CMS Issues FY 2019 Final Rules for IRF PPS and SNF PPS

The Centers for Medicare & Medicaid Services (CMS) July 31 issued final rules for the inpatient rehabilitation facility (IRF) and the skilled nursing facility (SNF) prospective payment systems (PPS) for fiscal year (FY) 2019. In general, these rules take effect Oct. 1; however, some key provisions were finalized for implementation in FYs 2020 and 2021.

Our preliminary take on the IRF rule is that, while we understand CMS’s interest in updating the IRF PPS case-mix system, the lack of a strong evidence base for the final changes will require stakeholders to closely monitor access to care to identify any unintended consequences. With regard to the SNF rule, we had hoped CMS would address several flaws in its payment reform model, but do support its overall approach, which would increase payment accuracy for medically complex patients, who are treated at a higher rate by hospital-based providers.

Key takeaways from each of the rules follow; detailed regulatory advisories will be issued in the coming weeks. In addition, the AHA’s IRF and SNF members will receive separate invitations for calls to discuss each rule.

**IRF PROPOSED RULE**

**FY 2019 Payment Update:** Payments in FY 2019 will increase by a net 1.3 percent ($105 million) relative to FY 2018. This includes a 2.9 percent market-basket update offset by statutorily mandated cuts of 0.8 percentage point for productivity and an additional cut of 0.75 percentage point, as well as a 0.1 percentage point decrease in outlier payments.
FY 2020 Changes to IRF Case-mix System: CMS finalized its proposal to eliminate, in FY 2020, "FIM™" instrument-collected data from the IRF PAI, which are currently used to help assign payment for each patient, in addition to other functions. This change will be coupled with refinements to the case-mix group (CMG) element of the case-mix system. In the final rule, CMS makes multiple references to the data that will replace the FIM™ items – 22 data items that are already collected in the quality indicators section (Section GG) of the IRF PAI, but not currently used for setting payments. As its rationale for this change, CMS cites its broader effort to standardize data collection across post-acute settings, as selected IRF-PAI items are similar to data elements used by SNFs and long-term care hospitals. CMS also notes that the IRF payment units, CMGs, warrant a revision due to changes that have occurred since they were last revised, including in treatment patterns, technology, case-mix, and other factors that affect the relative use of resources across the classification system.

In response to stakeholders’ opposition to the proposed use of the Section GG items in FY 2020, the rule states CMS’s position that the replacement data:

- do not represent a new case-mix system, but rather only constitute revisions to the existing case-mix system;
- have been meaningfully evaluated and proven reliable and valid, with reliability examined using two distinct methods;
- are used with a new six-level scale that better distinguishes change in patients’ highest and lowest levels of function;
- will neither have an adverse effect on patient outcomes nor impede research on IRF treatment and care management; and
- were implemented with sufficient CMS guidance from 2016 through 2018 on proper coding.

Further, in response to the field’s critique that the proposed case-mix refinements were based on only one year of data, the rule notes that the quality indicator data have been collected for close to two years. Further, CMS states that it will update and revise the proposed case-mix changes using additional forthcoming data in its rulemaking for FY 2020.

Rehabilitation Physician Protocols: CMS finalized two changes to reduce burden on rehabilitation physicians. First, the initial physician evaluation following an admission will be allowed to count as one of the three required face-to-face visits per week. This change does not limit the number of times per week that patient visits will occur. In addition, rehabilitation physicians will be allowed to remotely lead the required, weekly interdisciplinary team via video or teleconferencing without any additional documentation requirements.
**Changes to the IRF Quality Reporting Program (QRP):** CMS finalized all proposed changes to the IRF QRP. As such, the agency will remove two measures that meet CMS’s removal criteria. One measure, National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure, will be removed beginning with the FY 2020 IRF QRP. The other, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay), will be removed beginning with the FY 2021 IRF QRP. Providers will no longer be required to collect data on either measure beginning with admissions and discharges on Oct.1. CMS also will begin publicly displaying data in CY 2020 on four assessment-based measures on which IRFs are already required to submit data as of Oct. 1, 2016.

**SNF PROPOSED RULE**

**FY 2019 Payment Update:** FY 2019 SNF payments will increase by 2.4 percent over FY 2018 levels, as mandated by the Bipartisan Budget Act of 2018, an $850 million increase. No forecast error correction would apply since the difference between the estimated and actual FY 2017 market-basket index does not exceed the 0.5 percent threshold.

**FY 2020 Redesign of the SNF PPS:** As follow-up to the SNF reform model released by CMS in May 2017, the agency finalized its proposal to overhaul of the SNF case-mix system for FY 2020. Specifically, it will replace the current unit of payment known as "RUGs," with the "patient-driven payment model" (PDPM). The PDPM is closely based on the reform model put forward last year, including the following case-mix adjusters used to set per diem rates for each case:

- Nursing;
- Non-therapy ancillaries (NTA);
- Physical therapy;
- Occupational therapy; and
- Speech-language pathology.

Using data collected with the SNF patient assessment instrument, the case-mix system also takes into account each case’s clinical condition and functional status, using data from the same Section GG quality indicator items discussed above in the IRF section.

In addition, the final rule implements the following PDPM elements as proposed:

- Variable per-diem rates to pay more for earlier days of care to reflect the increased resource utilization in the early portion of a stay;
- An interrupted stay policy that treats any case that leaves a SNF for four or more days and then returns as a new admission, which would be initiated with a new patient assessment. Patients returning within three or fewer days would be
subject to the prior payment classification with no adjustment to the variable per diem rate; and

- A combined 25 percent limit on group and concurrent therapy, per each therapy discipline (physical therapy, occupational therapy, and speech language pathology). This reflects CMS’s position that individual therapy is usually the best mode of therapy and that current levels of group and concurrent therapy fall below the 25 percent threshold.

In response to extensive feedback from AHA and the field, CMS will not implement the proposed requirement to record on the patient assessment the inpatient surgical procedure performed during the prior inpatient hospital stay using an ICD-10-PCS code. Instead, providers will be required to select, as necessary, a surgical procedure category in a sub-item within Item J2000 to identify the procedure, which would affect the patient’s per diem rate.

CMS will implement PDPM in an overall budget-neutral manner using a “parity adjustment” that will align overall SNF PPS payments under the proposed PDPM with the amount that would have been paid under the current model. While budget neutral overall, CMS estimates that under PDPM, payments will increase for patients with the following types of complex needs, which occur in higher proportions in hospital-based settings:

- Extensive service use;
- High NTA use;
- Intravenous medication use;
- End stage renal disease;
- Diabetes;
- Wound infections; and
- Amputation/prosthesis care.

**Changes to the SNF Quality Reporting Program (QRP):** CMS finalized all proposed changes to the SNF QRP. The agency will expand the methods by which the agency would notify an SNF of noncompliance with the SNF QRP requirements to include United States Postal Service mail and email from the Medicare Administrative Contractor (MAC) in addition to the current procedure that uses the QIES ASAP system; CMS noted that the agency will notify providers regarding the specific method of communication via the SNF QRP Reconsideration and Exception and Extension website following the May 15th data submission deadline. In addition, CMS will increase the number of years of data used to calculate the Medicare Spending Per Beneficiary (MSPB) and Discharge to Community measures, which are publicly displayed on Nursing Home Compare, from one year to two. According to the agency, this will increase the number of SNFs with enough data adequate for public reporting of these measures. CMS also will begin publicly displaying data in CY 2020 on the four
assessment-based measures on which SNFs are already required to submit data as of Oct. 1.

**Changes to the SNF Value-Based Purchasing (VBP) Program:** CMS finalized its proposal that SNFs with fewer than 25 eligible stays during the baseline period will not be measured on improvement, but rather only on achievement. Also for low-volume SNFs, the agency finalized its proposal that rather than calculating performance scores for SNFs with fewer than 25 eligible stays, CMS will assign scores. These scores will result in an incentive payment equal to the adjusted federal per diem rate the SNF would have received if the VBP program were not in place. This scoring adjustment will result in an additional $6.7 million in incentive payments to low-volume SNFs for FY 2019 services. Finally, the agency will adopt an extraordinary circumstances exemption policy to provide relief to SNFs affected by natural or man-made disasters or other circumstances beyond the facilities’ control that affect the care provided.

**NEXT STEPS**

Watch for more detailed Regulatory Advisories and invitations to AHA members-only calls to discuss the final rules. Contact Rochelle Archuleta, AHA director of policy, at (202) 626-2320 or rarchuleta@aha.org for questions on payment, and Caitlin Gillooley, AHA associate director of policy, at 202-626-2267 or cgillooley@aha.org with any questions related to quality reporting.