AHCA Summary of 2019 Skilled Nursing Center Prospective Payment System Final Rule

Our rates increase 2.4 percent starting October 1, 2018

July 31, 2018

On July 31, the Centers for Medicare & Medicaid Services (CMS) issued a final rule [CMS- 1696-F] outlining proposed Fiscal Year (FY) 2019 Medicare payment rates and quality programs for skilled nursing facilities (SNFs).

Additionally, CMS finalized a payment system called the Patient-Driven Payment Model (PDPM) to replace the current RUGs-based SNF PPS. The PDPM is an updated version of the 2017 Advanced Notice of Proposed Rulemaking Resident Classification System Version 1 (RCS-1). CMS notes RCS-1 was revised based on stakeholder input. The implementation date for the final system is October 1, 2019 (Fiscal Year 2020). CMS proposes to implement PDPM in a budget neutral manner.

Also, of note, AHCA has identified a number of anomalies in various tables through-out the final rule primarily pertaining to the FY19 RUG rates, as well as the FY19 Impact Analysis. AHCA staff and Reimbursement Committee members are in the process of analyzing these items and other items that changed from the proposed to the final rule.

Below please find a preliminary overview of the payment updates, the SNF value-based purchasing (VBP) program proposed new components, the IMPACT Act quality reporting additions, and an overview of the payment reform discussion.

A. Payment Policy

1. FY19 Payment Update Notice of Proposed Rulemaking

On July 31, CMS issued our annual payment update regulation. The final rule for FY19 establishes a market basket increase of 2.4 percent. This figure is statutorily mandated by Congress. Based on changes contained within this final rule, CMS indicates aggregate payments to SNFs will increase in FY19 by $820 million, or 2.4 percent, from payments in FY18 – $30 million less than in the Notice of Proposed Rulemaking which projected $850 million. At the same time, CMS notes that the overall economic impact of the SNF Value-Based Purchasing Program (VBP) is an estimated reduction of $211 million in aggregate payments to SNFs during FY19.

2. Market Basket Update

Specifically, for FY19, the market basket update is a result of the Bipartisan Budget Act of 2018 (BBA) which requires that skilled nursing facilities receive a 2.4 percent market basket increase in FY19 to offset part of the cost of the bill. The 2.4 percent and related savings was calculated by the Congressional Budget Office. The FY19 update would have otherwise been a net increase of 2.0 percent, which reflects an increase of 2.8, updated from the Notice of Proposed Rulemaking (NPRM) figure of 2.7 percent, minus a 0.8 percent multifactor productivity adjustment as required by Section 3401(b) of the Affordable Care Act (ACA). This adjustment factor is a tenth of a percent higher than the NPRM figure. No forecast error was incurred in the CMS modeling in the absence of the BBA in the final rule.

CMS used the SNF market basket to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY19 from average prices for FY18. CMS indicates it would further adjust the rates by a wage index budget neutrality factor. Tables 3 and 4 reflect the updated components of the unadjusted federal rates for FY18 prior to adjustment for case-mix.

Table 4
FY19 Unadjusted Federal Rate Per Diem
Urban

RATE COMPONENT	NURSING CASE-MIX	THERAPY CASE MIX	THERAPY NON-CASE-MIX	NON-CASE MIX
PER DIEM AMOUNT	$181.44	$136.67	$18.00	$92.60

Table 5
FY19 Unadjusted Federal Rate Per Diem
Rural

RATE COMPONENT	NURSING CASE-MIX	THERAPY CASE MIX	THERAPY NON- CASE-	NON-CASE-MIX
PER DIEM	$173.34	$157.60	$19.23	$94.31

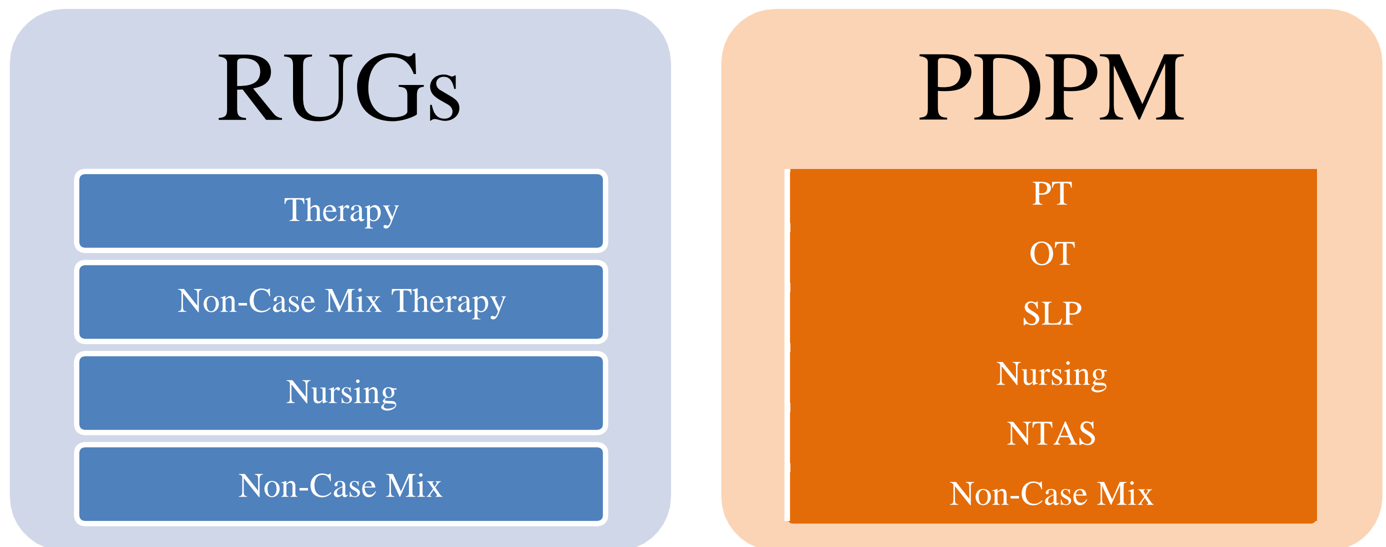
3. Payment Reform Provisions

In the Balanced Budget Act of 1997, Congress established a SNF prospective payment system (PPS) for Medicare Part A fee-for-service (FFS) payment called the Resource Utilization Group (RUGs) system. However, since its inception, RUGs has been criticized for not truly being a PPS. Specifically, critics note RUGs is utilization driven by therapy minutes and is a per diem. Additionally, the strong tie of payment to therapy minutes is perceived to be a powerful flaw in RUGs, which incentivizes therapy delivery. At the same time, critics, as well as the original RUGs evaluation reports, indicate that the RUGs nursing and nontherapy ancillary services (NTAS) component likely is underfunded and that use of nursing does not relate to NTAS utilization.

In June 2017, CMS used an unusual regulatory vehicle called an Advanced Notice of Proposed Rulemaking to request feedback on a payment system reform proposal called the Resident Classification System Version 1 (RCS-1) to replace the existing Medicare Part A FFS payment system. Based on feedback on RCS-1, CMS made an array of changes and released a new, and formally proposed, payment system in our FY19 NPRM. The proposed payment system is called the Patient-Driven Payment Model (PDPM).

Patient-Driven Payment Model – The PDPM is a fundamental shift from RUG-IV and would replace RUGs entirely for Medicare Part A FFS payment to SNFs. Payment is based upon an array of patient characteristics, primarily medical information, associated with newly designed care components. Therapy minutes no longer drive payment. See ***Figure 1*** for a comparison of RUG-IV and PDPM.

Figure 1. RUG-IV Compared to PDPM



CMS finalized several core PDPM elements which are included in the summary provided below:

i. ***Payments is a Per Diem Equal to the Sum of Component Rates.*** PDPM still is a per diem payment system. Specifically, PDPM per diem payments are the sum of five independently determined case mix adjusted payment components plus a non-case mix

component, rather than a single hierarchical RUG case-mix group (CMG). In the final rule, CMS made no changes to the approach to the PDPM per diem calculations. CMS also will continue to use the existing market basket calculation approach used under RUGs with PDPM.

ii. ***PDPM is Patient Characteristics-Based and Therapy Minutes Are No Longer Relevant to Payment.*** Therapy minutes no longer play a role in determining payment. While CMS still will require therapy minute reporting on the Discharge MDS, therapy minutes and related thresholds no longer drive payment. Rather, patients are assigned to a CMG for each component using clinical information which differs by component. In the final rule, CMS made no substantive changes to the underlying patient characteristics and related classification and only nominal coding changes. See ***Figure 2*** for a basic overview.

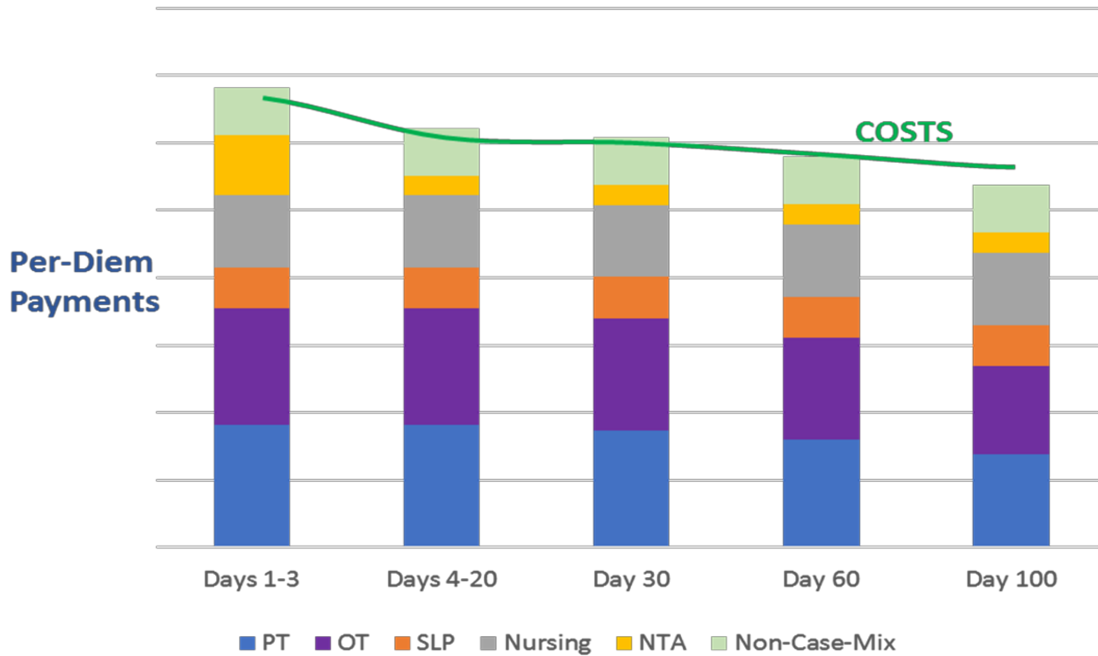
Figure 2. PDPM Component and Patient Characteristics Used for CMG Assignment

Component	PT	OT	SLP	Nursing	NTA
Patient Characteristics	• Primary reason for SNF Care via MDS Section I ICD-10-CM code • Functional Status – Section GG Early and Late Loss	• Primary reason for SNF Care via MDS Section I ICD-10-CM code • Functional Status – Section GG Early a Late Loss	• Primary Reason for SNF care is acute neurologic via MDS Section I ICD-10 code • SLP related comorbidities • Cognitive Status • Presence of swallowing disorder or mechanically altered diet	• Clinical info from SNF Stay • Functional Status – Section GG Early and Late Loss • Extensive Services Received • Presence of depression • Restorative nursing services received	• Comorbidities present • Extensive services used
Per Diem Structure	Payment Decreases After Day 20	Payment Decreases After Day 20	Average Daily Payment No Variable Payment	Average Daily Payment No Variable Payment	Payment Decreases After Day 3
# of Case Mix Groups	16	16	12	25	6

iii. ***Variable Payment Schedule is Finalized.*** Payments would taper for PT, OT, and NTAS but beginning on different days for PT and OT. Rather than on day 14 for the RCS-1 PT/OT component, the now separate PT and OT components begin to taper on day 20 and then every seven days rather than three, as under RCS-1. NTAS tapering remains unchanged in terms of start date – day three of a stay. These declining payments will align the SNF Medicare Part A FFS payment system with Medicare Advantage and Accountable Care Organization incentives for shorter lengths of stay. See Figure 3, below, for an illustration.

Concern was expressed over CMS' proposal that providers could not reset variable payments for PT, OT and NTAS to day one under any circumstances. In the final rule, CMS finalized this their proposal that tapering components cannot be reset to day one.

Figure 3. Variable Per Diems Relative to Costs



iv. ***PDPM Finalized Elimination of Multiple Mandatory SNF PPS Assessments.*** PDPM eliminates most scheduled SNF PPS and OMRA assessments required under RUG-IV. PDPM requires only an admission and a discharge assessment and would permit an optional interim payment assessment (IPA) discussed below. PDPM requires a Five-Day Admission Assessment based on the existing MDS Five-Day assessment. In this assessment, SNF clinicians will identify diagnoses applicable to resident needs, resident characteristics, co-morbidities, and treatments that most impact care, and, in concert with the MDS Coordinator, enter the applicable information on the MDS to permit resident assignment to the PDPM component CMGs based upon this information. The second required PDPM assessment is a Discharge Assessment. As with the Admission Assessment, the Discharge Assessment will be based upon the existing MDS Discharge Assessment but will add therapy reporting items. Specifically, the PDPM MDS Discharge Assessment will require SNFs to report per-stay therapy days and minutes using the MDS Section O (more on therapy below).

v. ***Interim Payment Assessment (IPA) Now Optional***. The third PDPM assessment is the IPA, which is intended to allow SNFs to reclassify patients into CMGs which differ from their admission assignments based on changes in condition. CMS had

proposed to require ongoing monitoring for the need for an IPA and potential penalties for missing an IPA. In the final rule, CMS has made an IPA optional, will not impose penalties for not performing an IPA assessment, and notes it will solicit additional input on the IPA triggering events and related policies.

vi. ***ICD-10 Diagnosis Coding on MDS and Related Coding Becomes the Basis for Payment is Final.*** Since October 2015, SNFs have been required to use International Statistical Classification of Diseases and Related Health Problems (ICD) codes on claims. The current required version is ICD-10. PDPM finalizes the requirement to use ICD-10 diagnosis codes on the Admission MDS and as part of PT, OT, and NTAS classification into a CMG. ICD-10 coding on claims now will drive payment.

vii. ***Concurrent and Group Therapy Policies Finalized as Proposed.*** CMS proposed that under PDPM, SNF therapists (physical and occupational therapists and speech-language pathologists (PT/OT/SLP) would be able to use up to 25 percent of a resident's treatment time per discipline per stay using concurrent or group therapy modalities (combined). Therapy days and minutes for the stay would be reported one on the SNF PPS discharge MDS. The final rule was unchanged; however, CMS stated it would consider revising the therapy flexibilities in future rulemaking.

viii. ***Administrative Presumption Coverage Protections Under PDPM Significantly Expanded from Proposed.*** Under RUGs, CMS traditionally provided administrative coverage protections to SNF residents qualifying for higher need nursing and for residents needing daily therapy trough the admission assessment reference period without need for automatic MAC coverage audits. The proposed rule severely limited these protections for residents requiring extensive therapy services. The final PDPM rule restored most of those protections.

4. Other Payment Proposals – Wage Index and Consolidated Billing

Stakeholders have long requested that CMS develop a SNF-specific wage index and update its Consolidated Billing policies. CMS made no changes to the existing wage index methodology nor to the Consolidated Billing exclusions list.

B. IMPACT Act Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Social Security Act and applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Under the SNF QRP, CMS reduces by 2 percentage points the annual market basket percentage update in the case of a SNF that does not submit specified quality data for that fiscal year. CMS did not propose any measure changes but did finalize several operational aspects of the SNF QRP program as follows:

i. Added a measure removal factor: Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program

ii. Finalized a proposal to notify a SNF of non-compliance with the SNF QRP requirements for a program year via a letter sent through at least one of the following notification methods: the QIES ASAP system; the United States Postal Service; or via an e-mail from the Medicare

Administrative Contractor (MAC).

iii. Finalized a proposal to notify SNFs in writing of the CMS final decision regarding any reconsideration request via a letter sent through at least one of the following notification methods: the QIES- ASAP system, the United States Postal Service, or via an e-mail from the Medicare Administrative Contractor (MAC).

iv. Finalized a proposal, to increase the number of years of data used to calculate the Medicare Spending per Beneficiary-PAC SNF QRP measure and Discharge to Community-PAC SNF QRP measure for purposes of public display from 1 to 2 years, starting in CY 2019 or as soon thereafter as operationally feasible.

v. Finalized a proposal to begin publicly displaying data in CY 2020, or as soon thereafter as is operationally feasible, on the four assessment-based functional outcomes measures for mobility and self-care (applications of NWF#2633, NWF #2634, NWF #2635 and NQF #2636).

C. Rehospitalization Value-Based Purchasing Program

As required by the Protecting Access to Medicare Act of 2014 (PAMA), CMS has implemented a SNF VBP Program aimed at reducing rehospitalizations. The first financial impact related to VBP begins October 1, 2018. CMS will apply either a positive or negative incentive payment to Medicare Part A (FFS) services provided by SNFs. Providers may see up to a 2 percent reduction in rates. The exact payment impact will be based on readmission performance measured by SNFRM in calendar years 2015 and 2017. Either the improvement from 2015 to 2017 or the performance in 2017 will determine the payment. SNFs will be notified of their VBP incentive payment 60 days prior to October 1 through Performance Score Reports accessible using the QIES-CASER system.

In the rule, CMS finalized all the changes it proposed without any changes. The highlights of the finalized changes include:

i. The 2 percent reductions and the SNF-specific value-based incentive payment adjustment to claims will occur simultaneously. Net SNF incentive payment percentages range from a cut of nearly 2 percent to a return of the 2 percent plus more (e.g. a small increase in payment).

ii. Achievement and benchmark threshold rates from the 2018 final rule will continue to be used for 2020: 19.782 percent and 16.279 percent, respectively. Achievement and benchmark thresholds for 2021 have been finalized at 20.524 percent and 16.788 percent, respectively.

iii. Reporting for the 2017 baseline and 2019 performance periods for the 2021 Program year will be based on Fiscal Years instead of calendar years, and this will continue for future Program years.

iv. SNFs with insufficient baseline period data (<25 Medicare part A stays in a 12 month period), but sufficient performance period, data will only receive an achievement score.

v. SNFs with insufficient performance period data (<25 Medicare part A stays in a 12 month period) will be assigned a performance score based on the average of all SNF scores.

vi. SNFs with observed readmission rates of zero may receive risk-standardized readmission rates that are greater than zero due to risk adjustment.

vii. CMS is adopting an Extraordinary Circumstances Exceptions policy for SNF VBP Program that will exclude data from the extraordinary circumstances period from their measurement rate calculations. Extraordinary circumstances can be natural or manmade disasters—hurricanes, fires, terrorism, civil disorder, etc.—or other circumstances outside the facility's control that may affect the ability to provide high-quality health care.

Contacts and Next Steps

Comments, suggestions and questions may be directed to:

- Market Basket Update: Mike Cheek
- Value-Based Purchasing: David Gifford
- IMPACT Act Quality Reporting Program: Dan Ciolek and Holly Harmon
- PDPM: Mike Cheek and Dan Ciolek