CMS ISSUES FINAL RULE ON FY 2019 PAYMENT AND POLICY CHANGES FOR SKILLED NURSING FACILITIES

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 updates and quality program changes for skilled nursing facilities ("SNF")("Final Rule"). The Final Rule finalized the value-based purchasing payments that start October 1, 2018, updated several SNF Quality Reporting Program details and established the Patient-Driven Payment Model (the "PDPM"). CMS stated the overall economic impact of this final rule is an estimated increase of $820 million in aggregate payments to SNFs during FY 2019. This article focuses on the PDPM.

EXECUTIVE SUMMARY

Effective October 1, 2019, CMS will be replacing the current Resource Utilization Groups ("RUG") system and start using a new case-mix model, the PDPM. CMS believes the PDMP focuses on the patient's condition and resulting care needs rather than on the amount of care provided in order to determine Medicare payment. CMS stated set the PDPM to be effective October 1, 2019 to allow time for education and training of SNFs to prepare for this new model.

CHANGE IN REIMBURSEMENT

Currently, nursing facilities are required to classify residents into one of several RUG based on assessment data from the resident assessment,with a single payment for all services. By contrast, the PDPM classifies each resident into five primary components (nursing, physical therapy, occupational therapy, speech language pathology and need for non-therapy), plus a sixth – non-case-mix for overhead. The PDPM approach then provides a single payment based on the sum of these individual classifications. The payment for each component would be calculated by multiplying the case-mix index for the resident's group first by the component federal base payment rate (either urban or rural) then by the specific day in the variable per diem adjustment schedule. The new case-mix model, the PDPM, focuses on clinically relevant factors, rather than volume-based service for determining Medicare payment, by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification.

CMS believes that the PDPM, because it is based on the observed relationship between patient characteristics and resource utilization, represents an improvement over the current payment model in terms of payment accuracy. Further, CMS stated that its investigations show that for many of the specific cases cited by the commenters as potential concerns, CMS expects the PDPM actually to increase associated payment compared to RUG-IV. CMS also stated that while the variable per diem schedule decreases pay throughout the stay, the overall increase in payment accounts for the treatment cost of chronic conditions, which is costly due to the sustained level of care needed to manage chronic conditions.

CAPPED PERCENTAGE

In the PDPM, concurrent and group therapy added together, in any combination, is capped at 25 percent of total therapy for each discipline individually (physical therapy, occupational therapy and speech therapy). CMS believes that this will best ensure that SNF residents will continue to receive the highest caliber of therapy specific to their individual needs and goals. CMS stated that it will also continue to work with stakeholders to consider potential modifications to this finalized policy for future rulemaking, including whether to adjust the combined limit of 25 percent for concurrent and group therapy to ensure sufficient flexibility for therapists without compromising beneficiary care.

VARIABLE PER DIEM ADJUSTMENT FACTORS AND PAYMENT SCHEDULES

The PDPM adjusts the SNF per diem payments to reflect varying costs throughout the stay and incorporate safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals. CMS believes that a resident's needs change throughout the resident's stay, so the Final Rule includes a per diem adjustment factor based on the length of a resident's stay. The case mix index for physical therapy and occupational therapy will be adjusted downward gradually throughout a resident's stay, beginning after the 20th Medicare payment day.

Some commenters supported the use of the variable per diem adjustment under the PDPM. However, several commenters stated that the PDPM, specifically the variable per diem payment adjustments included in the physical therapy and occupational therapy components, may

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negatively affect access for beneficiaries with long stays and complex medical needs. These commenters stated that the variable per diem payment adjustments will encourage early discharges and the provision of fewer services.

RESIDENT ASSESSMENTS

In terms of scheduled assessments, SNFs are currently required to complete assessments on or around certain days of a resident's Part A SNF stay. Under the PDPM, once a resident is classified into a case-mix group, that payment group would be maintained through the entire stay unless an Interim Payment Assessment ("IPA") is completed and reclassifies the patient into a different case-mix group.

CMS initially proposed to require facilities to reclassify residents under the PDPM using the IPA if certain criteria are met. CMS reconsidered and made this interim assessment optional, thereby leaving completion of this assessment at the discretion of the individual provider.

CMS stated that it believes it is necessary for SNFs to continually monitor the clinical status of each and every patient in the facility regularly regardless of payment or assessment requirements and that it believes that there should be a mechanism in place that would allow facilities to do this. CMS decided to make the IPA an optional assessment to further ease the administrative burden associated with the PDPM and improve clarity on when an IPA should be completed. As a result, facilities will be able to determine when IPAs will be completed for their patients to address potential changes is clinical status and what criteria should be used to decide when an IPA would be necessary. Since the IPA will be optional, facilities should determine their own criteria for when an IPA is completed.

EFFECTIVE DATE

Effective October 1, 2019, CMS will be replacing the current RUG system and will start using a new case-mix model, the PDPM.

TECHNICAL SPECIFICATIONS AND MANUAL REVISIONS IN THE FUTURE

CMS recognizes the importance of provider education and training and will be providing opportunities and resources in the future. CMS also intends to release technical specifications and manual revisions as soon as possible, which will include specific instructions on operationalizing the transition from RUG to PDPM.

PRACTICAL TAKEAWAYS

- Facilities will feel pressure to keep resident stays short, as the case mix elements are reduced and adjusted after the resident's 20th day in the facility and weekly after that.
- Since the IPA will be optional, facilities should determine their own criteria for when an IPA is completed.
- With the 25 percent cap on group and concurrent therapy, tracking is important.

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