MEMORANDUM

TO: AHCA Members

FROM: Elise D. Smith, J.D., Vice President of Reimbursement and Research
       Peter Gruhn, Director of Research

SUBJECT: Review of the Proposed Rule For the Skilled Nursing Facility
         Prospective Payment System Update of Payment Rates for FY 2006

DATE: May 17, 2005

On May 13, 2005, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) FY 2006 update: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006. The proposed rule will be published in the May 19, 2005 Federal Register. Comments are due no later than 5 p.m. on July 12, 2005. AHCA will be submitting comments. The proposed rule and its appendix is available on the AHCA website at http://www.ahca.org/members/finance/medicare/pps/pps-general/050513.pdf and http://www.ahca.org/members/finance/medicare/pps/pps-general/050513addendum.pdf, respectively.

Key elements of the proposal notice are as follows:

- CMS has proposed revising the Resource Utilization Group (RUG) system. The revised RUGs system would remove the current add-ons of 6.7 percent and 20 percent and expand the number of RUGs from the current 44 categories to 53 with implementation of the new system on January 1, 2006. The current system would stay in place for the first three months of FY 2006.

- The proposed revision to the RUG system has two components:

  - Because of the substantial variability in non-therapy ancillary services (NTAS), CMS concluded that it would not be appropriate to create a NTAS case-mix weight. Rather, CMS is proposing to increase the nursing case-mix weight for all 53 RUG categories by 8.4%. This represents an overall increase in payments by about 3%, which for the 9 months from January through September 2006 is estimated by CMS to be $510 million.

  - Nine new RUG categories would be added that would be a combination of Rehabilitation and Extensive Services with payment higher than that for
patients currently receiving either Rehabilitation or Extensive Services alone. The nine categories that CMS proposes to add to the existing RUG-III system are as follows:

- RUX Rehabilitation Ultra High plus Extensive Services, High
- RUL Rehabilitation Ultra High plus Extensive Services, Low
- RVX Rehabilitation Very High plus Extensive Services, High
- RVL Rehabilitation Very High plus Extensive Services, Low
- RHX Rehabilitation High plus Extensive Services, High
- RHL Rehabilitation High plus Extensive Services, Low
- RMX Rehabilitation Medium plus Extensive Services, High
- RML Rehabilitation Medium plus Extensive Services, Low
- RLX Rehabilitation Low plus Extensive Services

- The proposed rule recommends a full market basket increase of 3.0% beginning October 1, 2005, which CMS estimates would increase SNF payments by approximately $510 million in FY 2006. There is no market basket forecast error correction since the under-forecast for FY 2004 (latest data) was less than .25 percent, the threshold for change provided in the FY 2004 rule.

- In accordance with the Medicare Modernization Act (MMA), the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) patients AIDS had been increased by 128 percent beginning October 1, 2004. Under the CMS proposed rule, this add-on would remain in effect.

- Overall, CMS estimates that for FY 2006, there would be zero net fiscal effect due to the proposed RUG refinement plus the market basket update. The table below summarizes the fiscal impact of these changes.

<table>
<thead>
<tr>
<th>Gain</th>
<th>Loss</th>
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<tr>
<td>Estimated Loss of add-ons in FY 2006 (Jan to Sept)</td>
<td>$1.02B1</td>
</tr>
<tr>
<td>FY2006 Market Basket Update</td>
<td>$510M</td>
</tr>
<tr>
<td>Nursing Case Mix Adjustment</td>
<td>$510M</td>
</tr>
<tr>
<td>Total effect</td>
<td>$1.02B</td>
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</table>

- All rates and wage indexes outlined in the notice for SNF PPS would also apply to all swing-bed rural hospitals but not to critical access hospitals (CAHs) which would continue to be paid on a reasonable cost basis for SNF services furnished under a swing-bed agreement.

1 The proposed rule notes that the SNF PPS add-ons for all of FY 2006 were estimated at $1.4 billion. The payments associated with the SNF PPS add-ons for the first three months of FY 2006 may be estimated at approximately $400 million given: that the estimated loss due to the expiration of the add-on for the last 9 months of FY 2006 was estimated at $1.02 billion; that the value of the FY2006 market basket update and nursing case mix adjustment was estimated at $1.02 billion; and that CMS estimated that there would be zero net effect due to the refinement together with the market basket update.
• CMS would continue to use the hospital wage index to adjust the labor related portion of the federal rate, which is 76.087 percent of the total rate.

• CMS has proposed adopting the Office of Management and Budget (OMB) revised definitions of Metropolitan Statistical Areas and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas for the SNF PPS as done for the hospital inpatient PPS and the long term care hospital (LTCH) PPS update.

• CMS proposes possible modifications to the Minimum Data Set (MDS), including the look-back period, the grace period, and projected therapy.

• CMS asks for comments on including observation days in the 3-day hospital stay requirement for SNF Part A services.

• CMS asks for comments on pay for performance issues and the development of a coordinated approach to payment and delivery of post-acute services.

**Discussion**

The proposed rule addresses, and asks for comments on, many aspects of the SNF PPS and consolidated billing system, and on additional issues including the 3-day hospital stay requirement and observation days, the Minimum Data Set (MDS), quality, and pay for performance. The following is a summary of the issues addressed by CMS and the comments requested.

**I. Proposed Refinements to The Case-Mix Classification System**

CMS is proposing to refine the SNF PPS RUG-III case mix classification system and apply the refined system starting in January 1, 2006.

Analysis by the Urban Institute and CMS continues to show that non-therapy ancillary costs are higher for Medicare beneficiaries in Extensive Services RUG-III categories than for those in other categories. CMS argues that the most viable way to refine the current RUG-III system would be to add 9 additional categories to the existing 44 RUG-III categories that capture beneficiaries who qualify for both the Extensive Services and Rehabilitation Therapy categories to create a 53 RUG-III group system. There are two charts in the Appendix to this summary that describe the new RUG-III categories and a crosswalk that maps the previous categories to the new categories. (See Appendix for Charts 1 and 2.) Unlike the previous rehabilitation categorization, the new RUG-III categories require a minimum of seven ADLs.

The case-mix indexes for the proposed RUG-III system adopts the same method used for calculating the initial SNF PPS case-mix indexes. The nursing and therapy indexes would continue to be based on minutes of staff time for nursing and therapy
services where appropriate by reclassifying patients into the proposed 53 RUG-III groups. The addition of the 9 new RUG-III categories would cause the nursing weights to change more than the therapy weights due to the redistribution of patients from existing groups to the newly created proposed groups. The therapy weights would be affected only slightly. With the reclassification, the nursing indexes in the new categories and in the existing rehabilitation categories would show less variability than those in the rehabilitation categories under the 44 RUG-III category system. CMS has calibrated the new payment model, such that aggregate payments under the new 53-group system are the same as those under the 44-group system, excluding the add-ons.

CMS argues that these 9 new categories will ensure that SNF PPS payments continue to support the quality of care furnished in SNFs. As such the 20 percent add-on for clinically complex RUG groups and the 6.7 percent add-on for rehabilitation RUG groups would expire with the case-mix refinement proposed for January 1, 2006.

With respect to the add-on payment for SNF residents with AIDS that was authorized under section 511 of the MMA, CMS concludes that the proposed 53 RUG-III group system, together with the other changes in the proposed rule, would not adequately compensate for the increased costs specifically associated with AIDS patients. Thus, CMS proposes that the 128 percent add-on payment for SNF residents with AIDS would continue to remain in effect during FY 2006.

In addition, CMS proposes an additional adjustment to the nursing component of the case-mix weights for all RUG-53 categories to better account for non-therapy ancillary variability. Given limitations of the data, the high degree of variability in non-therapy ancillary utilization both within and across the various RUG-III groups, and questions about the ability of the SNF PPS to account adequately for non-therapy ancillary services, CMS has proposed modifying the nursing case-mix weights for all RUG-53 categories rather than develop alternative approaches (such as the establishment of an additional medical ancillary case-mix index and the reconfiguration of the RUGs system as was proposed in the past).²

In determining the size of this adjustment, CMS notes the high degree of variability in non-therapy ancillary costs across patients and RUG-III categories and the absence of an outlier policy to capture high variability in resource utilization. As such CMS is proposing an increase to the nursing case-mix weights (which include reimbursement for non-therapy ancillaries) of approximately 8.4 percent, which equates to approximately three percent of aggregate expenditures under the SNF PPS. In support for this proposed adjustment, CMS relies on the fact that this is the same percent of aggregate expenditures used to establish outlier payments to inpatient rehabilitation facilities. CMS estimates that the adjustment to the nursing

² The coefficient of determination, \( R^2 \), seeks to explain the proportion of the variation in the dependent variable explained by variation in the model (independent variables). CMS reports that the Urban Institute found an \( R^2 \) of 10.3 percent for a 58 RUG-III model and an \( R^2 \) of 4.1 percent for the 44 RUG-III model. CMS does not report an \( R^2 \) for the 53 RUG-III model.
case-mix index represents an increase in aggregate expenditure of about $510 million. CMS also notes that any future changes to the case-mix weights or other components of the SNF PPS would be accomplished through staff time measures and other validated analytical studies.

CMS describes the research undertaken initially by Abt Associates and by the Urban Institute to assist it in making refinements to the case-mix classification system. While the full Urban Institute report has not yet been released, portions related to the data and methodology used by the Urban Institute and the RUG Refinement Model are available for download on the CMS website (http://www.cms.hhs.gov/providers/snfpps/DataAppendix.pdf and http://www.cms.hhs.gov/providers/snfpps/RUGchapforFY06NPRM.pdf, respectively). CMS also notes that its report to Congress, that was due to Congress on January 1, 2005, will be forthcoming.3

II. The SNF Market Basket

The SNF update for FY 2005 is 3.00 percent. This is the full market basket. Every year, CMS calculates a revised labor-related share based on the relative importance of labor-related cost categories in the in price index. The labor-related share for FY 2006 is 76.087 percent. (See Appendix for Chart 3.)

AHCA will continue to urge CMS to review the accuracy of all the weight and price proxy components of the SNF market basket, including labor, capital, and professional liability insurance.

III. The Forecast Correction to the SNF Market Basket

In 2004, AHCA succeeded in achieving an annual adjustment to account for forecast error correction. The initial adjustment applied to the update of the FY 2003 rate for FY 2004, taking into account FY 2000 through FY 2002. Subsequent adjustments take into account the forecast error from the most recently available fiscal year for which there are final data, and are applied whenever the difference between the forecasted and actual change in the market basket exceeds a 0.25 percent.

For FY 2004 (the most recently available fiscal year for which there are final data), the estimated increase in the market basket index was 3.0 percentage points, while the actual increase was 3.1 percentage points. Therefore, the payment rates for FY 2006 do not include a forecast error adjustment. Table 1 shows the forecasted and actual market basket amounts for FY 2004. (See Appendix for Chart 4.)

3 The Benefits Improvement and Protection Act of 2000 -- Section 311(e) required that the Secretary of HHS conduct a study of the different systems for categorizing patients in Medicare skilled nursing facilities in a manner that accounts for the relative resource utilization of different patient types; and not later than January 1, 2005 submit to Congress a report on the study which shall include recommendations regarding changes in the law as may be appropriate.
IV. Area Wage Index Adjustment to The Federal Rates

CMS is required to adjust federal rates to account for difference in area wage levels using an appropriate index. CMS would use the hospital wage index for FY 2006. The wage index adjustment for FY 2006 is 76.087 percent of the total rate, a decrease from 76.222 percent used in FY 2005.

In addition, CMS is proposing to apply revised definitions of Metropolitan Statistical Areas (MSAs) as detailed in the 2003 OMB Bulletin No. 03-04 to SNFs in FY 2006, effective October 1, 2005.4 These new definitions known as the Core-Based Statistical Areas (CBSAs) revise definitions for MSAs, and establish new definitions for Micropolitan Statistical Areas and Combined Statistical Areas. The new CBSA designations recognize 49 new (urban) MSAs and 565 new Micropolitan Areas, and revise the composition of many of the existing (urban) MSAs. The Addendum to the proposed rule provides the proposed CBSA-based wage index values for urban and rural areas, and a crosswalk that allows for a comparison of a county’s geographic designation under CBSAs with is designation under MSAs.

In its analysis of the impact of the proposed labor market area changes, CMS found that the majority of SNFs (61 percent) either maintained the same wage index or would get an increased wage index, while about 4 percent of SNFs would experience a decline of 5 percent or more in the wage index based. Overall, about 1.4 percent of SNFs would lose their urban designation, specifically those located in Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA.

CMS is proposing to adopt the new CBSA-based labor market area definitions for SNFs beginning in FY 2006 without a transition period and without a hold harmless policy. Given the relatively small number of affected providers, CMS notes that a hold harmless policy would result in decreased payment rates to all other providers due to the budget neutrality requirement of the wage index adjustment.

V. CMS Projected Impact of the Final Rule

CMS estimates the aggregate change in payments associated with this proposed rule to be $0 million for FY 2006. According to CMS, the decrease of $1.02 billion due to the elimination of the temporary add-ons as of January 1, 2006, together with the additional payment due to the proposed refined case-mix classification system of $510 million and the market basket increase of $510 million, results in a net change in aggregate payments of $0 million. (See Appendix for Chart 5.)

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4 See June 6, 2003, Office of Management and Budget (OMB) issuance, Bulletin No. 03-04. In the bulletin, OMB announced revised definitions of Metropolitan Statistical Areas and new definitions of Metropolitan Statistical Areas and Combined Statistical Areas. A copy of the bulletin may be attained at the following Internet address: http://www.whitehouse.gov/omb/bulletins/b03-04.html
VI. Proposed Policy Modifications Regarding the Minimum Data Set (MDS)

CMS is seeking comments on other policy options to enhance the accuracy of the payment system and improve the quality of care provided to Medicare beneficiaries during an SNF stay. In particular, CMS raises MDS issues regarding potential elimination of the look back period, the grace period, and the projection of anticipated therapy minutes and seeks comments on other alternatives.

- **Look-Back Period**

CMS asks for comments on removing the look-back period from the MDS. CMS indicates that the creation of the proposed new Rehabilitation plus Extensive Services groups underscores the importance of ensuring the accuracy of patient classifications that encompass medically complex patients. The agency asks whether this could be accomplished by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example, during the prior qualifying hospital stay).

CMS analysis in this area has focused on the four items contained in the Special Service section of the MDS (P1a – IV medications, suctioning, tracheostomy care, and use of a ventilator/respirator) that serve to classify residents into Extensive Services, the category used for the most medically complex SNF patients under the RUG-III classification system. According to CMS, this analysis indicates that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) that were furnished exclusively during the period before SNF admission. CMS acknowledges that elimination of the look-back period has the potential to reduce overall SNF payments by better aligning them with the services actually provided. Therefore, CMS seeks comment on the potential savings and other impacts of revising the MDS Manual instructions to include only those special care treatments and programs, MDS Section P1a, furnished to the resident since admission or re-admission to the SNF, similar to the requirement for MDS Section P1b. CMS anticipates that this change can be accomplished through an update to the MDS Manual instructions, and will not involve system changes at the facility, state agency, or federal level.

- **Grace Day Period**

CMS asserts that it has received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. It invites comments on this specific recommendation as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments.
• **Anticipated Therapy**

CMS also invites comment on whether to eliminate the projection of anticipated therapy services during the 5-day PPS assessment.

**VII. Quality Issues**

CMS also discusses broader initiatives related to quality of care. Through efforts such as the Nursing Home Quality Initiative, the Long Term Care Task Force and other forums for collaborative action, CMS has worked with the SNF profession on the development of valid quality measures, and a variety of quality improvement efforts focused on nursing homes. CMS acknowledges that these efforts and others have resulted in improvements in the quality of care, particularly in facilities that adopt a culture that promotes quality through continuous quality initiatives (CQI), culture change, and other similar programs.

• **Pay for Performance**

CMS expresses support for pay for performance as a tool that could provide additional support to improve the quality of care provided in nursing homes. In this way, CMS believes that it could recognize and support the ongoing efforts of nursing homes to improve quality. However, CMS also believes that designing pay for performance programs for the SNF setting presents some significant issues.

One fundamental issue is that CMS believes that practice patterns must change for all residents and not just in the Medicare Part A unit and that quality measures must be broad-based and designed to effect change across the mix of patients residing in the facility. CMS explains that while Medicare beneficiaries are the primary users of SNF services, only a small percentage of these beneficiaries (that is, approximately 10 percent) receive services that are reimbursed under Medicare Part A. The majority of beneficiaries receive services that are reimbursed by multiple payers, including Medicare Part B, Medicaid, and private insurance, and that are delivered within different parts of a nursing facility. In addition, CMS comments, the focus of the nursing, rehabilitative, and medical interventions will typically vary for persons who are receiving short-term skilled nursing facility services versus those persons who are long-term residents in nursing facilities.

There is also a need to consider how to design effective incentives; such as, superior performance measured against pre-established benchmarks and/or performance improvements.

• **Development of A Coordinated Approach to Payment and Delivery of Post-Acute Services**

CMS expresses its interest in developing a coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode. The
agency believes that it should consider a full range of options in analyzing its post-acute care payment methods, including the SNF PPS. CMS also encourages discussion of incremental changes that will help us build toward these longer-term objectives.

CMS envisions payment policy that is as neutral as possible regarding provider and patient decisions about the use of particular post-acute services. That is, Medicare should provide payments sufficient to ensure that beneficiaries receive high quality care in the most appropriate setting so that admissions and any transfers between settings occur only when consistent with good care, rather than to generate additional revenues. In order to accomplish this objective, CMS indicates that it would need to collect and compare clinical data across different sites of service. CMS concludes that, in the long run, its ability to compare clinical data across care settings is one of the benefits that will be realized as a basic component of its interest in the use of standardized electronic health records (EHRs) and other steps to promote continuity of care across all settings, including nursing homes.

Regarding incremental changes that will help CMS achieve these longer-term objectives, CMS mentions several automated medical record tools are now available that could allow hospitals and SNFs to coordinate discharge planning procedures more closely. These tools can be used to ensure communication of a standardized data set that can also be used to establish a comprehensive SNF care plan. Improved communications may reduce the incidence of potentially avoidable re-hospitalizations and other negative effects on quality of care.

CMS is looking at ways that Medicare providers could use these tools to generate timely data to support continuity across settings and expresses interest in comments on payment reforms that could promote and reward such continuity, and avoid the medical complications and additional costs associated with re-hospitalization.

VIII. CMS Clarification of Additional Clinical Issues

- Assessment Timeframes

CMS clarifies existing requirements regarding completion of Other Medicare Required Assessments (OMRAs) for beneficiaries reimbursed under the SNF PPS. An OMRA is due 8 to 10 days after the cessation of all therapy (occupational and physical therapies and speech-language pathology services) in all situations where the beneficiary was assigned a rehabilitation RUG-III group on the previous assessment. The “last day of therapy” is the last day on which a therapy service was furnished. It is not the day the discharge order for therapy was received and/or written on the resident's medical record. Therefore, when the last day that therapy was provided falls on a Friday, the Saturday and Sunday directly following are counted as days 1 and 2, respectively, toward the total 8 to 10 days of the OMRA window. The same principles apply when the "midnight rule" is initiated during a beneficiary’s Part A SNF stay.
In addition, in the relatively uncommon situations where a resident starts a leave of absence after the therapy services have been discontinued and is out of the facility for part of the 8 to 10 day period during which the OMRA must be completed, those therapeutic leave days are to be counted when determining the OMRA due date.

- **SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists**

CMS clarifies the requirement for physician signature on the certification and recertification of the need for SNF care as it relates to nurse practitioners (NPs) and clinical nurse specialists (CNSs) and invites comment on its proposal. CMS explains that Medicare law bars NPs and CNSs from having a direct or indirect employment relationship with a SNF in order to sign a certification or recertification of the need for care. By contrast, Medicaid law addressing the delegation of physician tasks in Medicaid nursing facilities only bars NPs, CNSs, and physician assistants (PAs) from performing delegated tasks if they are actually employed by the facility. CMS is providing a new regulation clarifying the meaning of indirect employment and invites comment on the proposed regulation.

In situations where there is no direct employment relationship between the SNF and the NP or CNS, CMS proposes that an indirect employment relationship exists whenever the NP or CNS not only performs delegated physician tasks, but also provides nursing services under the regulations at 42 CFR 409.21, which include such services within the scope of coverage under the Part A SNF benefit. CMS believes that this criterion is appropriate, because there would be a potential conflict of interest if an NP or CNS who is engaged in furnishing covered Part A nursing services to an SNF’s resident were also permitted to certify as to that resident’s need for Part A SNF care. CMS invites comments on the effects of establishing its proposed distinction in this context.

- **Concurrent Therapy**

CMS again invites comment on the most effective way to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

According to CMS, the practice involves a single professional therapist treating more than one Medicare beneficiary at a time. In contrast to group therapy, in which all participants are working on some common skill development, each beneficiary who receives concurrent therapy is not receiving services that relate to those needed by any of the other participants. CMS’ concern is that although the care that each beneficiary receives may be individually prescribed, it may not conform to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.
CMS raised this same issue in both the proposed and final rules for FY 2002. At that time CMS acknowledged that concurrent therapy can have a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations. However, while CMS declined to make any specific policy changes at that time, it reiterated that it is inappropriate for a facility to require, as a condition of employment, that a therapist agree to treat more than one beneficiary at a time in situations where providing treatment in such a manner would compromise the therapist's professional judgment. Accordingly, CMS is considering once again whether there is a need to issue additional guidelines to preclude the inappropriate provision of concurrent therapy and invites comment on the most effective way to prevent the abuse of this practice, and to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

**IX. Consolidated Billing**

CMS asks for comments on further exclusions from PPS consolidated billing of services within four categories specified by section 103 of the BBRA -- chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices). They must also be characterized by high cost and low probability in the SNF setting.

CMS notes that the law identified specific these categories for exclusion and provided the Secretary with additional authority to exclude further services from these categories. CMS states that any additional service codes that it might designate for exclusion under our discretionary authority must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability of being offered in the SNF setting.

CMS last invited comments on this issue in the proposed rule for FY 2004. AHCA provided recommendations for further excluded drugs. In the final rule, CMS proceeded with two additional exclusions. Zevalin, a new radiopharmaceutical (that is, radiotherapeutic substance linked to a radioisotope administered to deliver therapeutic radioactivity), which combines elements of both the chemotherapy and radioisotope categories excluded under the BBRA and Bexxar, a radiopharmaceutical equivalent to Zevalin.

**X. Qualifying Three-Day Inpatient Hospital Stay Requirement**

In order to be eligible to receive Part A skilled nursing care, a beneficiary must have a prior 3-day stay in an inpatient hospital. However, under Section 1812(f) the Secretary may authorize coverage of SNF care without a prior hospital stay if two conditions are met; first, the coverage of these services must not result in any increase in Medicare program payments, and second, the coverage must not alter the acute care nature of the benefit. AHCA has long held that the prior 3-day stay requirement for the SNF Part A benefit is a blunt and crude instrument for
controlling the utilization of Medicare Part A skilled nursing services. It has no clinical basis and should be reexamined from a clinical perspective as a requirement for a SNF Part A stay. AHCA is advocating for the elimination of the 3-day.

In the interim, AHCA has also proposed that observation days be counted in the calculation of the 3-days as counted for purposes of hospital DRG reimbursement. AHCA believes that such days should count, given likelihood that any patient who is “formally” admitted as an inpatient after an emergency or observation stay has experienced a continuous course of care, as pointed out by the United States District Court in *Elizabeth Jenkel v. Shalala*.5

CMS is now inviting comments on whether the time spent in observation status should be counted toward meeting the SNF benefit’s qualifying 3-day hospital stay requirement. CMS notes that in evaluating the potential impact of such a change, the agency will consider its effect on those beneficiaries who might not otherwise be able to meet the SNF benefit’s prior qualifying hospital stay requirement, and assess potential negative consequences.

CMS acknowledges prior arguments that hospital admission practices have changed since this was enacted and some patients are now placed in observation status initially, before being formally admitted as a hospital inpatient; this care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission, so that the beneficiaries themselves often learn of the difference only after they were transferred to the SNF and failed to meet the SNF benefit’s prior hospital stay requirement.

CMS points out that coverage of observation services under the outpatient prospective payment system is connected to patients with three specific diagnoses: chest pain, asthma, and congestive heart failure. It also distinguishes the possible use of observation time from time spent in the hospital's emergency room. Although both observation services and emergency room services are directed at patients who are expected to spend only a short period of time in that service area, CMS believes that in other ways they are dissimilar and differentiates them in several ways.

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5 In *Elizabeth Jenkel v. Shalala*, the United States District Court for the District of Connecticut held that the 3-day requirement was met by a combination of one night in the emergency room and two days in the hospital after formal admission. (Report and Recommendation of Smith, U.S. Magistrate U.S. District Court, District of Connecticut, No. 2:92-290 (AHN), Dec. 21, 1993, Magistrate's report and recommendation adopted by the court Jan. 26, 1994.) The court said that “the sequence of events established a continuous course of care that began when the beneficiary was treated in the emergency room and continued until her discharge and transfer to the SNF. Neither the beneficiary's condition nor the course of treatment varied from the time of her arrival at the emergency room to the time of her formal admission. Accordingly, the ALJ erred in reasoning that the beneficiary's hospital stay did not begin until she was formally admitted. The beneficiary's formal admission as an inpatient was merely a ratification of her de facto admission when she arrived at the emergency room. Therefore, the beneficiary satisfied the three-day prior hospitalization requirement, and the SNF services she subsequently received were covered.”
CMS remains cautious and comments that with respect to continuing assessment and treatment, observation services would appear to share some common elements with inpatient care, but that the latter involves a condition that is expected to require care for a significantly longer duration, and that also may well require medical intervention at a level of complexity that does not occur on an outpatient basis.

**XI. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals**

In accordance with section 1888(e)(7) of the Act (as amended by section 203 of the BIPA), Part A pays critical access hospitals (CAHs) on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, the services furnished by non-CAH rural hospitals are paid under the SNF PPS. In the July 31, 2001 final rule (66 FR 39562), CMS announced the conversion of swing-bed rural hospitals to the SNF PPS, effective with the start of the provider’s first cost reporting period beginning on or after July 1, 2002. As of June 30, 2003, all swing-bed rural hospitals have come under the SNF PPS. Therefore, all rates and wage indexes outlined in the proposed rule for the SNF PPS also apply to all swing-bed rural hospitals.

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If you have any questions, please call Elise Smith at 202-898-6305 or Peter Gruhn at 202-898-2819.
APPENDIX

Chart 1

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>RUX</td>
<td>Rehabilitation Ultra High plus Extensive Services, High</td>
</tr>
<tr>
<td>RUL</td>
<td>Rehabilitation Ultra High plus Extensive Services, Low</td>
</tr>
<tr>
<td>RVX</td>
<td>Rehabilitation Very High plus Extensive Services, High</td>
</tr>
<tr>
<td>RVL</td>
<td>Rehabilitation Very High plus Extensive Services, Low</td>
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<td>RHL</td>
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<tr>
<td>RMX</td>
<td>Rehabilitation Medium plus Extensive Services, High</td>
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<tr>
<td>RML</td>
<td>Rehabilitation Medium plus Extensive Services, Low</td>
</tr>
<tr>
<td>RLX</td>
<td>Rehabilitation Low plus Extensive Services</td>
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Chart 2 (All following Table numbers are the same as those in the proposed rule.)

Table 3a
Crosswalk between Existing RUG-III Rehabilitation Groups and the Proposed Extensive Plus Rehabilitation Groups

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<tr>
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<th>Current Rehabilitation Groups</th>
<th>New Combined Extensive Plus Rehabilitation Groups</th>
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<tr>
<td>Rehab High</td>
<td>RHC – ADL 13-18, RHB – ADL 8-12, RHA – ADL 4-7</td>
<td>RHX – ADL 13-18, RHL – ADL 7-12</td>
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<td>Rehab Medium</td>
<td>RMC – ADL 15-18, RMB – ADL 8-14, RMA – ADL 4-7</td>
<td>RMX – ADL 15-18, RML – ADL 7-15</td>
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<tr>
<td>Rehab Low</td>
<td>RLB – ADL 14-18, RLA – ADL 4-13</td>
<td>RUX – ADL 7-18</td>
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**Chart 3**

**Table 11**  
FY 2006 Labor-Related Share

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<tr>
<th>Cost Category</th>
<th>FY 2005 Relative Importance</th>
<th>FY 2006 Relative Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages and Salaries</td>
<td>54.720</td>
<td>54.572</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>11.595</td>
<td>11.691</td>
</tr>
<tr>
<td>Nonmedical Professional Fees</td>
<td>2.688</td>
<td>2.702</td>
</tr>
<tr>
<td>Labor-Intensive Services</td>
<td>4.125</td>
<td>4.116</td>
</tr>
<tr>
<td>Capital-Related</td>
<td>3.094</td>
<td>3.006</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76.222</strong></td>
<td><strong>76.087</strong></td>
</tr>
</tbody>
</table>

**Chart 4**

**Table 1**  
FY 2004 Forecast Error Correction for CMS SNF Market Basket

<table>
<thead>
<tr>
<th>Index</th>
<th>Forecasted FY 2004 Increase*</th>
<th>Actual FY 2004 Increase**</th>
<th>FY 2004 Forecast Error Correction***</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>3.0</td>
<td>3.1</td>
<td>0.0</td>
</tr>
</tbody>
</table>

*Published in August 4, 2003 Federal Register; based on second quarter 2003 Global Insight/DRI-WEFA forecast.  
**Based on the fourth quarter 2004 Global Insight/DRI-WEFA forecast.  
***The FY 2004 forecast error correction will be applied to the FY 2006 PPS update. Any forecast error less than 0.25 percentage points is not reflected in the update.
## Chart 5

### Table 12
Projected Impact of FY 2006 Update to the SNF PPS

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Number of Facilities</th>
<th>Update Wage Data</th>
<th>MSA to CBSA</th>
<th>Eliminate Add-On to certain RUGs</th>
<th>Case-Mix Refinements</th>
<th>Total FY 2006 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>15,675</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-6.0%</td>
<td>3.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Urban</td>
<td>10,599</td>
<td>0.0%</td>
<td>0.2%</td>
<td>-6.0%</td>
<td>2.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Rural</td>
<td>5,076</td>
<td>0.1%</td>
<td>-0.8%</td>
<td>-6.0%</td>
<td>3.4%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Hospital based urban</td>
<td>1,097</td>
<td>0.0%</td>
<td>0.2%</td>
<td>-6.3%</td>
<td>5.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Freestanding urban</td>
<td>8,693</td>
<td>0.0%</td>
<td>0.2%</td>
<td>-5.9%</td>
<td>2.4%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Hospital based rural</td>
<td>1,160</td>
<td>0.0%</td>
<td>-0.7%</td>
<td>-6.8%</td>
<td>5.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Freestanding rural</td>
<td>3,372</td>
<td>0.2%</td>
<td>-1.0%</td>
<td>-5.9%</td>
<td>2.9%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Proprietary</td>
<td>9,317</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-5.9%</td>
<td>2.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>3,493</td>
<td>-0.1%</td>
<td>-0.1%</td>
<td>-6.0%</td>
<td>3.1%</td>
<td>-0.1%</td>
</tr>
</tbody>
</table>

Note: Since the market basket increase of 3.0 percentage points is constant for all providers, CMS has not shown it individually but notes that the “Total FY 2006 change” column does incorporate this increase. Again, CMS projects that aggregate payments would not change in total, assuming facilities do not change their care delivery and billing practices in response.
MEMORANDUM

TO: AHCA Members

FROM: Elise D. Smith, J.D., Vice President of Reimbursement and Research
       Peter Gruhn, Director of Research

SUBJECT: FY 2006 SNF PPS Proposed Rule Summary

DATE: May 16, 2005

On May 13, 2005, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) FY 2006 update: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006. Comments are due no later than 5 p.m. on July 12, 2005. AHCA will be submitting comments. The proposed rule is available on the AHCA website at http://www.ahca.org/members/finance/medicare/pps/pps-general/050513.pdf.

Key elements of the notice are as follows:

• CMS has revised the Resource Utilization Group (RUG) system to remove the current add-ons of 6.7 percent and 20 percent and expand the number of RUGs from the current 44 categories to 53 with implementation of the new system on January 1, 2006. The current system will stay in place for the first three months of FY 2006.

• The revision to the RUG system has two components:
  • The nursing case-mix weight for all 53 RUG categories will be increased by 8.4%. This represents an overall increase in payments by about 3%, which for the 9 months from January through September 2006 is estimated by CMS at $510M.
  
• Nine new RUG categories will be added that will be a combination of Rehabilitation and Extensive Services. The payment for this group will be higher than that for patients currently receiving either Rehabilitation or Extensive Services alone. The nine categories that CMS proposes to add to the existing RUG-III system are as follows:
  
  o RUX Rehabilitation Ultra High plus Extensive Services, High
  o RUL Rehabilitation Ultra High plus Extensive Services, Low
  o RVX Rehabilitation Very High plus Extensive Services, High
- The proposed rule recommends a full market basket increase of 3.0% beginning October 1, 2005, which CMS estimates will increase SNF payments by approximately $510 million in FY 2006 alone. There is no market basket forecast error correction since the under-forecast for FY 2004 (latest data) was less than .25 percent, the threshold for change provided in the FY 2004 rule.

- In accordance with the Medicare Modernization Act (MMA), the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) had been increased by 128 percent beginning October 1, 2004. This add-on remains in effect.

- Overall, CMS estimates that for FY 2006, there will be zero net fiscal effect due to the proposed RUG refinement plus the market basket update. The table below summarizes the fiscal impact of these changes.

<table>
<thead>
<tr>
<th></th>
<th>Gain</th>
<th>Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Loss of add-ons in FY 2006 (January through September)</td>
<td></td>
<td>$1.02B^6</td>
</tr>
<tr>
<td>FY2006 Market Basket Update</td>
<td>$510M</td>
<td></td>
</tr>
<tr>
<td>Nursing Case Mix Adjustment</td>
<td>$510M</td>
<td></td>
</tr>
<tr>
<td>Total effect</td>
<td>$1.02B</td>
<td>$1.02B</td>
</tr>
</tbody>
</table>

- All rates and wage indexes outlined in the notice for SNF PPS also apply to all swing-bed rural hospitals but not to critical access hospitals (CAHs) that are paid on a reasonable cost basis for SNF services furnished under a swing-bed agreement.

^6 The proposed rule notes that the SNF PPS add-ons for all of FY 2006 were estimated at $1.4 billion. The payments associated with the SNF PPS add-ons for the first three months of FY 2006 may be estimated at approximately $400 million given: that the estimated loss due to the expiration of the add-on for the last 9 months of FY 2006 was estimated at $1.02 billion; that the value of the FY2006 market basket update and nursing case mix adjustment was estimated at $1.02 billion; and that CMS estimated that there would be zero net effect due to the refinement together with the market basket update.
• CMS continues to use the hospital wage index to adjust the labor related portion of the federal rate, which is 76.087 percent of the total rate a decrease from the 76.222 percent used in FY 2005.

• CMS has adopted the Office of Management and Budget (OMB) revised definitions of Metropolitan Statistical Areas and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas for the SNF PPS as it has now done for the inpatient hospital PPS and the long term care hospital (LTCH) PPS update.

• CMS describes the research undertaken by the Urban Institute to assist it in making refinements to the case-mix classification system. While the full Urban Institute report has not yet been released, portions related to the data and methodology used by the Urban Institute and the RUG Refinement Model are available for download on the CMS website (http://www.cms.hhs.gov/providers/snfpps/DataAppendix.pdf and http://www.cms.hhs.gov/providers/snfpps/RUGchapforFY06NPRM.pdf, respectively). CMS also notes that its report to Congress, that was due to Congress on January 1, 2005, will be forthcoming.

• Other Issues

  • **Minimum Data Set (MDS) Issues** -- CMS proposes possible modifications to the Minimum Data Set (MDS), including the look back period, the grace period, and projected therapy.

    • *Look Back Period* -- CMS asks for comments on removing the look back period from the MDS. CMS indicates that the creation of the proposed new Rehabilitation plus Extensive Services groups underscores the importance of ensuring the accuracy of patient classifications, particularly with regard to those categories that encompass medically complex patients, such as Extensive Services. It inquires if one way to accomplish this could be by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example, during the prior qualifying hospital stay).

    • *Grace Day Period* -- CMS asserts that it has received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. It invites comments on this specific recommendation, as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments.
• **Anticipated Therapy** -- CMS also invites comment on whether it might be appropriate to eliminate the projection of anticipated therapy services during the 5-day PPS assessment period.

• **Pay for Performance** -- CMS expresses support for pay for performance which it considers a tool to provide additional support in improving the quality of care provided in nursing homes. In this way, CMS believes that it could recognize and support the ongoing efforts of nursing homes to improve quality. However, CMS also believes that designing pay for performance programs for the SNF setting presents some significant issues. CMS believes that practice patterns must change for all residents and not just in the Medicare Part A unit. CMS concludes quality measures must be carefully constructed; that is, broad-based and designed to effect change across the mix of patients residing in the facility. Similarly, there is the necessity to consider how to design effective incentives; that is, superior performance measured against pre-established benchmarks and/or performance improvements.

• **Development of A Coordinated Approach to Payment and Delivery of Post-Acute Services** -- CMS expresses its interest in developing a coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode. Consideration should be given to a full range of options in analyzing its post-acute care payment methods, including the SNF PPS and also encourage incremental changes that will help us build toward these longer-term objectives.

• **Assessment Timeframes** -- CMS clarifies existing requirements regarding completion of Other Medicare Required Assessments (OMRAs) for beneficiaries reimbursed under the SNF PPS. An OMRA is due 8 to 10 days after the cessation of all therapy (occupational and physical therapies and speech-language pathology services) in all situations where the beneficiary was assigned a rehabilitation RUG-III group on the previous assessment.

• **SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists** -- CMS clarifies the requirement for physician signature on the certification and recertification of the need for SNF care as it relates to nurse practitioners (NPs) and clinical nurse specialists (CNSs) and invites comment on its proposal. CMS explains that Medicare law that bars NPs and CNSs from having a direct or indirect employment relationship with a SNF in order to sign a certification or recertification of the need for care is very restrictive. By contrast, Medicaid law addressing the delegation of physician tasks in Medicaid nursing facilities only bars NPs, CNSs, and physician assistants (PAs) from performing delegated tasks if they are actually employed by the facility. CMS is providing a new regulation clarifying the meaning of indirect employment and invites comment on the proposed regulation.
• **Concurrent Therapy** -- CMS again invites comment on the most effective way to prevent what it sees as an abuse of the practice known as concurrent therapy, and to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

• **Consolidated Billing** -- CMS asks for comments on further exclusions from PPS consolidated billing of services within four categories specified by section 103 of the BBRA -- chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices. The services must also be characterized by high cost and low probability in the SNF setting.

• **Qualifying Three-Day Inpatient Hospital Stay Requirement** -- CMS is inviting comments on the possibility of counting the time spent in observation status toward meeting the SNF benefit’s qualifying 3-day hospital stay requirement.

A more comprehensive summary will be available shortly. If you have any questions, please call Elise Smith at 202-898-6305 or Peter Gruhn at 202-898-2819.