacks an outlier component to capture high variability in resource utilization.

To address the high degree of variability in non-therapy ancillary utilization within and across the RUGs, CMS is proposing an 8.4 percent increase to the nursing component of the case-mix weights for all 53 RUGs. The amount of the adjustment equates to approximately 3 percent of aggregate expenditures under the SNF PPS. The amount was set at 3 percent to align with the amount of the outlier pool for inpatient rehabilitation facilities (IRFs), which is set at 3 percent of aggregate IRF PPS expenditures. CMS views this adjustment as a proxy for a non-therapy ancillary index— an element that was previously considered but found to add substantial complexity to the payment system without improving cost predictability. CMS is refraining from increasing the number of payment groups to capture different levels of non-therapy ancillary use, although other Medicare payment systems have significantly greater groups of payment categories than the currently proposed 53 RUGs.

Under the proposed rule, the current 44 RUGs and payment add-ons would continue to be in effect for the first quarter of FY 2006 (October through December 2005). However, beginning Jan. 1, 2006 the new 53 RUGs for the SNF PPS would take effect along with the new 8.4 percent payment adjustment. The impact of the 8.4 percent increase to the nursing component increases Medicare payments by $510 million for the final three quarters of FY 2006. This payment increase would restore half of the $1 billion in Medicare funding that would have been lost during the same period because of the expiration of the current payment add-ons as required under BBRA and BIPA. On an annual basis, SNFs will experience a $700 million payment decrease.

According to the proposed rule, CMS will be issuing a report to Congress on the analysis used to develop the proposed refinement measures and a series of additional steps to address the payment issue in the future.

New Labor Market Area Definitions

Consistent with recent changes for general acute hospitals and long-term care hospitals, the proposed rule would apply core-based statistical areas (CBSA) in place of metropolitan statistical areas (MSA) to reflect current labor markets and account for wage differences across markets. This change would take effect Oct. 1, 2005. The Office of Management and Budget developed CBSAs based on the 2000 census. A CBSA is defined as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." CBSAs are comprised of several county-based area definitions, including "metropolitan areas," "micropolitan areas," and rural areas "outside CBSAs." A metropolitan division is urbanized with a population of at least 50,000, while a micropolitan area is a smaller area of between 10,000 and 49,999 residents.

Under the proposed rule, labor market areas in New England would be included within the CBSA parameters and would no longer be treated under a separate provision.

CMS considered several ways of transitioning SNFs to the new CBSA-based labor market area definitions, as it did with acute hospitals. The agency concluded that because the new definitions

are being proposed as a budget neutral change, a transition would help a small number of SNFs phase-in their reduced payment, but funding the phase-in would require a reduction in the SNF PPS standard payment. For this and other reasons, CMS is proposing to adopt the CBSA parameters in FY 2006 without a transition period and without a hold harmless policy. CMS estimates that urban hospital-based SNFs would experience an average 0.2 percent payment increase as a result of the transition to CBSAs. Conversely, rural hospital-based SNFs would experience an average 0.7 percent payment decrease as a result of the shift.

In addition to changing labor market definitions, CMS is also proposing to base wage indices on SNF location relative to the CBSAs, rather than MSAs. The proposed wage indices for each CBSA are available in Tables 8 (urban CBSAs) and Table 9 (rural CBSAs) of the proposed rule. Table A of the proposed rule provides a crosswalk between MSA and CBSA designations for each county.

Other Provisions

The 128 percent payment add-on for AIDs patients would remain in effect during FY 2006. CMS will conduct further examination of this add-on, which was authorized by Congress in 2003 to address the higher costs associated with treating AIDs patients.

In response to requests from providers and other stakeholders that CMS clarify the definition of "indirect employment relationships," the agency proposes criteria for SNF services performed by nurse practitioners (NPs) and clinical nurse specialists (CNS). CMS proposes that in situations where there is no direct employment relationship between the SNF and the NP or CNS, an indirect employment relationship does exist whenever the NP or CNS not only performs delegated physician tasks, but also provides nursing services within the scope of coverage under the Medicare Part A SNF benefit.

CMS also clarifies the existing requirement to complete an Other Medicare Required Assessment (OMRA) 8-to-10 days after the cessation of all physical, speech and occupational therapy for patients assigned to a rehabilitation RUG on the previous patient assessment. CMS states that the "last day of therapy" used when establishing the 8-to-10 day OMRA timeframe, is the final day on which a therapy service was furnished – not the date on which a therapy discharge order is received or written in the patient's medical record. CMS also notes that Saturdays and Sundays are to count toward the 8-to-10-day timeframe.

CMS' Call for Input from the Field

CMS is requesting input on the following issues.

- CMS is seeking recommendations on services that should be added to the SNF PPS consolidated billing exclusions. The consolidated billing policy requires SNFs to be responsible for virtually all services provided to SNF patients, except for a small number of excluded codes for high-cost, low probability services eligible for a separate Medicare payment. Further recommendations should consist of Healthcare Common Procedure Coding System (HCPCS) codes that fall within the categories of chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices that are high cost and low probability in the SNF setting.

- The agency is also requesting input on its current position that observation days in the hospital are not counted when determining whether a SNF patient qualifies for Medicare coverage. As previously noted, Medicare coverage for SNF care requires a prior three-day stay in an inpatient hospital.

- CMS is soliciting comments on whether there is a need for the agency to issue additional guidelines to ensure that concurrent therapy— the practice of a single professional therapist simultaneously treating more than one patient who receives unrelated services— occurs only where it is clinically justified.

- CMS is requesting comments on the potential savings and other impacts of revising the instructions for the Minimum Data Set (MDS) patient assessment instrument to consider only those special care treatments and programs furnished to the resident during the period of the SNF admission, rather than including services provided *prior to* SNF admission. Special care treatments and programs, such as intravenous medications, suctioning, tracheostomy care, and the use of ventilator/respirator services, classify patients in the extensive service RUGs, which are used for the most medically complex SNF patients. CMS analysis indicates that the current MDS instructions use of a 15-day look-back to determine whether patients classify into the extensive services RUGs is resulting in a significant number of patients being classified into these payment categories based solely on services furnished prior to SNF admission.

- CMS is also asking for input on the following MDS assessment policies:
    - Should the MDS grace period associated with all MDS assessments be decreased or eliminated?
    - Should the process for projecting anticipated therapy services during the five-day MDS assessment be eliminated?

Comments

The AHA will submit comments to CMS on many of the proposed changes featured in the FY 2006 SNF PPS rule, and we urge you to do the same. All comments are due to CMS by July 12. Mail written comments (an original and two copies) to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS—1282—P
P.O. Box 8011
Baltimore, MD 21244-8011