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CMS Issues FY 2019 SNF PPS Final Rule

On July 31, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule [CMS-1696- F] outlining 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). The implementation date for the final system is October 1, 2019 (Fiscal Year 2020).

Summary of Key provisions in the FY 2019 SNF PPS Final Rule:

SNF PPS Payment Update

The final rule for FY2019 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 FY2019 by $820 million, or 2.4 percent, from payments in FY2018. 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 FY2019. This payment update begins October 1, 2018.

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.

In April 2017, CMS released a regulatory update called an Advanced Notice of Proposed Rulemaking (ANPRM), which outlined a new case-mix model, 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 significant changes and released a new payment system in the proposed and now final rule called the Patient-Driven Payment Model (PDPM).

The PDPM is a fundamental shift from RUG-IV and will replace RUGs entirely for Medicare Part A FFS payment to SNFs. The new case-mix model, PDPM, focuses on clinically relevant factors, rather that volume -based service for determining Medicare payment, by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. Therapy minutes will no longer drive payment.

CMS finalized several key PDPM elements:

- **Payment 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 (PT, OT, SLP, Nursing and Non-Therapy Ancillary) plus a non-case mix component.

- **PDPM is Patient Characteristics-Based.** 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 Case mix group (CMG) for each component using clinical information that differs by component.

- **Variable Payment Schedule.** Daily payments will taper after day 20 of the stay for PT and OT components. The Non-Therapy Ancillary (NTA) payments will taper after day 3 of the 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. CMS finalized that tapering components cannot be reset to day one.

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- **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). PDPM requires a Five-Day Admission Assessment based on the existing MDS Five-Day assessment. 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.

- **Interim Payment Assessment (IPA) Now Optional**. The third PDPM assessment is the IPA, which is intended to allow SNFs to reclassify patients into CMGs that 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, they 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.

- **ICD-10 Diagnosis Coding on MDS and Related Coding Becomes the Basis for Payment**. 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.

- **Concurrent and Group Therapy Policies** Therapists (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 on the SNF PPS discharge MDS.

SNF 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.

In the final rule, CMS added an additional factor to consider when evaluating measures for removal from the SNF QRP measure set. This factor takes into account costs that are associated with a measure and weighs them against the benefit of its continued use in the program. CMS will also publicly display the four SNF QRP assessment-based quality measures, and increase the number of years of data used to display two claims-based SNF QRP measures (Discharge to the Community and Medicare Spending per Beneficiary), from 1 year to 2 years.

SNF Value-Based Purchasing Program

As required by law, beginning October 1, 2018, the SNF VBP Program will apply either positive or negative incentive payments to services furnished by skilled nursing facilities based on their performance on the program's readmissions measure. The single claims-based all cause 30-day hospital readmissions measure in the SNF VBP aims to improve individual outcomes through rewarding providers that take steps to limit the readmission of their patients to a hospital. This single measure does not require SNFs to report information in addition to the information they already submit as part of their claims, CMS uses existing Medicare claims information to calculate the measure.

The FY 2019 final rule discusses updates to policies, including performance and baseline periods for FY 2021 SNF VBP Program year, an adjustment to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception (ECE) policy

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