Medicare Skilled Nursing Facility
Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2020

Overview and Resources

On April 19, 2019, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2020 proposed payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

A copy of proposed rule *Federal Register* (FR) and other resources related to the SNF PPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

An online version of the proposed rule is available at https://www.federalregister.gov/documents/2019/04/25/2019-08108/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

Program changes finalized by CMS will be effective for discharges on or after October 1, 2019, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $887 million in aggregate payments to SNFs in FFY 2020 over FFY 2019, as well as a reduction of $213.6 million due to SNF VBP.

Comments on the proposed rule are due to CMS by June 18, 2019 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file codes "1718-P".

Note: Text in italics is extracted from the April 25, 2019 *Federal Register*.

SNF Payment Rates

FR pages 17,624 - 17,625

Incorporating the proposed updates with the effect of a budget neutrality adjustment, the table below shows the proposed urban and rural SNF federal per-diem payment rates for FFY 2020 compared to the rates currently in effect. These rates apply to hospital-based and freestanding SNFs, as well as to payments made for non-Critical Access Hospital (CAH) swing-bed services. While the Patient-Driven Payment Model (PDPM) goes into effect for FFY 2020, in the FFY 2019 SNF Final Rule, CMS released PDPM rate values that would be in effect had the model gone into effect in FFY 2019:

Case-Mix Rate Component		Urban SNFs			
		RUG-IV	PDPM		Percent Change
		Final FFY 2019	Final FFY 2019	Proposed FFY 2020	
Nursing	**Nursing**	**$181.44**	**$103.46**	**$106.64**	**+3.1%**
	Non-Therapy Ancillary		**$78.05**	**$80.45**	
Therapy	**Physical Therapy**	**$136.67**	**$59.33**	**$61.16**	
	Occupational Therapy		**$55.23**	**$56.93**	
	Speech Language Pathology		**$22.15**	**$22.83**	
Therapy Non-Case-Mix		**$18.00**	**Eliminated**		
Non-Case-Mix		**$92.60**	**$92.63**	**$95.48**	

Case-Mix Rate Component		Rural SNFs			
		RUG-IV	PDPM		Percent Change
		Final FFY 2019	Final FFY 2019	Proposed FFY 2020	
Nursing	**Nursing**	**$173.34**	**$98.83**	**$101.88**	**+3.1%**
	Non-Therapy Ancillary		**$74.56**	**$76.86**	
Therapy	**Physical Therapy**	**$157.60**	**$67.63**	**$69.72**	
	Occupational Therapy		**$62.11**	**$64.03**	
	Speech Language Pathology		**$27.90**	**$28.76**	
Therapy Non-Case-Mix		**$19.23**	**Eliminated**		
Non-Case-Mix		**$94.31**	**$94.34**	**$97.25**	

For FFY 2020, CMS will continue the 118% add-on to the per-diem payment for patients with Acquired Immune Deficiency Syndrome (AIDS) as adopted in FFY 2019 for the PDPM methodology.

The table below provides details of the proposed updates to the SNF payment rates for FFY 2020:

	SNF Rate Proposed Updates and Budget Neutrality Adjustment
Marketbasket Update	**+3.0%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.5 percentage points**
Wage Index/Labor-Related Share Budget Neutrality	**1.0060**
Other Budget Neutrality	**0.9996**
Overall Rate Change	***+3.1%***

Wage Index and Labor-Related Share

FR pages 17,628 – 17,630

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the SNF rates that CMS considers to be labor-related. The labor-related share for FFY 2020 is proposed at 70.8% compared to 70.5% in FFY 2019.

CMS is proposing a wage index and labor-related share budget neutrality factor of 1.0060 for FFY 2020 to ensure that aggregate payments made under the SNF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

A complete list of the wage indexes proposed for payment in FFY 2020 is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Case-Mix Adjustment

FR pages 17,625 - 17,628, 17,633 - 17,636

CMS currently classifies residents into resource utilization groups (RUGs) that are reflective of the different resources required to provide care to SNF patients. Each of the 66 RUGs recognized under the current SNF PPS have associated nursing and/or therapy case-mix indexes (CMIs) which are applied to the federal per-diem rates. The higher the CMI, the higher the expected resource utilization and cost associated with residents assigned to that RUG.

Resident classification under the existing therapy component is based primarily on the amount of therapy the SNF provides to a SNF resident. Under the RUG-IV model, residents are classified into rehabilitation groups, where payment is determined primarily based on the intensity of therapy services provided to the resident, and into nursing groups, based on the intensity of nursing services received by the resident and other aspects of the resident's care and condition. However, only the higher paying of these groups is used for payment purposes. The vast majority of Part A covered SNF days are paid using a rehabilitation RUG.

Since the RUG-IV was implemented in 2011, CMS had noticed many concerning trends. One of these trends is that the percentage of residents classifying into the Ultra-High therapy category had increased steadily. Another is that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. Since SNFs are providing just enough therapy for residents to surpass the relevant therapy thresholds, CMS believes this is a strong indication of service provision predicated on financial considerations rather than resident need. The Office of the Inspector General (OIG) concluded that the difference between Medicare payments and SNFs' costs or therapy, combined with the current payment method, creates an incentive for SNFs to bill for higher levels of therapy than necessary.

In May 2017, CMS released an Advance Notice of Proposed Rulemaking which sought comments on a possible replacement to the current RUG-IV model with the Resident Classification System, Version I (RCS-I). After considering numerous comments on a wide variety of aspects of the RCS-1 model, CMS made significant revisions to the RCS-I and therefore is replacing the RUG-IV system with the Patient-Driven Payment Model (PDPM), effective October 1, 2019.

The PDPM is intended to better account for resident characteristics and care needs while reducing both systemic and administrative complexity. The model removes service-based metrics from the SNF PPS and derives payment from verifiable resident characteristics.

The new component structure under the PDPM compared to that of RUG-IV is below:

<table>
<tr><td rowspan="2">Nursing Case-Mix</td><td rowspan="6"></td><td>Nursing</td></tr>
<tr><td>Non-Therapy Ancillary (NTA)</td></tr>
<tr><td rowspan="3">Therapy Case-Mix</td><td>Physical Therapy (PT)</td></tr>
<tr><td>Occupational Therapy (OT)</td></tr>
<tr><td>Speech-Language Pathology (SLP)</td></tr>
<tr><td>Non-Case-Mix</td><td>Non-Case-Mix</td></tr>
<tr><td>Therapy Non-Case-Mix</td><td></td></tr>
</table>

The case-mix components of the PDPM address costs associated with an individual's specific needs and characteristics, while the non-case-mix component addresses consistent costs that are incurred for all residents, such as room and board and various capital-related expenses. CMS classifies all residents into one of 16 PT and OT case-mix groups (August 8, 2018 *Federal Register* page 39,209) for each of the two components, one of 12 SLP case-mix groups (August 8, 2018 *Federal Register* pages 39,212-39,213), one of 25 nursing case-mix groups (August 8, 2018 *Federal Register* pages 39,217 – 39,218), and one of 6 NTA case-mix groups (August 8, 2018 *Federal Register* page 39,223).

The FFY 2020 proposed CMI updates for each component may be found on pages 17,627-17,628 of the April 25, 2019 *Federal Register*.

In the RUG-IV, each RUG is paid at a constant per diem rate, regardless of how many days a resident is classified in that particular RUG. Under the PDPM, CMS uses a variable per diem adjustment to the PT, OT, and NTA components to account for changes in resource utilization over a stay, as detailed below. There are no such adjustments to the SLP and nursing components as resource use tends to remain relatively constant for these components over the course of a SNF stay.

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

Variable Per-Diem Adjustment Factors and Schedule – NTA	
Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

Currently, the RUG-IV classifies each resident into a single RUG, with a single payment for all services. The PDPM classifies each resident into five components and provide a single payment based on the sum of these individual characteristics. The payment for each component is calculated by multiplying the CMI for the resident's group by the component federal base payment rate and then by the specific day in the variable per diem adjustment schedule. Additionally, for residents with HIV/AIDS indicated on their claim, the nursing portion of the payment is multiplied by 1.18 (as opposed to the 1.28 add-on in effect under RUG-IV). These payments are added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate. CMS is implementing the PDPM in a budget neutral manner relative to RUG-IV by multiplying every CMI by a budget neutrality ratio, which at this time is proposed at 1.463.

The PDPM does not calculate new federal base payment rates but modifies the existing base rate case-mix components for therapy and nursing. CMS used the FFY 1995 cost reports (the same data source used to calculate the original federal base payment rates in FFY 1998) to determine the portion of the therapy case-mix component base rate that would be assigned to each of the therapy component base rates (PT, OT, and SLP). The portion of the nursing component base rate that corresponds to NTA costs was already calculated using the same data source used to calculate the federal base payment rates in FFY 1998.

Additionally, at a component level (PT, OT, SLP), when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, a non-fatal warning edit appears on the validation report that the provider receives when submitting an assessment. This will alert the provider that the therapy provided exceeds the 25 percent threshold.

CMS adopted a five-day SNF PPS scheduled assessment to classify a resident under the SNF PDPM for the entirety of his or her Part A SNF stay. Facilities will have the option to reclassify residents as appropriate from the initial 5-day classification using an Interim Payment Assessment (IPA) in order to address potential changes in clinical status. The assessment reference date (ARD) for the IPA will be the date the facility chooses to complete the IPA and payment based on the IPA will begin the same day as the ARD. Furthermore, the IPA will not be susceptible to assessment penalties.

SNF PPS Assessment Schedule under PDPM		
Medicare Minimum Data Set (MDS) assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
Initial Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless IPA is completed)
Interim Payment Assessment (IPA)	Date IPA is completed	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

Additionally, the current SNF PPS RUG-IV policy does not require an interrupted stay policy because given a resident's case-mix group, payment does not change over the course of a stay. However, the PDPM policy includes variable per diem adjustments and therefore CMS will utilize an interrupted stay policy in order to avoid a SNF discharging a resident and then readmitting the resident shortly thereafter to reset the resident's variable per diem adjustment schedule and maximize payment rates for that resident. CMS' interrupted stay policy is as follows:

- In cases where a resident is discharged from a SNF and returns to the same SNF by 12:00am at the end of the third day of the interruption window (defined below); the resident's stay would be treated as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule; or
- In cases where the resident's absence from the SNF exceeds the 3-day interruption window, or in any case where the resident is readmitted to a different SNF, the readmissions would be treated as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1. The only relevant factors in determining if the interrupted stay policy would apply are the number of days between the residents discharge from a SNF and subsequent readmission to a SNF, and whether the resident is readmitted back to the same SNF or a different SNF.

CMS defines the interruption window as the 3-day period starting with the calendar day of discharge and additionally including the 2 immediately following calendar days.

CMS estimates that for FFY 2020, urban hospital-based SNF revenue will increase by 10.0%, while rural hospital-based SNF revenue will increase by 20.4% as a result of the PDPM implementation.

Group Therapy Definition

FR pages 17,633 – 17,635

In the past, CMS has had concerns that a group of more than four participants would not allow for adequate supervision by a single therapist, whereas groups of fewer than four would not provide enough opportunity for interaction to best achieve the goal of providing group therapy. However, based on the use of group therapy in the IRF and outpatient settings (areas with less restrictive definitions) CMS now believes that therapists have the clinical judgment to determine whether groups of varying sizes would benefit their patients, which should be documented as to why it is the most appropriate mode of therapy for the patient.

In order to allow therapists flexibility in the determination of an appropriate group size, CMS is proposing to define group therapy in the SNF Part A setting as: *"A qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities."*

SNF Value-Based Purchasing Program

FR pages 17,679 - 17,683

Background: For FFYs 2019 and beyond, CMS is required by the Protecting Access to Medicare Act of 2014 (PAMA) to utilize a VBP (Value-Based Purchasing) program for SNFs under which value-based incentive payments are made to the SNFs.

SNF VBP Measures

FR pages 17,679 – 17,680

In the FFY 2016 final rule, CMS adopted the Skilled Nursing Facility 30-Day All-Cause Readmission Measure, (SNFRM) (NQF #2510) as the sole measure to be used in the SNF VBP Program. In the FFY 2017 final rule, CMS finalized that they will replace the SNFRM measure in the SNF VBP Program with the SNF 30-Day Potentially Preventable Readmission measure (SNFPPR) as soon as is practical.

The SNFPPR is one of two potentially preventable readmission measures which apply to the SNF setting, the other being the "Potentially Preventable 30-Day Post-Discharge Readmission Measure" currently in use under the SNF QRP program. As the SNFPPR uses a 30-day post-hospital discharge window, rather than the 30-day post-SNF window used under SNF QRP, CMS will attempt to reduce confusion between the two measures by renaming the SNFPPR to "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge."

CMS intends to submit the renamed measure to the National Quality Forum (NQF) for endorsement review as soon as is feasible.

Performance Standards and Scoring

FR pages 17,680 –17,681

CMS will calculate rates for the SNF VBP quality measures using one year of data for each of the baseline and performance periods. The baseline and performance periods for each program year for FFYs 2022+ are set to the following one year period for each of the baseline and performance periods from the prior program year.

CMS will use the following baseline and performance periods for the FFYs 2021-2022 program years:

Baseline period	Performance Period	Payment Period
October 1, 2016 – September 30, 2017	**October 1, 2018 – September 30, 2019**	**FFY 2021**
October 1, 2017 – September 30, 2018	**October 1, 2019 – September 30, 2020**	**FFY 2022**

In the FFY 2019 final rule, CMS adopted the following performance standards for the SNFRM measure for the FFY 2021 program year as follows:

Measure ID	Performance Standards
SNFRM	**Achievement threshold 0.79476**
	Benchmark 0.83212

In this FFY 2020 proposed rule, CMS is proposing the following performance standards for the SNFRM measure for the FFY 2022 program year as follows:

Measure ID	Estimated Performance Standards
SNFRM	Achievement threshold 0.79476
	Benchmark 0.83212

CMS uses a scoring methodology for the SNF VBP Program that utilizes a 0 to 100 point scale for achievement scoring and a 0 to 90 point scale for improvement, similar to that of the Hospital VBP Program. In order to avoid ties CMS will round scores on the achievement and improvement scales to the nearest ten-thousandth of a point, rather than the nearest whole number.

The equation for SNF achievement scores is below. SNFRM scores will be inverted so that a higher rate represents better performance:

$$\textbf{SNF Achievement Score} = \left([9 \times \frac{(SNFs' Perf.Period\ Inverted\ Rate - Achievement\ Threshold)}{(Benchmark - Achievement\ Threshold)}]\right) + 0.5) \times 10$$

The equation for SNF improvement scores is:

$$\textbf{SNF Improvement Score} = \left([10 \times \frac{(SNFs' Perf.Period\ Inverted\ Rate - SNF\ Baseline\ Period\ Inverted\ Rate)}{(Benchmark - SNF\ Baseline\ Period\ Inverted\ Rate)}]\right) - 0.5) \times 10$$

Under the PAMA, the SNF VBP program will take the higher of achievement and improvement scores in calculating the SNF performance score. SNFs that do not have sufficient baseline period data available for scoring for a program year (fewer than 25 eligible stays) will not receive an improvement score and will be scored only on their achievement during the performance period. CMS will apply a logistic exchange function to translate these SNF performance scores into value-based incentive payments under the SNF VBP Program.

Under the PAMA, 2% of SNF's adjusted federal per diem rate will fund the value-based incentive payments for a given FFY. CMS will return 60% of these reductions to payments back to SNFs as value-based incentive payments each program year. Each SNF's individual value-based incentive payment percentage will vary according to its SNF performance score. CMS will use a scaling factor in the calculation of incentive payments to ensure that value-based incentive payments under the program equal the 60% of reductions.

If a SNF has less than 25 eligible stays during a performance period, CMS will assign the SNF the "break-even" performance score (meaning the SNF will have no impact from the program but will still be included in the logistic exchange function). In the FFY 2020 proposed rule, CMS estimates that this policy would redistribute an additional $8.1 million to those SNFs deemed low volume for the FFY 2020 program year, resulting in an estimated payback percentage of 61.51%.

In order to determine how value-based incentive payments will be distributed to SNFs, CMS compares SNF Medicare revenue for the program year to the total amount of reductions returned to SNFs for that year (i.e. 60% of the 2% reductions) and apply a value-based payment multiplier to each SNF, based on its performance score, that corresponds to a point on the logistic exchange function:

$$y_i = \frac{1}{1 + e^{-0.1(x_i - 50)}}$$

Where x_i is the SNF's performance score.

Reporting/Review, Correction and Appeals Process

FR pages 17,681 – 17,682

Since October 1, 2016, CMS has been required by PAMA to provide quarterly feedback reports to SNFs on their performance on the readmission or resource use measure (see below). In the FFY 2018 final rule, CMS finalized a two-phase data review and collection process for SNFs' measure and performance data that will be made public.

CMS is proposing to adopt a 30-day deadline for Phase One correction requests, from the date that CMS issues the June report to review the claims and measure data. If a provider believes that any of that information is inaccurate, they may submit a correction request to CMS within that timeframe. This would not preclude providers from submitting corrections for claims where errors are discovered prior to receipt of the June report.

For SNF's with fewer than 25 eligible stays during a scoring period (baseline or performance), CMS is proposing to redact that SNF's Risk-Standardized Readmission Rate (RSRR) from the published performance information for that given period, but will still publish the relevant achievement and/or improvement score. For those with zero eligible cases during the performance period, CMS is proposing to not display any information for that SNF.

SNF Quality Reporting Program (QRP)

FR pages 17,636 – 17,679

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the implementation of a quality reporting program for SNFs. Beginning in FFY 2018, the IMPACT Act requires a 2 percentage point penalty, applied to the standard market basket rate adjustment, for those SNFs that fail to submit required quality data to CMS.

Summary Table of Domains and Measures Currently Adopted for the FFY 2021 SNF QRP	
Short Name	**Measures**
Resident Assessment Instrument Minimum Data Set Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/Care Plan	Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631)
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Change in Self-Care Score	Application of Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues
Claims-Based Measures	
MSPB SNF	Total Estimated Medicare Spending per Beneficiary (MSPB)
DTC	Discharge to Community
PPR	Potentially Preventable 30-Day Post Discharge Readmission Measure

For the FFY 2022 SNF QRP, CMS is proposing to adopt two process measures in order to promote effective communication and coordination of care, for residents beginning with October 1, 2020 discharges (using data from the MDS assessment instrument for SNF residents):

- Transfer of Health Information to the Provider-Post-Acute Care (PAC); and
- Transfer of Health Information to the Patient-Post-Acute Care (PAC).

In addition, CMS is proposing to:

- Update the "Discharge to Community – PAC SNF QRP" measure to exclude baseline nursing facility (NF) residents.

CMS is seeking input on the value of the following measures for inclusion in the SNF QRP for future years:

- Assessment-Based Quality Measures and Measure Concepts
    - Functional maintenance outcomes
    - Opioid use and frequency
    - Exchange of electronic health information and interoperability
- Claims-based
    - Healthcare-Associated Infections in Skilled Nursing Facility (SNF) – claims-based
- Standardized Patient Assessment Data Elements (SPADEs)
    - Cognitive complexity, such as executive function and memory
    - Dementia
    - Bladder and bowel continence including appliance use and episodes of incontinence
    - Care preference, advance care directives, and goals of care
    - Caregiver Status
    - Veteran Status
    - Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

For FFY 2019 and each subsequent year, SNFs must report standardized patient assessment data elements (SPADE), as required by the IMPACT Act of 2014. Previously, CMS had adopted SPADEs for the two categories:

- Functional Status: Data elements currently reported by SNFs to calculate the measure Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); and
- Medical conditions and comorbidities: the data elements used to calculate the pressure ulcer measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and the replacement measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Beginning with the FFY 2022 SNF QRP, CMS is proposing that SNFs begin reporting the following additional SPADE categories, for admissions and discharges starting October 1, 2020:

- Cognitive Function and Mental Status Data (*FR* pages 17,645 – 17,647);
- Special Services, Treatments, and Inventions Data (*FR* pages 17,648 – 17,666);
- Impairment Data (*FR* pages 17,668 – 17,671); and
- Social Determinants of Health (*FR* pages 17,671 – 17,678) [NEW].

Finally, CMS believes that the most accurate representation of the quality provided to Medicare residents in SNFs would be best portrayed utilizing data collected through the Long Term Care Minimum Data Set (MDS) on all SNF residents, regardless of payer. As a result, CMS is proposing that, to meet the requirements of the SNF QRP, a SNF must collect and submit MDS data on all SNF residents, regardless of payer, beginning with the FFY 2022 program year.

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