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CMS Outlines Patient-Driven Payment Model in 2019 SNF Proposed Rule

by Jenny Boese

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On April 27, 2018, the Centers for Medicare and Medicaid Services (CMS) released the FY 2019 proposed Skilled Nursing Facility (SNF) rule. The following includes a high level overview of key provisions in the proposed rule (CMS-1696-P). The comment deadline for the rule is June 26, 2018. For assistance commenting, contact the Director of Health Care Policy Jenny Boese.

SNF PROSPECTIVE PAYMENT SYSTEM

CMS indicates the proposed FY 2019 SNF prospective payment system (PPS) rule would increase payment rates to SNFs in the aggregate by $850 million, and decrease payments to SNFs under the Valued-Based Payment program by $211 million.

Market basket update

CMS proposes a 2.4 percent update for SNFs as required by *The Bipartisan Budget Act of 2018*.

Patient-Driven Payment Model

In a 2017 Advanced Notice of Proposed Rulemaking, CMS proposed the creation of a new Resident Classification System-1 (RCS-1) model. The RCS-1 model was never implemented, but CMS uses it as the general basis upon which its newly-named classification system, the Patient-Driven Payment Model (PDPM), is built.

The proposed PDPM is a case-mix classification that derives payment classifications almost exclusively from verifiable resident characteristics, not volumes of services. The new system will adjust five different case-mix components for the varied needs and characteristics of a resident's care, and then combine these with the non-case-mix component to form the full SNF PPS per diem rate for that resident.

This new model would begin on October 1, 2019.

Federal base payment rate adjustments

Under the PDPM model, CMS is proposing to make several changes to the four components that go into the federal base payment per diem rate:

- Nursing case-mix component — This would be broken into two parts: nursing and non-therapy ancillary (NTA) components.
- Therapy case-mix rate component — This would be broken into three components: physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP).
- Therapy non-case-mix component — This component would be eliminated, and those dollars would be redistributed among the therapy components.
- Non-case-mix component — This will be maintained in its current form.

Calculating therapy case-mix component

CMS proposes the PT portion would be set at 43.4 percent, OT at 40.4 percent, and SLP at 16.2 percent of the therapy component of the federal per diem rate for urban SNFs. For rural SNFs, the PT rate would be at 42.9 percent, OT at 39.4 percent, and SLP at 17.7 percent of the therapy component of the federal per diem rate.

Calculating nursing component

For the nursing component, CMS proposes to assign 57 percent to the new nursing category and 43 percent to the NTA component of the federal base rates.

PT and OT case-mix groups

As opposed to the Resource Utilization Group (RUG) IV system that determines therapy payments based only on the amount of therapy provided, these groups classify residents based on the two resident characteristics shown to be most predictive of PT and OT utilization: clinical category and function score. Under the proposed PDPM, all residents would be classified into only one of 16 PT and OT case-mix groups as proposed by CMS for each of the two components. The PT and OT components will be variable rates and will be reduced by two percent every seven days after the first 20 days of the SNF stay.

SLP case-mix groups

Similar to its approach with PT and OT, CMS identified a set of categories of predictors relevant in predicting relative differences in SLP costs. These include:

- Clinical reasons for the SNF stay
- Presence of a swallowing disorder or mechanically-altered diet
- The presence of an SLP related comorbidity or cognitive impairment

CMS is proposing all residents would then be classified into one of only 12 SLP case-mix groups under the proposed PDPM.

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Nursing component

CMS proposes to use the existing RUG-IV methodology for classifying residents into non-rehabilitation RUGs. In doing so, CMS indicates its desire is to develop a nursing classification that helps ensure nursing payment reflects expected nursing utilization, rather than therapy utilization. Despite using RUG-IV methodology to guide resident classification, CMS proposes several modifications in order for it to conform to the proposed PDPM.

Non-therapy ancillary

The existing RUG-IV methodology does not adequately account for the high utilization of NTA services. The proposed NTA component would be based on the presence of comorbidities and extensive services received. All residents would be classified into one of six NTA case-mix groups, and payment for NTA services would be broken out from nursing services as currently is done under RUG-IV. The NTA component is also a variable rate and is reduced over the length of stay.

Overall payment

The proposed PDPM would classify each resident into five components (PT, OT, SLP, NTA, and nursing) and provide 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 (CMI) for the resident's group first by the component federal base payment rate, then by the specific day in the variable per diem adjustment schedule. These payments would then be added to the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate under the proposed PDPM.

SNF PPS swing bed assessment

Beginning October 1, 2019, hospitals without critical access hospitals designation that use swing beds would need to report several new MDS items (K0100, I4300, O0100D2) on their Swing Bed PPS Assessment.

Changes to SNF PPS resident assessments

Under current regulations, SNFs are required to conduct resident assessments on or around days 5, 14, 30, 60, and 90 of a Part A SNF stay. The proposed PDPM rule reduces this to two or three assessments, depending on changes in the residents care needs. Effective October 1, 2020, CMS is proposing to use the five-day assessment to classify a resident under the SNF PDPM for the entirety of the stay Part A stay. CMS goes on to state that Medicare beneficiaries' clinical needs can change. To address this, CMS is proposing to conduct an Interim Payment Assessment (IPA) if two criteria are met:

1. There is a change in the resident classification in at least one of the first tier classification criteria for any components under the proposed PDPM, such that a resident would be classified into a classification group for that component that differs from the five-day scheduled PPS assessment, and results in a change in payment (either in one component or in overall payment);
2. The change(s) are such that the resident would not be expected to return to the original clinical status within a 14-day period.

CMS proposes to continue to require SNFs to complete the PPS discharge assessment for each Part A SNF resident at the time of Part A or facility discharge. CMS is proposing certain revisions to this discharge assessment.

Added therapy collection items in SNF PPS discharge assessment

With the proposed reductions in resident assessments, CMS is concerned about reductions in necessary therapy services. To prevent this, CMS is proposing various PT, OT, or SLP items be reported in order to track therapy services and ensure appropriate services are provided under the new PDPM system. Further, CMS proposes that no more than 25 percent of an individual's therapy time should be spent in group or concurrent therapy, meaning at least 75 percent of time should be individual therapy. CMS believes individual therapy is the most person-centered care, and it does not want to incentivize SNFs under the new PDPM model to move towards providing higher levels of group or concurrent therapy than is warranted. A non-fatal warning edit will trigger should a SNF use too much group or concurrent therapy time.

SNF Quality Reporting Program

CMS proposes no measures changes to the SNF Quality Reporting Program (QRP) for the coming year.

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SNF Valued-Based Purchasing Program

In prior rulemaking, CMS included the performance and baseline years. Now, it is proposing for FY 2021 that FY 2019 (October 1, 2018, through September 30, 2019) serve as the performance period for the SNF Valued-Based Purchasing (VBP) Program year, and that FY 2017 (October 1, 2016, through September 30, 2017) hospital discharges serve as the baseline period for the FY 2021 SNF VBP Program year.

Going forward, CMS wants to provide stability for SNFs in the VBP Program and proposes that beginning with the FY 2022 program year and for subsequent program years to:

- Adopt a performance period that is the one-year period following the performance period for the previous program year.
- Adopt a baseline period that is the one-year period following the baseline period for the previous year.

CMS requests feedback on interoperability

CMS seeks input from the public and stakeholders on a number of topics, including moving forward with interoperability. CMS has consistently expressed its support for advancing interoperability and is seeking comments on how to move forward. CMS asks commenters to provide feedback before June 26, 2018, and include specific proposals the agency should consider.

Author

Jenny Boese is the Director of Health Care Policy. She has more than 23 years of government relations and policy experience, and has spent more than half of her career dedicated to health care policy and the health care industry. Contact Jenny at 608-662-7636.

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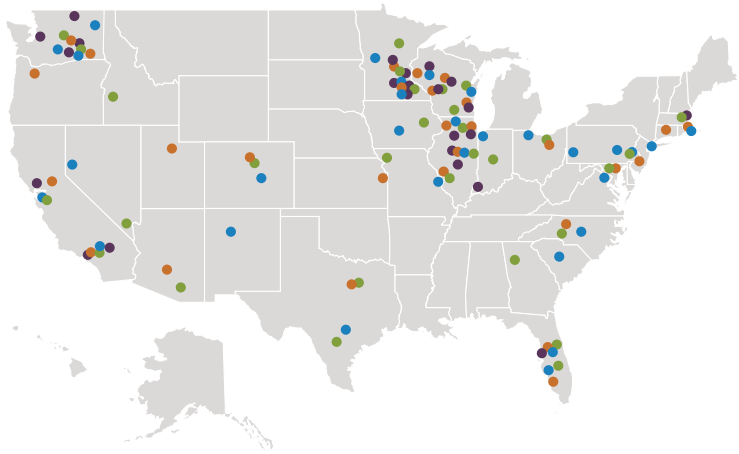

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