

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Skilled Nursing Facility Prospective Payment System

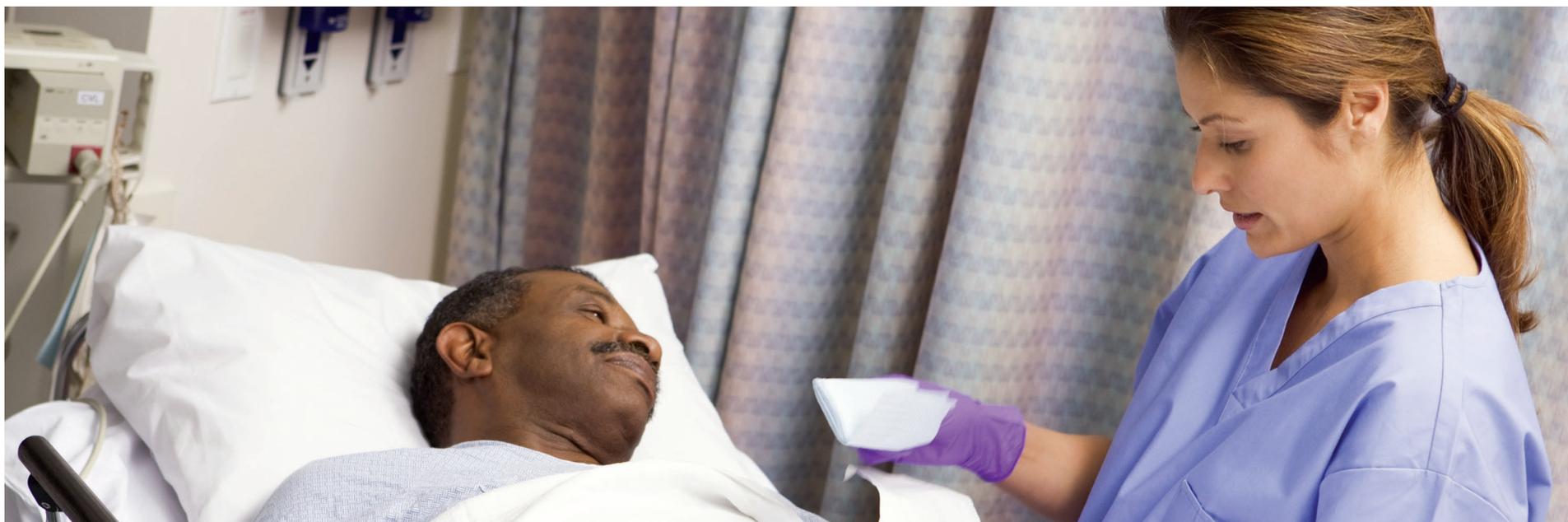
PAYMENT SYSTEM SERIES

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these SNF PPS topics:

- ❖ Background
- ❖ Elements of the SNF PPS
- ❖ SNF QRP
- ❖ SNF VBP Program
- ❖ Resources

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When “you” is used in this publication, we are referring to SNFs.

Background

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how facilities are paid for SNF services. For cost reporting periods beginning on or after July 1, 1998, you are paid a comprehensive per diem under a 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 services excluded from SNF CB, the SNF “bundling” requirement.

Elements of the SNF PPS

The SNF PPS includes these elements: rates and the CB provision.

Rates

As required by [Section 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 furnished during the FY 1995 base period to SNF residents during a Part A covered stay but billed separately under Part B. Providers that received new provider exemptions in FY 1995 and routine cost limit exceptions payments are excluded from the database. The data are

aggregated nationally by urban and rural areas 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.

Adjustments are made to Federal rates to reflect:

- ❖ Geographic differences in wage rates, using the hospital wage index.
- ❖ 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).
 - On 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. On October 1, 2010, the Centers for Medicare & Medicaid Services (CMS) implemented a 66-group Version 4 of the RUGs (RUG-IV), which reflects updated staff time measurement data derived from the Staff Time and Resource Intensity Verification (STRIVE) project as well as an updated resident assessment tool, Version 3.0 of the Minimum Data Set (MDS 3.0).

CMS updates Federal rates annually:

- ❖ To reflect inflation in the cost of goods and services used to produce SNF care using the SNF market basket index
- ❖ As of October 1, 2011, to reflect a Multifactor Productivity Adjustment to the SNF market basket index to account for increases in provider productivity that could reduce the actual cost of providing services
- ❖ To incorporate 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 for which there is final data

- ❖ To reflect changes in local wage rates using the latest hospital wage index
- ❖ By means of rulemaking that by law ([Section 1888\(e\)\(4\)\(H\) of the Act](#)) must be provided to the Federal Register prior to the August 1 that precedes the October 1 start of each new Federal FY

For more information about SNF PPS payment updates, refer to [Final Fiscal Year 2017 Payment and Policy Changes for Medicare Skilled Nursing Facilities](#).

The CB Provision

The CB provision, which is similar in concept to hospital bundling, requires you to include on your Part A bill all Medicare-covered services that a resident received 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. Under the CB requirement, you are also responsible for billing Medicare for **all** of your 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, you could elect to furnish services to a resident in a covered Part A stay either:

- ❖ Directly, using your own resources
- ❖ Through your transfer agreement hospital
- ❖ Under arrangement with an independent therapist (for PT, OT, and SLP services)

In each of these circumstances, you billed Medicare Part A for the services. However, you also had the further option of unbundling a service altogether; that is, you 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 on your part. This practice created several problems, including:

- ❖ A potential for duplicate (Parts A and B) billing if both you 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.
- ❖ A dispersal of responsibility for resident care among various outside suppliers that adversely affected quality (coordination of care) and program integrity, as documented in reports by both the Office of Inspector General (OIG) and the Government Accountability Office (GAO). For more information, refer to OIG report OEI-06-92-00863, [Medicare Services Provided to Residents of Skilled Nursing Facilities](#) (October 1994) and GAO report HEHS-96-18, [Providers Target Medicare Patients in Nursing Facilities](#) (January 1996).

Under the CB requirement, **you must submit all Medicare claims for the services your residents receive 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 residents by an outside supplier.

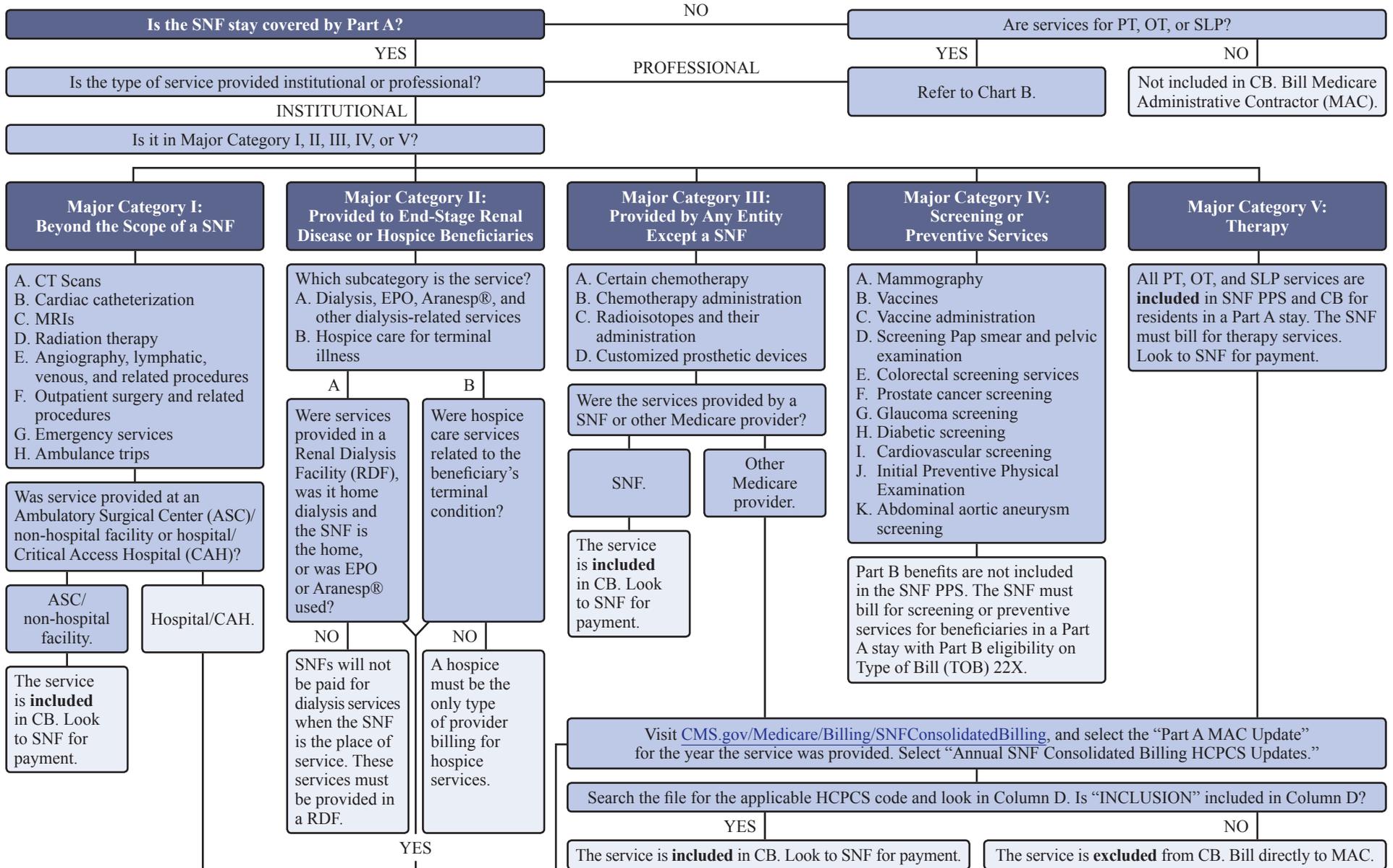
These services are **categorically excluded** from SNF CB:

- ❖ Physician services as 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 as defined by the Medicare PFS when furnished by physician assistants, 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
- ❖ These categories of exceptionally intensive outpatient hospital services (along with transportation from the SNF to the hospital and back when the resident's medical condition requires the use of 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 (accordingly, 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 involves using an operating room or comparable setting
 - Emergency services
 - Radiation therapy services
 - Angiography
 - Certain lymphatic and venous procedures
- ❖ Certain specified "high-cost, low probability" items within these categories of services, identified by HCPCS code:
 - Chemotherapy items and their administration
 - Radioisotope services
 - Customized prosthetic devices
- ❖ Ambulance services necessary to transport a SNF resident 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\(p\)\(2\)\(xii\)](#))

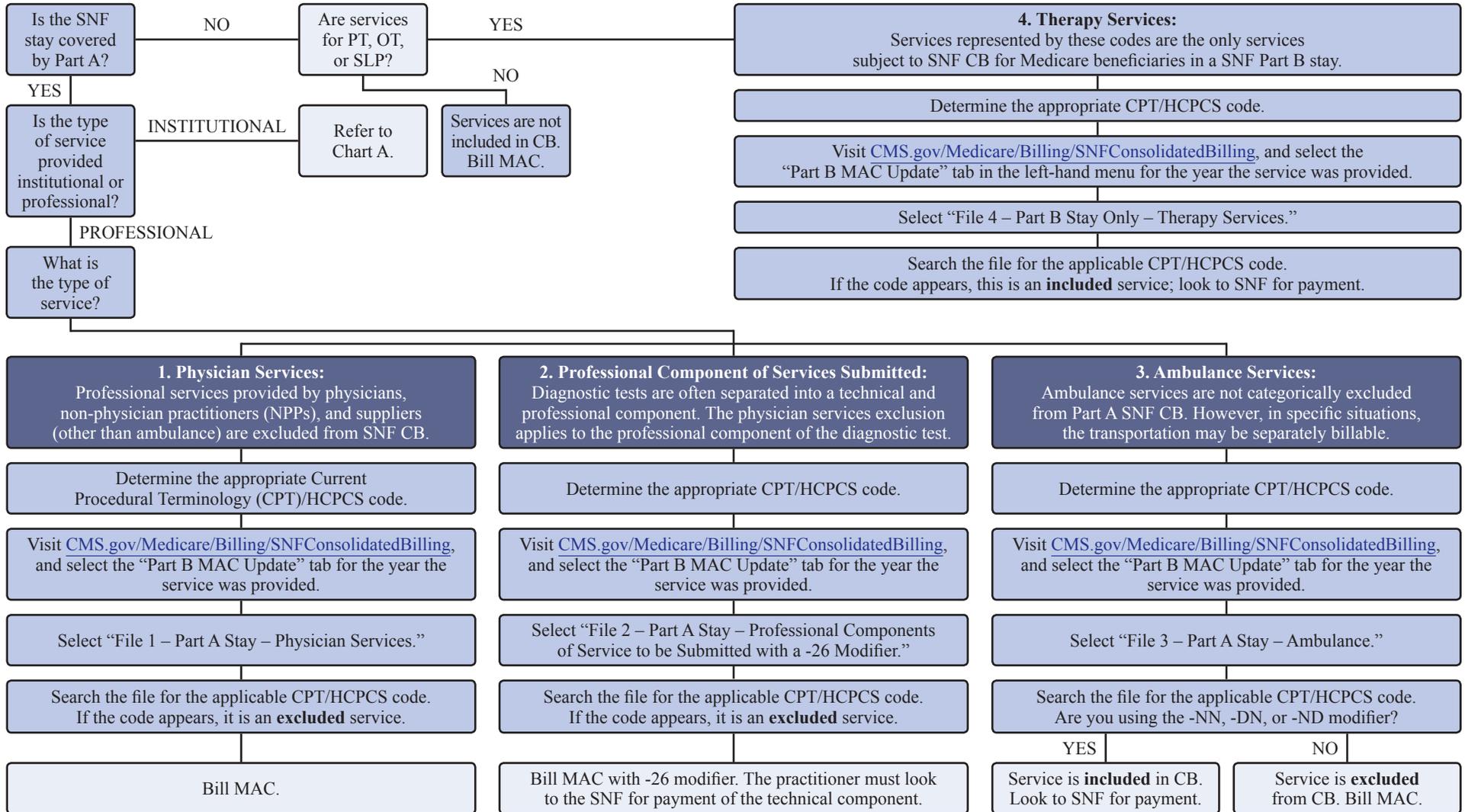
These charts provide information on determining whether institutional or professional services are included or excluded from CB.

Chart A: Determining Consolidated Billing for Institutional Services



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Chart B: Determining Consolidated Billing for Professional Services



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SNF QRP

Under [Section 1888\(e\)\(6\)\(B\)\(i\)\(II\) of the Act](#), you must submit data to the Secretary of the Department of Health & Human Services on quality measures specified by the Secretary. Under [Section 1888\(e\)\(6\)\(A\)\(i\) of the Act](#), beginning with FY 2018 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any SNF that does not comply with quality data submission requirements with respect to that FY.

Measures for Annual Payment Update

These tables provide the six measures required for the FY 2018 annual payment update and one measure for the FY 2020 annual payment update.

Measures Required for FY 2018 Annual Payment Update

| Number | Required Measure | Data Source |
|--------|---|----------------|
| 1 | National Quality Forum (NQF) #0678 – Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) | MDS assessment |
| 2 | NQF #0674 – Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) | MDS assessment |
| 3 | NQF #2631 – Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function | MDS assessment |
| 4 | Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) Skilled Nursing Facility Resource Use Measure | Claims-based |
| 5 | Discharge to Community- Post-Acute Care Skilled Nursing Facility Quality Reporting Program | Claims-based |
| 6 | Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program | Claims-based |

Measure for the FY 2020 Annual Payment Update

| Number | Required Measure | Data Source |
|--------|---|----------------|
| 1 | Drug Regimen Review Conducted with Follow-Up for Identified Issues – Post-Acute Care Skilled Nursing Facility Quality Reporting Program | MDS assessment |

SNF VBP Program

Under Section 215 of the Protecting Access to Medicare Act of 2014, Subsections (g) and (h) were added to [Section 1888 of the Act](#) to establish the SNF VBP Program. Beginning with FY 2019, value-based incentive payments will be made to SNFs based on their performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510). 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 an admission to an Inpatient Prospective Payment System hospital, CAH, or psychiatric hospital.

Resources

This table provides SNF PPS resource information.

SNF PPS Resources

| For More Information About... | Resource |
|---|---|
| SNF PPS | CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP Chapter 8 of the Medicare Benefit Policy Manual (Publication 100-02) Chapters 6 and 7 of the Medicare Claims Processing Manual (Publication 100-04) |
| SNF QRP | CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQuality/znits/SNF-Quality-Reporting.html |
| SNF VBP | CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html |
| All Available Medicare Learning Network® (MLN) Products | MLN Catalog |
| Provider-Specific Medicare Information | MLN Guided Pathways: Provider Specific Medicare Resources |
| Medicare Information for Patients | Medicare.gov |

Hyperlink Table

| Embedded Hyperlink | Complete URL |
|---|---|
| Section 1888(e)(4) of the Social Security Act Section 1888(e)(4)(H) of the Act | https://www.ssa.gov/OP_Home/ssact/title18/1888.htm |
| Final Fiscal Year 2017 Payment and Policy Changes for Medicare Skilled Nursing Facilities | https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-29.html |
| Medicare Services Provided to Residents of Skilled Nursing Facilities | https://oig.hhs.gov/oei/reports/oei-06-92-00863.pdf |
| Providers Target Medicare Patients in Nursing Facilities | http://www.gao.gov/products/HEHS-96-18 |
| 42 CFR 411.15(p)(2)(xii) | http://www.ecfr.gov/cgi-bin/text-idx?SID=c660cb254c94a07bf21a225fa248cc59&mc=true&node=se42.2.411_115&rgn=div8 |
| Section 1888(e)(6)(B)(i)(II) of the Act Section 1888(e)(6)(A)(i) of the Act Section 1888 of the Act | https://www.ssa.gov/OP_Home/ssact/title18/1888.htm |
| Chapter 8 of the Medicare Benefit Policy Manual | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf |
| Medicare Claims Processing Manual | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html |
| MLN Catalog | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf |
| MLN Guided Pathways: Provider Specific Medicare Resources | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf |



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