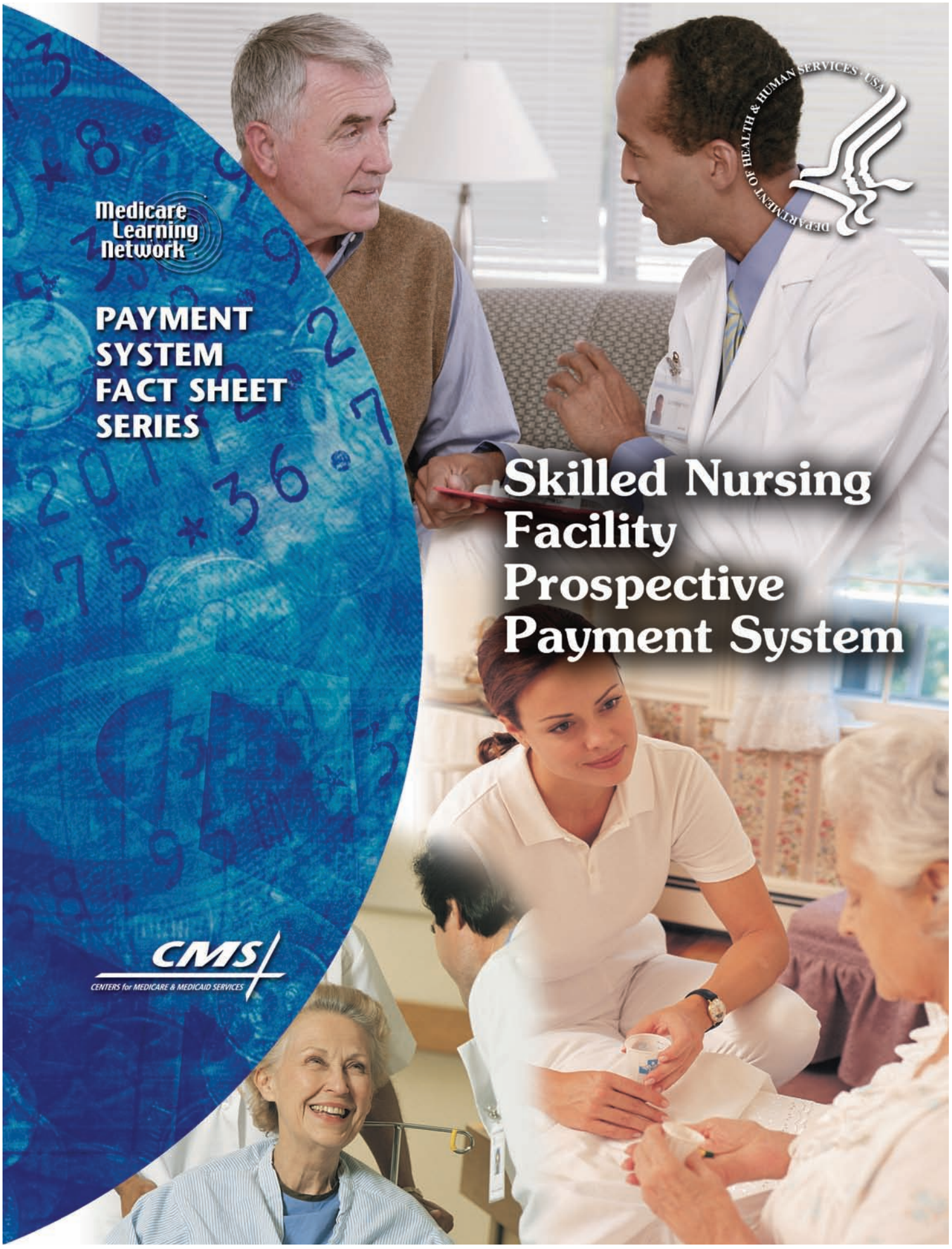
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
Skilled Nursing Facility Prospective Payment System
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how payment is made for **Skilled Nursing Facility (SNF)** services. Effective with cost reporting periods beginning on or after July 1, 1998, SNFs are paid a comprehensive per diem under a prospective payment system (PPS). This SNF PPS per diem represents Medicare's payment for all costs of furnishing covered Part A SNF services (routine, ancillary, and capital-related costs), except for costs associated with operating approved educational activities and costs of those services that are excluded from SNF Consolidated Billing (CB).

ELEMENTS OF THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

The SNF PPS includes the following elements:

RATES

As required by §1888(e)(4) of the Social Security Act (the Act), the Federal rates reflect SNF historical costs derived from cost reports that began during the base period, Fiscal Year (FY) 1995. The rates also include a Part B add-on to account for the estimated cost of services that were furnished during the FY 1995 base period to SNF residents during a Part A covered stay, but were billed separately under Part B. Providers that received new provider exemptions in FY 1995 and routine cost limit exceptions payments are excluded from the data base. The data is aggregated nationally by urban and rural area to determine standardized Federal per diem rates to which case mix and wage adjustments apply. Under a three-phase transition provision, SNFs initially received a blend of a facility-specific rate (reflecting the individual SNF's actual historical cost experience) and the Federal rate.

Federal rates are adjusted to reflect:

- Geographic differences in wage rates, using the hospital wage index; and
- Patient case-mix (the relative resource intensity that would typically be associated with each patient's clinical condition as identified through the resident assessment process), using a patient classification system of Resource Utilization Groups (RUGs). Effective January 1, 2006, refinements to the original case-mix classification system added 9 new "Rehabilitation Plus Extensive Services" RUGs at the top of the previous 44-group hierarchy, for a total of 53 RUGs.

Federal rates are updated annually:

- To reflect inflation in the cost of goods and services used to produce SNF care, using the SNF market basket index;
- To reflect changes in local wage rates, using the latest hospital wage index; and
- By means of rulemaking that by law (§1888(e)(4)(H) of the Act), must be provided for publication in the ***Federal Register*** prior to the August 1 that precedes the October 1 start of each new Federal FY.

CONSOLIDATED BILLING

The CB provision, which is similar in concept to hospital "bundling," requires the SNF to include on its Part A bill all Medicare-covered services furnished to a resident during the course of a covered Part A stay, other than a small list of "excluded" services that can be billed separately under Part B by an outside entity. CB also places with the SNF itself the Medicare billing responsibility for *all* of its residents'

physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services, regardless of whether the resident who receives the services is in a covered Part A stay.

Prior to the BBA, a SNF could elect to furnish services to a resident in a covered Part A stay either:

- Directly, using its own resources;
- Through the SNF's transfer agreement hospital; or
- "Under arrangement" with an independent therapist (for PT, OT, and SLP services).

In each of these circumstances, the SNF billed Medicare Part A for the services. However, the SNF also had the further option of "unbundling" a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident and the outside supplier would submit a Part B bill, without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A and B) billing if both the SNF and outside supplier billed;
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
- A dispersal of responsibility for resident care among various outside suppliers that adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of Inspector General and the Government Accountability Office.

Under the CB requirement, *a SNF itself must submit all Medicare claims for the services that its residents receive during a covered Part A stay*, except for specifically excluded services that are outside the PPS bundle and are separately billable under Part B when furnished to the SNF's resident by an outside supplier. The following services are categorically excluded from SNF CB:

- Physician services, including the professional component of diagnostic tests (representing the physician's interpretation of the test);
- Services of physician assistants working under a physician's supervision;
- Services of nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Services of certified nurse-midwives;
- Services of qualified psychologists;
- Services of certified registered nurse anesthetists;
- Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

- Part B coverage of Epoetin Alfa (EPO) and Darbepoetin Alfa for certain dialysis patients;
- Services furnished by a Rural Health Clinic or Federally Qualified Health Center that would otherwise fall within one of the exclusion categories listed above;
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;
- The following categories of exceptionally intensive outpatient hospital services, which are so far beyond the typical scope of SNF care plans as to require the intensity of the hospital setting in order to be furnished safely and effectively (accordingly, this exclusion *does not apply* if these services are furnished in a freestanding [nonhospital] setting):
  - Cardiac catheterization
  - Computerized axial tomography scans
  - Magnetic resonance imaging services
  - Ambulatory surgery that involves the use of an operating room or comparable setting
  - Emergency services
  - Radiation therapy services
  - Angiography
  - Certain lymphatic and venous procedures;

- Certain specified items within the following categories of services, identified by Healthcare Common Procedure Coding System Code:
  - Chemotherapy items and their administration
  - Radioisotope services
  - Customized prosthetic devices;
- Ambulance services that are necessary to transport a SNF resident offsite to receive Part B dialysis services; and
- Two radiopharmaceuticals, Zevalin and Bexxar (per regulations at 42 CFR 411.15(p)(2)(xii)).

To find additional information about the SNF PPS, visit **http://www.cms.hhs.gov/SNFPPS/01_Overview.asp** and **http://www.cms.hhs.gov/center/snf.asp** on the CMS website.

October 2007 ICN: 006821