SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

Target Audience: Medicare Fee-For-Service Providers

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Learn about these Skilled Nursing Facility Prospective Payment System (SNF PPS) topics:

- Background
- SNF PPS Elements
- SNF Quality Reporting Program (QRP)
- SNF Value Based Purchasing Program (VBP)
- Resources

**BACKGROUND**

The Federal government enacted Section 4432(a) of the Balanced Budget Act (BBA) of 1997 and amended Section 1888(e)(4) of the Social Security Act (the Act) to implement a SNF services per diem PPS. Beginning on or after July 1, 1998, for cost reporting periods, the SNF PPS per diem represents Medicare’s payment for all costs of providing covered Part A SNF services (routine, ancillary, and capital-related costs), except costs associated with operating approved educational activities and services excluded from SNF Consolidated Billing (CB).

**SNF PPS ELEMENTS**

**Rates**

The Federal rates reflect SNF historical costs derived from cost reports that began during the base period, fiscal year (FY) 1995. The rates include a Part B add-on to account for the estimated cost of services furnished during the FY 1995 base period paid by Part B for SNF patients during a Part A covered stay.

The Federal government determines the standardized per diem rates based on national data combined by urban and rural areas. Case-mix and wage adjustments also apply to the per diem rates. Under a three-phase transition provision, SNFs initially received a blend of a facility-specific rate (reflecting the SNF’s actual historical cost experience) and the Federal case-mix adjusted rate. Medicare pays all facilities at the full Federal rate with cost reporting periods beginning in FY 2002.

Adjustments to Federal rates reflect:

- Geographic differences in wage rates, using the hospital wage index
- Patient case-mix (the relative resource intensity associated with each patient’s clinical condition identified through the resident assessment process), using a patient classification system of Resource Utilization Groups (RUGs)
  - On October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) implemented a 66-group Version 4 of the RUGs (RUG-IV). It reflects updated staff time measurement data derived from the Staff Time and Resource Intensity Verification (STRIVE) project and an updated resident assessment tool, Version 3.0 of the Minimum Data Set (MDS 3.0).
Effective October 1, 2019, CMS will use the Patient-Driven Payment Model (PDPM) as the basis for classifying SNF patients in covered Part A stays to determine Medicare payment, replacing RUG IV. PDPM classifies patients into a separate group for each of the case-mix adjusted components. Each group has their own associated case-mix indexes and per diem rates. PDPM applies variable per diem payment adjustments to physical therapy (PT), occupational therapy (OT), and non-therapy ancillary (NTA), to account for changes in resource use over a stay. The adjusted PT, OT, and NTA per diem rates are added together with the unadjusted Speech-Language Pathology (SLP) and nursing component rates and the non-case-mix component to determine the full per diem rate for a given patient.

CMS updates Federal rates annually:

- To reflect SNF care inflation in the cost of goods and services using the SNF market basket index
- As of October 1, 2011, to reflect a Multifactor Productivity Adjustment (MFP) to the SNF market basket index, which accounts for increases in provider productivity that could reduce the actual cost of providing services
- To use a forecast error adjustment whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold for the most recently available FY final data
- To reflect changes in local wage rates using the latest hospital wage index
- According to Section 1888(h) of the Act, beginning October 1, 2018, the adjusted Federal per diem rate is reduced by 2 percent, and the resulting rate is adjusted by the amount earned by the SNF for that FY under the SNF VBP Program

Refer to the [FY 2019 SNF PPS Final Rule](#) for more information about payment updates.

**CB Provision**

The CB provision is similar to hospital bundling. It requires a SNF to include all Medicare-covered services a patient receives during the course of a covered Part A stay, other than a small list of excluded services billed separately under Part B by an outside entity, on the Part A bill. Under the CB requirement, SNFs must bill Medicare for all patients’ PT, OT, and SLP services, regardless of whether the patient receiving the services is in a covered Part A stay.

Prior to the BBA, SNFs could furnish services to a patient in a covered Part A stay:

- Directly, using their own resources
- Through their transfer agreement hospital
- Under arrangement with an independent therapist (for PT, OT, and SLP services)
In each circumstance, SNFs billed Medicare Part A for the services. However, they could also unbundle a service; that is, permit an outside supplier to directly serve the patient. The outside supplier then submitted a Part B bill without involvement from the SNF. This practice created several problems, including:

- A potential for duplicate (Parts A and B) billing if both the SNF and the 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
- No shared responsibility for coordination of care by outside suppliers adversely affected the quality of care and created program integrity issues

Medicare requires you to **submit all Medicare claims for services you furnish during a covered Part A stay**, except for specifically excluded services outside the PPS bundle and separately billable under Part B when furnished to your patients by an outside supplier.

These services are **categorically excluded** from SNF CB:

- Physician services defined by the Medicare Physician Fee Schedule (PFS), including the professional component of diagnostic tests (representing the physician’s interpretation of the test)
- Physician professional services defined by the Medicare PFS when furnished by physician assistants, nurse practitioners, and clinical nurse specialists working 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 patient’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
- These categories of exceptionally intensive outpatient hospital services (along with transportation from the SNF to the hospital and back when the patient’s medical condition requires an ambulance), which are so far beyond the typical scope of SNF care plans as to require the intensity of the hospital setting to be furnished safely and effectively (this exclusion **does not apply** if these services are furnished in a freestanding [non-hospital] setting):
  - Cardiac catheterization
  - Computerized axial tomography (CT) scans
  - Magnetic resonance imaging (MRI) services
- Ambulatory surgery that uses an operating room or comparable setting
- Emergency services
- Radiation therapy services
- Angiography, lymphatic, venous, and related procedures

- Certain specified “high-cost, low probability” items within these categories of services, identified by HCPCS codes:
  - Chemotherapy items and their administration
  - Radioisotope services
  - Customized prosthetic devices

- Ambulance services to transport a SNF patient off-site to receive Part B dialysis services

- Two radiopharmaceuticals, Zevalin and Bexxar (refer to the Code of Federal Regulations at 42 CFR 411.15(p)(2)(xy))
Chart A: Determining Institutional Services Consolidated Billing

These charts provide information to determine whether institutional or professional services are included or excluded from CB.

1. **Is the SNF stay covered by Part A?**
   - **YES**
     - Is the type of service provided institutional or professional?
       - **INSTITUTIONAL**
       - Refer to Chart B.
     - **PROFESSIONAL**
     - Are services for PT, OT, or SLP?
       - **YES**
         - Not included in CB. Bill Medicare Administrative Contractor (MAC).
       - **NO**
         - Refer to Chart B.

2. **Is it in Major Category I, II, III, IV, or V?**
   - **NO**
     - **YES**
       - Refer to Chart B.

**Major Category I: Beyond the Scope of a SNF**
- A. CT Scans
- B. Cardiac catheterization
- C. MRIs
- D. Radiation therapy
- E. Angiography, lymphatic, venous, and related procedures
- F. Outpatient surgery and related procedures
- G. Emergency services
- H. Ambulance trips

**Major Category II: Provided to End-Stage Renal Disease or Hospice Beneficiaries**
- A. Certain chemotherapy
- B. Chemotherapy administration
- C. Radioisotopes and their administration
- D. Customized prosthetic devices

**Major Category III: Provided by Any Entity Except a SNF**
- A. Dialysis, EPO, Aranesp®, and other dialysis-related services
- B. Hospice care for terminal illness

**Major Category IV: Screening or Preventive Services**
- A. Mammography
- B. Vaccines
- C. Vaccine administration
- D. Screening Pap smear and pelvic examination
- E. Colorectal screening services
- F. Prostate cancer screening
- G. Glaucous screening
- H. Diabetic screening
- I. Cardiovascular screening
- J. Initial Preventive Physical Examination
- K. Abdominal aortic aneurysm screening

**Major Category V: Therapy**
- All PT, OT, and SLP services are included in SNF PPS and CB for patients in a Part A stay. The SNF must bill for therapy services. Look to SNF for payment.

Visit CMS.gov/Medicare/Billing/SNFConsolidatedBilling, and select the “Part A MAC Update” for the year the service was provided. Select “Annual SNF Consolidated Billing HCPCS Updates.”

Search the file for the applicable HCPCS code and look in Column D. Is “INCLUSION” included in Column D?
- **YES**
  - The service is included in CB. Look to SNF for payment.
- **NO**
  - The service is excluded from CB. Bill directly to MAC.
Chart B: Determining Professional Services Consolidated Billing

1. Physician Services:
   Professional services provided by physicians and by certain non-physician practitioners (NPPs) are excluded from SNF CB.
   - Visit CMS.gov/Medicare/Billing/SNFCongolidatedBilling, and select the "Part B MAC Update" tab for the year the service was provided.
   - Select "File 1 – Part A Stay – Physician Services."
   - Search the file for the applicable CPT/HCPCS code. If the code appears, it is an included service.
   - Bill MAC.

2. Professional Component of Services Submitted:
   Diagnostic tests are often separated into a technical and professional component. The physician services exclusion applies to the professional component of the diagnostic test.
   - Determine the appropriate CPT/HCPCS code.
   - Visit CMS.gov/Medicare/Billing/SNFCongolidatedBilling, and select the "Part B MAC Update" tab for the year the service was provided.
   - Select "File 2 – Part A Stay – Professional Components of Service to be Submitted with a -26 Modifier."
   - Search the file for the applicable CPT/HCPCS code. If the code appears, it is an excluded service.
   - Bill MAC with -26 modifier. The practitioner must look to the SNF for payment of the technical component.

3. Ambulance Services:
   Ambulance services are not categorically excluded from Part A SNF CB. In specific situations, the transportation may be separately billable.
   - Determine the appropriate CPT/HCPCS code.
   - Visit CMS.gov/Medicare/Billing/SNFCongolidatedBilling, and select the "Part B MAC Update" tab for the year the service was provided.
   - Select "File 3 – Part A Stay – Ambulance."
   - Search the file for the applicable CPT/HCPCS code. Are you using the -NN, -DN, or -ND modifier?
     - YES
       - Service is included in CB. Look to SNF for payment.
     - NO
       - Service is excluded from CB. Bill MAC.

4. Therapy Services:
   Services represented by these codes are the only services subject to SNF CB for Medicare beneficiaries in a SNF Part B stay.
   - Determine the appropriate CPT/HCPCS code.
   - Visit CMS.gov/Medicare/Billing/SNFCongolidatedBilling, and select the "Part B MAC Update" tab in the left-hand menu for the year the service was provided.
   - Select "File 4 – Part B Stay Only – Therapy Services."
   - Search the file for the applicable CPT/HCPCS code. If the code appears, this is an included service; look to SNF for payment.

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SNF QRP

Section 1888(e)(6)(B)(i)(II) of the Act authorizes the SNF QRP. It applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH non-swing bed rural hospitals. SNFs must submit quality data measures specified by the Secretary of Health & Human Services.

Beginning with FY 2018 and each subsequent FY, CMS will reduce the market basket update by 2 percentage points for any SNF that does not comply with quality data submission requirements for any FY.

Measures for Annual Payment Update

This table provides the twelve measures required for the FY 2020 annual payment update. Please refer to SNF Quality Reporting Program Data Submission Deadlines and the “Downloads” section at the bottom of the webpage for more information.

Measures Required for FY 2020 Annual Payment Update

<table>
<thead>
<tr>
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<tr>
<td>Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (National Quality Forum [NQF] #0678**)</td>
<td>MDS Assessment</td>
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<tr>
<td>Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Short Stay)</td>
<td>MDS Assessment</td>
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<tr>
<td>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</td>
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<td>Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</td>
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<td>Drug Regimen Review Conducted with Follow-Up for Identified Issues—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td>MDS Assessment</td>
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<td>Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)</td>
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<td>Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)</td>
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<td>Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)</td>
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</tr>
<tr>
<td>Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)</td>
<td>MDS Assessment</td>
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<td>Medicare Spending Per Beneficiary (MSPB)—Post-Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td>Claims-Based Measure No additional data submission required by SNFs</td>
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<tr>
<td>Discharge to Community—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td>Claims-Based Measure No additional data submission required by SNFs</td>
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<tr>
<td>Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td>Claims-Based Measure No additional data submission required by SNFs</td>
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</table>

**CMS removed the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure and replaced it with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Short Stay) measure, effective October 1, 2018.**

**SNF VBP PROGRAM**

Beginning October 1, 2018, the Federal government pays value-based incentive payments to SNFs based on their performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510). SNFs receive incentive payments on an annual basis, at the start of each new fiscal year. The claim-based SNFRM assesses the risk-standardized rate of all-cause, all-condition, and unplanned inpatient hospital readmissions of Medicare Fee-For-Service SNF patients within 30 days of discharge from admission to an Inpatient Prospective Payment System hospital, CAH, or psychiatric hospital. SNFs receive confidential quarterly and annual reports about their performance.
## RESOURCES

### SNF PPS Resources

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<td>SNF VBP</td>
<td>CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html</td>
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<td>Section 1888(e)(4) of the Social Security Act</td>
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<td>Section 1888(e)(6)(B)(i)(II) of the Act</td>
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