American Hospital Association™
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Regulatory Advisory

August 31, 2018

SKILLED NURSING FACILITY PPS: FINAL RULE FOR FY 2019

At A Glance

At Issue

On Aug. 8, the Centers for Medicare & Medicaid Services (CMS) published the fiscal year (FY) 2019 final rule for the skilled nursing facility (SNF) prospective payment system (PPS). While most provisions in the final rule will take effect Oct. 1, others will be implemented on subsequent dates.

Key Takeaways

- **Payment Update**: Increases SNF payments by 2.4 percent in FY 2019, as statutorily mandated.
- **Payment System Reform**: Implements a new SNF PPS case-mix system for FY 2020.
- **Quality Reporting**: Does not add any new SNF quality reporting requirements; provides additional SNF Value-based Payment updates.

Our Take

While the FY 2019 payment provisions in the SNF PPS rule are relatively straightforward, the new case-mix system finalized for FY 2020 will transform the field by aligning payments with patients' clinical characteristics rather than with the volume of therapy services. Under this new system, Medicare margins for hospital-based SNFs are expected to materially improve, as it appears that the new approach will more adequately reimburse providers treating greater proportions of high-complexity/low-therapy patients. On quality reporting, we appreciated that quality requirements were not expanded.

What You Can Do

- ✓ Share the attached summary with your senior management team to examine the impact these payment changes may have on your organization for FY 2019.
- ✓ **Participate in the AHA-member call on Tuesday, Sept. 4, at 3:00 p.m. ET.** Click here to register in advance.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org for questions on payment provisions, and Caitlin Gillooley, associate director of policy, at cgillooley@aha.org for quality-related questions.

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Background

On Aug. 8, the Centers for Medicare & Medicaid Services (CMS) published its final rule for fiscal year (FY) 2019 for the skilled nursing facility (SNF) prospective payment system (PPS). Comment letters on this rule are due to CMS by June 26. Most provisions in the final rule will take effect Oct. 1, however, other changes will be implemented on subsequent dates.

Final FY 2019 Payment Update

Market-basket Update

As mandated by Congress, SNF PPS payments in FY 2019 will be updated by 2.4 percent, per the Bipartisan Budget Act of 2018 (BiBA), which translates into an $820 million increase over FY 2018 payments. CMS did not finalize a market-basket forecast error adjustment for FY 2019 since the difference between the actual and estimated market basket for FY 2017 did not exceed 0.5 percentage points.

Case-mix Adjustment

For FY 2019, no change is made to the SNF PPS's resource utilization group version 4 (RUG-IV) case-mix classification system, or to version 3.0 of the Minimum Data Set (MDS), which categorizes patients for payment. The rule lists the 66 RUG-IV payment categories for urban and rural SNFs for FY 2018, along with corresponding case-mix values, in Tables 6 and 7, respectively.

Area Wage Index

To establish the SNF PPS wage index for FY 2019, CMS will use the same methodology as prior years, along with hospital wage data from cost reports beginning in FY 2015. The final SNF PPS wage index tables applicable for FY 2019 are exclusively available on the CMS webpage.

Labor-related Share

CMS finalized, as proposed, a labor-related share of 70.5 percent for FY 2019, a slight decrease compared with the FY 2018 share of 70.8 percent. Tables 9 and 10 in the rule provide the labor and non-labor related shares of the case-mix adjusted RUG-IV payments.

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SNF Quality Reporting Program (SNF QRP)

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires CMS to establish the SNF QRP. Starting in FY 2018, SNFs that fail to meet SNF QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 Legislative Advisory.

In this rule, CMS finalizes its proposals to alter how two existing measure rates are calculated for public display, to begin publicly displaying data on four measures, and to update the SNF Value Based Purchasing (VBP) program. Table 1 below examines the finalized measures for the SNF-QRP IN FY 2018 – FY 2021.

Table 1: Finalized and Proposed SNF QRP Measures, FYs 2018 – 2021

Measure	FY 2018	FY 2019	FY 2020	FY 2021
Percent of residents or patients with pressure ulcers that are new or worsened	X	X	*	
Unplanned all-cause, all-condition readmissions for 30-day post-discharge from IRFs	X			
Application of Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X	X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Self-Care Score for Medical Rehabilitation Patients			X	X
Change in Mobility Score for Medical Rehabilitation Patients			X	X
Discharge Self-Care Score for Medical Rehabilitation Patients			X	X
Discharge Mobility Score for Medical Rehabilitation Patients			X	X
Medicare spending per beneficiary for post-acute care SNF QRP	X	X	X	X
Discharge to community –Post-acute care SNF	X	X	X	X
Potentially preventable 30-day post-discharge readmission measure for SNF QRP		X	X	X
Drug regimen review conducted with follow-up for identified issues			X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury			X	X

X = Finalized
**= Measure will be replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure effective July 1, 2018*

FY 2020 Measurement Proposals

CMS proposes to change how the publicly displayed rates for two existing SNF QRP measures are calculated. Detailed specifications for the measures are available on CMS's SNF QRP website.

Change in Publicly Displayed Measure Rates. CMS will increase the number of years of data used to calculate the publicly displayed rates of two measures on *Nursing Home Compare*.

Instead of calculating rates based on one year of data, CMS will use two years of data to calculate the publicly displayed measure rates for the Medicare Spending Per Beneficiary (MSPB) and Discharge to Community (DTC) measures. Using two years of data, CMS argues, will increase the number of SNFs with enough data adequate for public reporting. **AHA agrees that using two years of data to calculate rates is more likely to capture provider performance, and AHA supports this change.**

New Measure Removal Factor for Previously Adopted SNF QRP Measures. As part of CMS's Meaningful Measures initiative (which applies to all CMS QRPs), the agency is reviewing measures currently in use to determine how QRPs can be developed in the least burdensome manner possible. In previous rulemaking, CMS finalized factors to determine whether a measure should be removed from a QRP on a case-by-case basis. Those factors are:

- Factor 1: Measure performance among providers is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- Factor 2: Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3: The measure does not align with current clinical guidelines or practice.
- Factor 4: A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5: A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6: A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7: Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

CMS will add an eighth measure removal factor to this list: CMS will also consider removing measures for which the costs associated with a measure outweigh the benefit of its continued use in the program. CMS defines "costs" as those affecting providers and clinicians (collection and submission/reporting burden, compliance with other programmatic requirements, participation in multiple quality programs, compliance with other federal or state regulations) as well as the costs to the agency associated with program oversight. CMS reiterates that the measure removal evaluation process will continue to be done on a case-by-case basis with the involvement of a variety of stakeholders, including (but not limited to) patients, caregivers, patient and family advocates, providers and their associations, healthcare researchers, and data vendors. Measures that are considered burdensome or "costly" might be retained in the QRP if the benefit to beneficiaries justifies the reporting burden. **The AHA supports the addition of this measure removal factor.**

SNF QRP Public Reporting

CMS will begin publicly reporting data in CY 2020 for four assessment-based measures for which data collection begins on Oct. 1, 2018. The measures, which were finalized in the FY 2018 SNF PPS final rule, include:

- Change in self-care score
- Change in mobility score

- Discharge self-care score
- Discharge mobility score

CMS will display measure performance based on four rolling quarters of data. If a SNF has fewer than 20 eligible cases during any four consecutive rolling quarters of data, a rate will not be displayed; instead, the agency will note that the number of cases is too small to publicly report.

Other QRP Updates

In addition to the changes to the SNF QRP, CMS also provides a few programmatic updates.

Noncompliance and Reconsideration Notifications. CMS sends SNFs written notifications of a decision of noncompliance with inpatient rehabilitation facilities (IRF) QRP requirements for a particular fiscal year, as well as notifications of final decisions regarding any reconsideration requests. In addition to written notification, CMS also uses the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system to provide these notifications. CMS will expand the methods by which the agency will provide notifications to include at least one of the following: the QIES ASAP system, the US Postal Service, or via an email from the Medicare Administrative Contractor (MAC). CMS explains that this proposal is in response to feedback from providers requesting additional methods of notification.

In the final rule, CMS clarifies that the agency will use at least one method of notification, and providers will be notified about which method CMS will use via the SNF QRP Reconsideration and Exception & Extension website and announcements via the PAC listserv. These announcements will be posted annually following the May 15 data submission deadline. Notifications are sent to the point of contact on file in the QIES database, which is populated via the Automated Survey Processing Environment (ASPEN) system. The policy will be effective Oct. 1, 2018.

Development of Transfer of Health Information and Patient Preferences Measures. The IMPACT Act requires CMS to develop standardized and interoperable quality measures and implement them across all four post-acute care settings. These measures must meet certain domains, one of which is the transfer of health information and patient care preferences. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 Legislative Advisory.

In the FY 2018 SNF PPS final rule, CMS stated that the agency intended to specify and propose two measures that would satisfy the transfer of health information and patient preferences domain for the FY 2021 SNF QRP with data collection beginning on April 1, 2019. However, CMS is currently engaging in continued development of these measures and now intends to specify and propose them for the FY 2022 SNF QRP, with data collection beginning with April 1, 2020 admissions and discharges.

CMS made the draft specifications of these measures, known as the Medication Profile Transferred measures, available for a public comment period which ended May 3. The draft specifications and information about the measures' development can be found on CMS's

Public Comment website. **AHA submitted comments on these measures, which can be found here. We support CMS's delayed implementation of these measures, as continued development was necessary to ensure that the measures were as valid as possible.**

SNF Value-based Purchasing Program (SNF VBP)

The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019. The SNF VBP program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access, swing-bed rural hospitals. The SNF VBP program must tie a portion of SNF Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs or a "potentially avoidable readmission" measure. A pool of funding will be created by reducing each SNF's Medicare per-diem payments by 2 percent. However, as finalized in the FY 2018 SNF PPS final rule, only 60 percent of the total pool will be distributed back to SNFs as incentive payments, which will be applied as a percentage increase to the Medicare per-diem rate. SNFs scoring at or below the 40th percentile of performance are not eligible for any incentive payment and will receive the full 2 percent reduction. Details on the finalized scoring methodology can be found in the FY 2018 SNF PPS final rule Regulatory Advisory.

In this rule, CMS finalizes the performance period and baseline periods for the FY 2021 program year and subsequent years, adjustments to scoring methodologies, and an extraordinary circumstances exception policy.

Proposed FY 2021 Performance and Baseline Periods

CMS will use FY 2019 (Oct. 1, 2018-Sept. 30, 2019) as the performance period for the FY 2021 SNF VBP program year. The agency will use FY 2017 (Oct. 1, 2016- Sept. 30, 2017) as the baseline period for the FY 2021 program year.

In this rule, CMS also establishes the numerical values for the achievement threshold and benchmarks using the finalized performance and baseline periods. These values represent performance on the SNF 30-Day All-cause Readmission measure (SNFRM) used in the program. The values are:

- Achievement: 0.79476
- Benchmark: 0.83212

In addition, CMS established that for FY 2022 and all subsequent program years, the baseline and performance periods will be defined as the 12-month periods following the baseline and performance periods for the previous year.

Proposed Scoring Adjustments

CMS finalized a few scoring adjustments to the methodology used to determine improvement and achievement scores for SNFs under the VBP program.

SNFs Without Sufficient Baseline Period Data. If a SNF has fewer than 25 eligible stays during the baseline period—that is, the period on which the improvement score is based—then that SNF will not be measured on improvement for that program year. Instead, the SNF will only be scored on its achievement during the performance period. CMS found that it is not operationally feasible or fair to use different baseline periods or extended baseline periods to calculate improvement scores for those SNFs that had fewer than 25 eligible stays during the established baseline period.

Scoring Adjustment for Low-volume SNFs. CMS notes that the risk standardization approach used in the calculation of the VBP readmissions measure shifts outliers towards the mean; this may result in SNFs (especially smaller SNFs) with zero readmissions having calculated risk-standardized readmissions rates greater than zero, or other inaccurate performance scores. Because of this concern, CMS finalized a scoring adjustment to ensure that low-volume SNFs, defined for this purpose as SNFs with fewer than 25 eligible stays during the performance period, receive sufficiently reliable performance scores.

Under the change, low-volume SNFs will be assigned a performance score rather than have a score calculated based on their readmissions rates. This assigned score will result in a value-based incentive payment equal to the adjusted Federal per diem rate that the SNF would have received in the absence of the VBP program. The exact score will depend on the distribution of all SNFs' performance scores in the logistic exchange function finalized in the FY 2018 SNF PPS final rule.

Based on its calculations for the FY 2019 program year, CMS estimates that this approach will result in an additional $6.7 million being paid to low-volume SNFs. Because the approach assigns scores that align with a specific payment amount rather than including all low-volume SNFs in the overall performance distribution (which would result in a mere redistribution of the 60 percent payback of the withheld funds), CMS notes that this additional payout will increase the 60 percent payback that was finalized in last year's rule to 61.28 percent. CMS notes that the payback percentage will similarly increase for all other program years, although the exact increase would vary based on the distribution of SNF performance scores.

Extraordinary Circumstances Exception (ECE). In response to public comments on the FY 2018 SNF PPS proposed rule regarding the possibility of adding an ECE policy to the SNF VBP program, CMS will adopt such a policy to offer relief from program requirements to SNFs affected by circumstances beyond the facility's control. CMS will use the same definition of "disaster" as is used in other programs, which is "any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation or otherwise affect the facility's ability to continue normal operations."

Under this policy, CMS will exclude data from the months during which a SNF was affected by the extraordinary circumstance from the calculation of the measure rate. SNFs will then be scored on achievement or improvement for any remaining months during the performance period as long as the SNF met the proposed 25 eligible stay threshold during the period.

A SNF requesting an ECE will have to provide the dates of the duration of the circumstance along with any available evidence (e.g., photographs, newspaper articles) within 90 days following the circumstance. In addition to applying for an ECE, the agency also can grant ECEs to SNFs that did not request them if the agency determines that an extraordinary circumstance affects an entire region.

New Case-mix System Finalized for FY 2020

In May 2017, in conjunction with its issuance of the FY 2018 SNF PPS proposed rule, CMS published an advance notice of proposed rulemaking that requested comments from the field on a new SNF case-mix system called "RCS-I." As proposed, this rule finalizes the implementation in FY 2020 the next iteration of that model, now called the Patient Driven Payment Model (PDPM). To share full details on its SNF PPS case-mix research, including data sources, analytical background and methodologies, CMS has issued RCS-I and SNF PDPM technical reports at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

CMS will implement the PDPM as a single transition to be completed in FY 2020, rather than a multiyear phased transition. CMS states that the administrative and operational burdens created by the need for the agency and providers to maintain two case-mix systems and resultant payments (RUG-IV and PDPM) and implement a multiyear transition would be excessive.

In response to concerns raised with CMS through public comments, CMS noted that it:

- Plans to monitor changes in practice and coding under PDPM to determine whether further adjustments are needed, including administrative action against providers with aberrant claims;
- Is not concerned about some states not using the SNF PPS payment methodology, as this is already the case for both some states and Medicare Advantage plans and is generally not a source of problems;
- Clarifies that PDPM does not affect Medicare and Medicaid conditions of participation for SNFs;
- Used data from 2014 through 2017 when building other elements of the new model (comorbid conditions, services associated with SNF stays), however due to a statutory mandate, SNF PPS rates must remain based on 1995 cost reports; and, .
- Is not focused on alignment with that future PPS model, as the post-acute care PPS mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 is not yet established.

Background. Under the current system, SNF PPS payments are based on a per diem base payment that is adjusted for geographic factors and case mix. Per diem payments are assigned using the case-mix system that classifies patients into payment classification groups, called resource utilization groups (RUG). The unadjusted RUG rate is the sum of:

- A nursing component which is case-mix adjusted;
- A therapy component (which is case-mix adjusted for rehabilitation RUGs) or a therapy component which is not case-mix adjusted for non-rehabilitation RUGs; and
- A non-case mix adjusted component reflecting the costs of room and board, linens, and administrative services.

The RUG-based model has been widely criticized by policymakers for assigning a RUG amount by therapy amounts that maximize billing rather align with patients' clinical needs. The new models are designed to address this issue by shifting the basis from the provision of RUG therapy minutes to verifiable resident characteristics.

PDPM Impact by Sector and Provider. CMS estimates that under PDPM, payments for hospital-based SNFs will increase by 16.7 percent over what they would have been under the current payment system. In addition, the agency developed a provider-specific impact analysis file, which details the estimated impact of the PDPM model for each SNF. These provider and resident data are from FY 2017 and represent estimated payments under PDPM, assuming no changes in provider behavior or resident case-mix. The agency also published a SNF PDPM Provider Specific Impact Analysis.

PDPM Structure

The PDPM uses five case-mix elements to set payments: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), non-therapy ancillary (NTA) services, and nursing services, with a single payment based on the sum of these five classifications. The payment also will be adjusted according to the variable per diem adjustment schedule, as discussed below on page 7. Under PDPM, a case-mix factor will be applied to each of these items and they will then be combined with the non-case-mix component payment rate to create a resident's total SNF per diem rate. In addition, for residents with HIV/AIDS, the nursing portion of payment will be multiplied by 1.18.

The proposed PDPM structure was finalized with one change related to cases with a related surgical procedure during the prior SNF-qualifying inpatient stay, as discussed below.

Physical and Occupational Therapy Case-mix Classification

CMS finalized its proposals related to PT and OT case-mix classification under the PDPM, with a modification for recording the type of inpatient surgical procedure performed during the prior inpatient hospital stay, as described below. While the same clinical characteristics will be used to classify a resident for PT or OT component assignment, the resident will be placed into distinct PT and OT case-mix groups with differing payment rates. That is, at the time of SNF admission, each resident will be assigned into a single PT case-mix group and a single OT case-mix group.

Clinical Categories. CMS finalized the 10 inpatient clinical categories incorporated in Table 21 of the rule reproduced below, which CMS believes capture the range of general resident types found in a SNF. These clinical categories correspond with, and will be used to assign a patient

to, one of four PT and OT clinical categories. Any related surgical procedure during the prior inpatient stay also will be indicated to appropriately classify a patient's PT or OT needs.

CMS acknowledges commenters' concerns about the complexity of the proposed methodology for collecting diagnosis and procedure information. The rule states that CMS will continue to refine this methodology to align with the main PDPM model and make the reporting protocols more streamlined and the agency will share these pending refinements in the Resident Assessment Instrument (RAI) manual.

CMS discusses the comments it received about ICD-10 coding requirements under PDPM; commenters were concerned about the challenges associated with mastering ICD-10 coding. CMS notes that ICD-10 has been an aspect of Medicare reporting since FY 2016 and provides the necessary information for determining payment. CMS also disagrees with a comment that ICD-10 coding does not contain adequate specificity to indicate whether a condition is active/stable or active/non-stable. CMS intends to provide information for how providers should report diagnosis and procedure information in the MDS RAI manual. CMS also disagrees with commenters' concerns about potential logistical issues for SNFs in receiving clinical information on admitted patients about their preceding inpatient stays. CMS notes that the PDPM does not require SNFs to obtain additional clinical information, except for the surgical procedure information, beyond what is currently required.

CMS also recognizes stakeholder concerns regarding the use of Medicare Severity Diagnosis Related Groups (MS-DRGs) to develop the PDPM clinical categories. CMS clarifies that although the MS-DRGs were used to identify patient categories in the SNF, they were not used to determine the cost of treating patients and it does not believe using the MS-DRGs compromises the integrity of the clinical categories. CMS notes that multiple clinician consultants and participants at technical expert panels also validated the clinical categories.

Functional Status. CMS has discussed how regression analyses demonstrated that a resident's functional status is also predictive of PT and OT costs. Based on comments received about the RCS-I functional score, PDPM will include a functional score for PT and OT payments based on section GG functional items (IMPACT Act-compliant items). Specifically, the functional items from section GG (Functional Abilities and Goals) will be used to calculate the functional score for resident classification under PDPM. A list of the section GG items included in the functional measure for the PT and OT components is shown in Table 18 in the rule.

Section GG item are assigned a score of up to four points. CMS notes that in contrast to the RUG-IV activity of daily living (ADL) score, points are assigned to each response level to track functional independence instead of functional dependence, such that higher points are assigned to higher levels of independence. Based on its analyses, CMS observed that residents who were unable to complete an activity had similar PT and OT as dependent residents and will group an activity that cannot be completed with the GG response "dependent" for assigning points. CMS also will use an additional response level for the walking items to reflect residents who are unable to walk. Tables 16 and 17 in the rule provide the scoring algorithm for the PT and OT functional measure. The scoring algorithm produces a

function score that ranges from 0 to 24, which is incorporated in Table 21 below. As also shown in Table 21, 16 case-mix categories will be used to classify residents for PT and OT payment; that is, all residents will be classified into one and only one of these 16 PT and OT case-mix groups for each of the two components.

Table 21: Final PT and OT Case-Mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

Cognitive Impairment. As proposed, CMS finalized its plan to not use the cognitive score as a factor of classification for the PT and OT components under PDPM

Speech Language Pathology Case-mix Classification

CMS identified three relevant predictors of SLP cost:

- Clinical reasons for the SNF stay;
- Swallowing disorder or mechanically-altered diet; and
- A SLP-related co-morbidity or cognitive impairment.

As proposed, for the initial classification into a SLP group, residents will first be categorized into one of two groups by the clinical reason for the SNF stay: the "Acute Neurologic" or "Non-Neurologic" group. In addition, CMS will classify residents as having a swallowing disorder, being on a mechanically altered diet, both or neither. Further, CMS identified the following 12 SLP-related comorbidities that it believes best predict relative differences in SLP costs, per Table 22 of the rule, reproduced below. Table 23 on page 21051 of the rule displays the 12 case-mix groups and their related case-mix indexes (CMIs) for SLP.

Table 22: Proposed SLP-related Comorbidities	
Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

Nursing Case-mix Classification

As proposed, to calculate nursing payments under PDPM, CMS will use a modified version of the existing methodology to classify residents into non-rehabilitation RUGs to develop a nursing classification, which will reduce the 43 nursing RUGs to 25 case-mix groups. Another change will update the nursing ADL score to incorporate section GG items. In addition, section G items of MDS 3.0 will be replaced with a functional score based on the seven section GG items in Table 25 below. In addition, CMS will update the existing CMIs using the existing time measurement data that were originally used to create these indexes.

Table 25: Section GG Items Included in Proposed Nursing Functional Measure		
Section GG Number	**Section GG Descriptor**	**Score**
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4
GG0170E1	Mobility: Chair/bed-to chair transfer	
GG0170F1	Mobility: Toilet transfer	

Table 26 in the rule lists the final nursing CMIs for PDPM. Nursing group CMIs will be calculated based on the average per diem nursing average wage weighted staff time per case-mix group relative to the population average.

CMS also used existing time study data to quantify the effects of an HIV/AIDS diagnosis on nursing resource use and found that after controlling for nursing RUG, HIV/AIDS status is associated with a positive and significant increase in nursing utilization. Thus, as part of the case-mix adjustment of the nursing component, CMS finalized an 18 percent increase in payment for the nursing component for residents with HIV/AIDS. CMS notes this adjustment will be based on the presence of ICD-10-CM code B20 on the SNF claim.

NTA Case-mix Classification

The current SNF PPS, in which NTA resource use is incorporated into the nursing component, has been criticized for failing to adequately and accurately reimburse NTA costs. CMS is responding to this criticism by creating a distinct NTA services component within the PDPM. Specifically, CMS will use a patient's NTA score to select one of six NTA case-mix classification groups. Each comorbidity and services that factor into a resident's NTA classification will be assigned a certain number of points based on its relative impact on a resident's NTA costs, per Table 27 in the rule. Conditions and services with a greater impact on NTA costs are assigned more points. CMS believes that under this methodology, the NTA component will adequately reflect differences in the NTA costs for each condition or service as well as the additive effect of having multiple comorbidities.

Variable Per Diem Adjustment Factors and Payment Schedule

As proposed, variable payments will be used under the PDPM. Specifically, the SNF PPS currently makes payment at a specified per diem rate for each RUG regardless of the duration of a resident's classification into a given RUG. SNF PPS researchers, however, found that resource utilization, as measured by claims-derived costs, varies during a SNF stay in that PT, OT, and NTA costs typically decline (at different rates) while SLP costs remain constant over time. The analyses found that PT and OT components decline slowly over the course of the SNF stay. The NTA component cost analyses indicated significantly increased NTA costs at the beginning of the stay that then drop to a much lower level, which is relatively constant over the remainder of the SNF stay. CMS notes this is consistent with the finding that most SNF drug costs are typically incurred at the onset of a SNF stay. Because nursing costs are not tracked separately, they could not be analyzed. As proposed, CMS is applying variable per-diem adjustments to PDPM payments for the PT, OT, and NTA components to accurately account for this length of stay effect. CMS did not finalize similar adjustments to the SLP and nursing components.

The case-mix adjusted federal per diem payment for a given component and a given day will be equal to the base rate for the relevant component (either urban or rural), multiplied by the CMI for that resident, multiplied by the variable per diem adjustment factor for that specific day, as applicable. Distinct adjustment factors will reflect the different rates of decline for various components. Final PT/OT and NTA adjustment factors and schedules are shown in Tables 30 and 31 of the rule, respectively, reproduced below.

Table 30: Proposed Variable Per Diem Adjustment Factors and Schedule – PT and OT	
Medicare Payment Days	**Adjustment Factor**
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Table 31: Proposed Variable Per-diem Adjustment Factors and Schedule - NTA	
Medicare Payment Days	**Adjustment Factor**
1-3	3.0
4-100	1.0

Patient Assessment Policy

The MDS 3.0 RAI is used to classify patients and has been criticized for its administrative burden and complex rules. In contrast, the PDPM significantly streamlines the current requirements for scheduled assessments on days 5, 14, 30, 60, and 90, and makes other changes. Specifically, as proposed, all assessments other than the 5-day assessment will be phased out. Patients initially will be assigned to a payment amount based on the 5-day classification and may be reassigned using the new interim payment assessment (IPA). The IPA will be comprised of the 5-day MDS item set, with no grace days. IPAs will be optional for providers to use when both of these criteria are met:

1. There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the proposed PDPM (see the first column in Tables 21, 23, 26 and 27), such that the resident will be classified into a classification group for that component that

differs from that provided by the five-day scheduled PPS assessment, and the change results in a payment change either in one particular payment component or in the overall payment for the resident; and

2. The change(s) are such that the resident is not expected to return to his or her original clinical status within a 14-day period.

The rule also requires that the Assessment Reference Date (ARD) for the IPA be no later than 14 days after a change in the resident's first tier classification is identified. When a facility fails to complete a required IPA, CMS proposed that the facility follow the guidelines for late and missed unscheduled MDS assessments. Table 33 from the final rule, reproduced below, shows the final PDPM assessment schedule.

In addition, in response to stakeholders, because the IPA will be optional, CMS is revising the ARD criteria such that the ARD for the IPA will be the date the facility chooses to complete the assessment relative to the triggering event that causes a facility to choose to complete the IPA. Payment based on the IPA will begin the same day as the ARD. Given the optional nature of the assessment, the IPA will not be susceptible to assessment penalties.

Table 33: PPS Assessment Schedule Under PDPM

Medicare MDS Assessment Schedule Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified	ARD of the assessment through Part A discharge (unless another IPA is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the end date of the most recent medicare stay (A2400C) or end date	N/A

Discharge Assessment Change. SNFs will continue to complete the PPS Discharge Assessment for each SNF Part A resident at the time of Part A or facility discharge. However, CMS finalized several changes to SNF discharge assessment. First, 18 therapy items from Section O of the MDS will be added to allow the agency to collect data on therapy volume, type (PT, OT and SPL) and mode (individual, concurrent or group), as listed in Table 35 of the rule. The rule also notes CMS's concern that under PDPM, providers may reduce the amount of therapy because of financial considerations and, therefore, it will monitor utilization and consider potential actions, either at the provider or systemic level, to address this issue.

Limits on Group and Concurrent Therapy

As proposed, an annual limit will be applied per beneficiary for both group and concurrent therapy. This reflects CMS's concern that, under PDPM, providers may base decisions regarding the mode of therapy on financial considerations rather than on clinical needs. In addition, the agency believes that individually tailored therapy is generally best provided one-on-one. Therefore, in conjunction with the implementation of PDPM, group and concurrent

therapy minutes combined will not constitute more than 25 percent of a resident's therapy minutes. This limit is intended to ensure that at least 75 percent of a resident's therapy minutes will be provided on an individual basis. The total unallocated minutes reported in the MDS will be used to determine compliance with the limit.

CMS will use a new audit mechanism for compliance with this limit – the validation reports issued to providers when submitting their resident MDS assessments to the QIES. When the 25 percent limit is exceeded, a warning of a non-fatal error will appear in the provider's validation report. The non-fatal warning will serve as a reminder to the facility that they are out of compliance with the therapy limit. CMS plans to monitor rates and patterns of QIES combined limit warnings and a provider who consistently exceeds the combined limit could be flagged for additional review. If necessary, CMS also will consider policy changes if QIES warning patterns suggest inappropriate patterns of therapy provision at other than the individual level.

Interrupted Stay Policy

CMS finalized its proposed interrupted stay policy, under which a temporary departure from the SNF of four or more days will be treated as a new stay when the patient returns. For temporary departures of one to three days, when the patient returns, a new patient assessment will not be required, and the variable payment schedule will not be reset. CMS believes that an interrupted stay policy will discourage inappropriate SNF discharges aimed at increasing payment by resetting the variable per diem payment adjustment schedule. The source of the readmission (e.g., acute care hospital) will not factor into the policy. For interrupted stay payment under the PDPM system, CMS finalized that:

- The variable per diem adjustment be reset whenever a resident is discharged then readmitted to a different SNF (where a new MDS assessment will be required);
- The variable per diem adjustment will be reset when a resident is discharged then readmitted to the same SNF only if the resident were out of the SNF at three or fewer days;
- Readmission of a resident to the same SNF more than three days after discharge will trigger a required new MDS assessment (and possible PDPM reclassification); and
- The resident's PDPM classification will not change from admission for a readmission to the same SNF occurring in three or fewer days after discharge. Similarly, a new MDS assessment will not be required, although the SNF could choose to complete an IPA assessment for reclassification if clinically appropriate.

CMS also notes its view that frequent SNF readmissions may be an indicator of poor quality of care and will monitor readmissions to identify patterns for which enhanced review is appropriate.

PDPM Administrative Presumption Policy

Under PDPM, administrative presumption of SNF necessity will be applied at the time of the initial MDS assessment to residents who meet certain criteria, not at the time of the MDS Day 5 assessment. The following are the administrative presumption criteria that were finalized as proposed:

- Assigned to the four most intensive RUG nursing categories (the PDPM nursing component includes a non-rehabilitation nursing RUG-IV group assignment);[1] or
- Receive the highest range PT or OT component functional score; or
- Receive the uppermost NTA component comorbidity score.

In addition, the final policy includes several modifications based on feedback from the field. Specifically, commenters urged CMS to designate other therapy groups that qualify for the presumption and additional PT, OT and SLP components. In response, CMS designates the following additional classifiers for PDPM administrative presumption:

- The case-mix classifiers in the following nursing categories: Extensive Services, Special Care High, Special Care Low, and Clinically Complex;
- The following PT and OT classifiers : TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- The following SLP classifiers: SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost comorbidity group (which is finalized as 12+).

Budget Neutrality Parity Adjustment

The rule finalized a parity adjustment intended MS to achieve budget neutral-implementation of PDPM with no provider behavioral offsets at the time of initial implementation. CMS's related impact analysis also assumes that any changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays.

Specifically, CMS finalized a "parity adjustment" of 1.46 to the case-mix weights; it believes this will maintain the relative value of each CMI while achieving parity on overall SNF payments relative to total payments under the existing system. To calculate the parity adjustment, CMS calculated total payments under PDPM using FY 2017 claims and compared them to actual payments. The non-case-mix component payments are subtracted from the actual payments, as this component does not change under the proposed PDPM. However, this subtraction does not include the AIDS temporary add-on payments since analogous payments are made through the PDPM case-mix adjusted components. Finally, the estimated PDPM payments are set to equal the total allowable Medicare payments under RUG-IV by dividing the remaining RUG-IV actual payments by the estimated remaining total PDPM payments. The result of the division is a ratio (parity adjustment) of 1.46 by which the CMIs are multiplied so that the total estimated payments under the PDPM are projected to be equal to total payments under the RUG-IV (assuming no changes in the population, provider behavior, and coding). Without the parity adjustment, total estimated payments under the PDPM were estimated to be 46 percent lower than total actual payments under RUG-IV.

The final rule notes that the most significant shift in payments under PDPM is expected to redistribute payments from residents receiving very high amounts of therapy under the current system to residents with more complex clinical needs. CMS projects that for residents whose most common therapy level is RU (ultra-high therapy, the highest therapy level), there is expected a reduction in associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation are expected to

[1] The categories are: Extensive Services; Special Care High; Special Care Low; and Clinically Complex.

increase by 50.5 percent. Resident groups with the following characteristics also are projected to see higher payments:

- High NTA costs;
- Receiving extensive services;
- Dually enrolled in Medicare and Medicaid;
- Use of IV medication;
- Have end-stage renal disease or diabetes or a wound infection;
- Receive post-amputation prosthesis care; and
- Have longer prior qualifying inpatient stays.

Next Steps

The AHA encourages SNFs to participate in our AHA-member call on Tuesday, Sept. 4, at 3:00 p.m. ET. During this call, we will review the provisions in the rule and collect feedback to help develop our comment letter to CMS. Click here to register.

For questions regarding the payment provisions in this rule, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For questions pertaining to the quality provisions, contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.