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CMS Releases FY 2020 SNF PPS Proposed Rule

On April 19, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for Fiscal Year (FY) 2020 that updates the Medicare payment rates and the quality programs for skilled nursing facilities (SNFs). Effective October 1, 2019, CMS will begin using a new case-mix model, the Patient Driven Payment Model (PDPM), which focuses on the patient's condition and resulting care needs rather than on the amount of care provided in order to determine Medicare payment.

Key provisions of the FY 2020 SNF PPS *Proposed Rule* per the CMS fact sheet:

CMS projects aggregate payments to SNFs will increase by $887 million, or 2.5 percent, for FY 2020 compared to FY 2019. This estimated increase is attributable to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment.

Updated Base Rates for PDPM Components:

For FY 2020, CMS proposes that the unadjusted federal rate per diem for urban and rural will be as follows, prior to adjustment for case-mix:

FY 2020 Unadjusted Federal Rate Per Diem--URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non - Case - Mix
Per-Diem Amount	$61.16	$56.93	$22.83	$106.64	$80.45	$95.48

FY 2020 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non - Case - Mix
Per-Diem Amount	$69.72	$64.03	$28.76	$101.88	$76.86	$97.25

*In addition, some of the case mix indexes have changed in the FY 2020 SNF proposed rule.

Sub-Regulatory Process for ICD-10 Codes Revisions:

CMS' Patient Driven Payment Model (PDPM) will be effective October 1, 2019 under the SNF Prospective Payment System (PPS) for classifying patients in a covered Medicare Part A SNF stay. PDPM utilizes ICD-10 codes to classify SNF patients into certain payment groups. Each year, the ICD-10 codes and guidelines are revised in a variety of non-substantive ways, such as a single code being split into two more specific codes. To help ensure SNFs have the most up-to-date ICD-10 code information as soon as possible, in the clearest and most useful format, CMS proposes a sub-regulatory process for making non-substantive changes to the list of ICD-10 codes used to classify patients into clinical categories under the PDPM. This sub-regulatory process aligns with similar policies in the SNF PPS and the Inpatient Rehabilitation Facility (IRF) PPS.

Align SNF PPS Group Therapy Definitions with Other PAC Settings:

Various PAC settings permit therapists to furnish therapy to their patients in three different modes: individual, concurrent, and group. Under the current SNF PPS, group therapy is defined as consisting of exactly four patients. Other payment systems, such as the IRF PPS, define group therapy as including as few as two patients. For more fair and consistent therapy definitions across care settings, CMS is proposing to adopt the definition of group therapy that is used in the IRF PPS: group therapy consists of two to six patients doing the same or similar activities.

SNF Value-Based Purchasing Program (VBP):

The SNF VBP Program began rewarding SNFs with incentive payments based on their quality measure performance on October 1, 2018. The program currently scores SNFs on an all-cause measure of hospital readmissions, and in the future, will transition to a measure of potentially preventable hospital readmissions. As required by statute, the program reduces SNFs' Medicare payments by two percentage points, then redistributes 60% of those funds as incentive payments.

In the FY 2020 SNF PPS proposed rule, the SNF VBP Program is changing the name of the program's measure to the "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge" measure. The measure will retain the same abbreviation (SNFPPR). The proposed rule also includes an update to the public reporting requirements to ensure that CMS publishes accurate performance information for low-volume SNFs.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP):

The SNF QRP applies to freestanding SNFs, any SNF affiliated with acute care facilities, and all non-critical access hospital (CAH) swing-bed rural hospitals. Under the SNF QRP, SNFs that fail to submit the required quality data to CMS will be subject to a 2-percentage point reduction from the applicable fiscal year's annual market basket percentage update.

CMS proposes to adopt two new quality measures in FY2020 to assess how health information is shared. The two proposed measures are: 1) Transfer of Health Information from the SNF to another Provider, and 2) Transfer of Health Information from the SNF to the Patient.

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In addition, CMS proposes to adopt a number of standardized patient assessment data elements that assess either cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, or social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, or social isolation). Finally, CMS proposes updates to specifications for the Discharge to Community PAC SNF QRP measure to exclude baseline nursing home residents.

In response to public input, CMS is proposing to collect standardized patient assessment data and other data required to calculate quality measures using the MDS on all patients, regardless of payer source.

The read the complete FY2020 SNF PPS Proposed rule: http://polaris-group.com/news_releases.asp

PDPM Transition Updates

The transition between RUG-IV and PDPM will be a "hard" transition, meaning the two systems will not run concurrently at any point. PDPM is effective October 1, 2019. Any RUG MDS for Sept must have an ARD on or before Sept 30, 2019, even if the MDS only captures a few days. There are no changes in short stay rules so facilities may achieve only a medical (nursing) RUG.

CMS updated their PDPM website on April 4, 2019 and again on April 11, 2019. This included updates to the PDPM FAQ, PDPM Classification walkthrough and the ICD-10 Mapping.
CMS PDPM website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Significant new ICD-10 Mapping Changes:

- There is now one ICD-10 Mapping, with tabs for Clinical, SLP, and NTA.
- PDPM clinical category mapping of all initial, subsequent and sequela encounters for femur fractures are mapped to the default clinical category of "Non-Surgical Orthopedic/ Musculoskeletal" and "May be Eligible for One of the Two Orthopedic Surgery Categories" as an alternative category if the resident had a major procedure during the prior inpatient stay that impacted the SNF care plan.
- Prior mapping sheet:
  - S72001D Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture mapped to "Other Orthopedic Surgery" and was not impacted by whether or not they had a past qualifying surgical procedure from Section J or not.
- New mapping sheet:
  - If facility achieves "Non-Surgical Orthopedic" then a Surgical Procedure will need to be coded in New Section J to achieve "Other Orthopedic Surgery".
  - Z47.89 Encounter for Other Orthopedic Aftercare still maps to "Other Orthopedic Surgery" but now "May be eligible for one of two orthopedic surgery categories".
  - Z47.1 Aftercare Following Joint Replacement Surgery still maps to "major joint replacement".

MDS Assessment Changes and Processes:

- MDS assessments are used to classify patients into payment categories under the Patient Driven Payment Model (PDPM).
- The Initial Patient Assessment and the PPS Discharge Assessment are required.
- Performance of an initial patient assessment no later than the 8th day of post-hospital SNF care.
- The IPA is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment.

New MDS Items:

Section I: SNF Primary Diagnosis (may be different from reason for qualifying hospital stay)

- Primary Diagnosis classifies patient into PDPM clinical category (Use ICD-10 Mapping file to determine clinical category)
- New Item I0020B : Primary SNF diagnosis
- Identifies main reason person is being admitted to the SNF
- I0020B is coded when item I0020 is coded any response of 1-13
- Item I0020A will be eliminated
- Only I0020 and I0020B will be used

Section J: Patient Surgical History

- New items in Section J: J2100 – J5000-Captures any major surgical procedures that occurred during the qualifying inpatient hospital stay immediately preceding the SNF admission and relevant to classifying patient into PDPM clinical category
- Used in conjunction with diagnosis code captured in I0020B to classify in PT and OT case mix classification group
- The PDPM Classification Walkthrough outlines impact of Section J coding on the patient's clinical category.
- The specific procedure code is not necessary for patient classification.

Section O: Discharge Therapy Items

- New Items O0425A1 – O0425C5-Captures concurrent and group therapy over the course of patient' entire Medicare Part A stay
- Look-back period is the entire PPS stay
- Warning message on final validation report if total amount of group/concurrent minutes combined comprises more than 25% of total amount of therapy for that discipline.

Section GG: Interim Performance-CMS goal of using standardized assessment items across payment settings

- IPA-GG items will have new column "5" to capture interim functional performance
- Look-back for the new column is the three day window preceding, including the ARD of the IPA.

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Existing MDS Items Added to PPS Item Sets

- **SNF**
  - Item I1300 Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease added to PPS Item Sets NP, SP and IPA
  - Captures Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease for NTA comorbidity score
- **Swing Bed**
  - Existing MDS items added to Swing Bed PPS Assessment used to classify swing bed residents under PDPM
  - K0100: Swallowing Disorder
  - I4300: Active Diagnosis: Aphasia
  - O0100D2: Special Treatments, Procedures and Programs: Suctioning, While a Resident

Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question: I have a resident who was skilled at our facility under an HMO Medicare Advantage plan. He had been in the hospital with an acute stroke. The HMO said they would only authorize nursing skilled services and not therapy because he had rehab at the hospital. The wife switched to traditional Medicare on 3/1/19 and therapy did not evaluate him until 3/6/19. Can we just open up a SOT and let the previous scheduled PPS MDSs cover payment until the day therapy evaluated her, or do we need to start the PPS schedule again?

Answer: You need to start the PPS schedule again with a 5-day PPS MDS. The Medicare start date under A2400B would be 3/1/19. Since therapy did not evaluate him until 3/6/19, I would recommend completing the 5-day PPS MDS by itself and opening a separate SOT. You would set the SOT ARD for 5-7 days after the therapy start date. The date of the therapy evaluation is counted as day one when determining the ARD for the Start of Therapy OMRA (SOT).

Question: We did an EOT with a resumption date of 3/6/19, which is day 13 of the stay. What day should I set my 14-day ARD so we can get a minimum of 5 days of therapy?

Answer: If you set the 14-day ARD for 3/10/19 or 3/11/19, which are days 17 and 18, then therapy has the opportunity to provide 5-6 days of therapy during the lookback.

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