# *Are Your Ready for FY 2020?*
# *Elise Smith, LTC Pharmacy News, December 2018*

Hope you are having a good Holiday Season and are getting ready for the coming year! With respect to post-acute care, both CMS and the Medicare Payment Advisory Commission (MedPAC) are off to a rousing start.

On Tuesday, December 11, CMS provided a two hour National Provider Call on the subject of the new Patient Driven Payment Model (PDPM) effective October 1, 2019 (FY 2020) accompanied by 92 slides Yes – 92![1]

For its part, MedPAC, at the December 6 and 7 Commission meeting, provided its preliminary recommendations for updating Medicare payments for FY 2020 to SNFs and over nine other provider categories. This is a first in the series of steps MedPAC will take before publishing its final update recommendations for all provider categories in the *MedPAC March 2019 Report*.

## ***CMS Highlights***

In its provider call of December 11, CMS staff delivered a highly detailed overview of the PDPM covering multiple aspects of the new system which will be implemented on October 1, 2019 (FY 2020). The PowerPoint presentation essentially attempted to distill major points that had been spelled out in the proposed and final rules. For those wanting or needing a very deep dive in to PDPM this slide show should be useful. I would however recommend that one first looks again at prior *LTCPharmacy* issues where we distilled the particulars of the new system and also look again at Paul's teaching aid and test to get a grounding in the major changes from RUG IV.[2] CMS also reiterated many times on the Call that guidance will be forthcoming soon via the usual key documents such as the RAI – MDS Manual etc. We note a few highlights.

- ***There is no so-called transition period.***

There were many questions on the call regarding payment for patients who enter the facility before October, 2019 and are classified under the RUG IV but who remain in the SNF beyond October 1. On slide 85 CMS reiterates what it tried to explain in the Final Rule. The RUG IV and PDPM will not be run concurrently. There is no transition period between RUG-IV and PDPM, given, according to CMS, that running both systems at the same time would be administratively infeasible for providers and CMS. CMS' solution is as follows.

  - RUG-IV billing ends September 30, 2019
  - PDPM billing begins October 1, 2019

To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an interim payment assessment (IPA) with an ARD no later than October 7, 2019 for all SNF Part A patients.

October 1, 2019, will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019. Any "transitional IPAs" with an ARD after October 7, 2019, will be considered late and relevant penalty for late assessments would apply.

- ***Proper patient classification is critical to appropriate care and appropriate billing.***

PDPM is squarely based on patient characteristics. SNF staff are already educating themselves on the coding skills required to capture patient characteristics. Medication is a huge percentage of the PDPM component of non-therapy ancillaries . (NTAs.) On the CMS Call, CMS said in effect -- "when you think NTA, think drugs." **Pharmacists may wish to become familiar with the 50 conditions or co-morbidities that CMS concluded were related to increases in NTA costs in the SNF**.

The NTA comorbidity score is a weighted count of certain comorbidities that a SNF patient has, which is then used to classify the patient into an NTA component payment group. The provider will report on the MDS of each of the comorbidities that a person has. The patient's NTA comorbidity score is the sum of the points associated with each relevant comorbidity.

The environment of coding for higher acuity patients with multiple co-morbidities may be new for many SNFs and administering drugs associated with such an increase in patients with high comorbid scores a key aspect of the challenge.

- ***CMS therapy monitoring will remain .***

In their introduction on the Call. CMS staff reiterated their position that perverse incentives drove the provision of therapy under RUG IV. PDPM with its emphasis on patient characteristics is meant to improve payment accuracy and appropriateness by focusing on the patient, rather than volume of services provided. However, CMS will continue to monitor therapy.

Comments received by CMS suggested that under PDPM therapy levels might decline since incentives have shifted from volume to the treatment of more complex patients and conditions. If therapy declines but the characteristics of the patient population remains the same, to CMS that would be an indication that payment was still the driver of care. On the call CMS staff said "Because if we don't observe changes in the patient population … that would suggest that payment incentives are continuing to have an impact on care decisions, as opposed to the needs of the patients. Then we'll have to consider the scope of those levels, whether it's at the facility level or the national level, and then consider what's appropriate… [to do]. "

- ***PDPM may have a number of effects on the Medicaid program.***

Upper Payment Limit (UPL) represents a limit on certain reimbursements for Medicaid providers. Specifically, the UPL is the maximum a given State Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid fee-for-service. State Medicaid programs cannot claim federal matching dollars for

provider payments in excess of the applicable UPL. CMS explained on the Call that while budget neutral in the aggregate, PDPM changes how payment is made for SNF services, which can have an impact on UPL calculations. States will need to evaluate this effect to understand revisions in their UPL calculations.

For purposes of Medicaid reimbursement, states utilize a myriad of different payment methodologies to determine payment for Nursing Facility (NF) patients. Some states use a version of the RUG-III or RUG-IV models as the basis for patient classification and case-mix determinations. With PDPM implementation, CMS will continue to report RUG-III and RUG-IV HIPPS codes, based on state requirements, in Item Z0200, through 9/30/2020.

Case-mix states also may rely on PPS assessments to capture changes in patient case-mix, including scheduled and unscheduled assessments. ***As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all current unscheduled PPS assessments will be retired.*** To fill this gap in assessments, CMS will introduce the Optional State Assessment (OSA), which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules.

## ***MedPAC Highlights***

MedPAC is an independent congressional agency established by Congress to advise the Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC also analyzes access to care, quality of care, and other issues affecting Medicare. Two reports—issued in March and June each year—are the primary outlet for Commission recommendations. MedPAC was instrumental in getting CMS to design and implement the PDPM.

MedPAC on December 6, at the Commission meeting, the Commissioners gave preliminary approval to the staff developed recommendations for updating Medicare payments to SNFs in 2020. [3] Final approval will be addressed in January and recommendations will be published in the March Report.

- ***MedPAC staff assessed the adequacy of current payments.***

MedPAC based its assessment of SNF payment adequacy on 2017 data which is the latest data available. The staff indicated that in 2017, there were about 15,000 SNF providers, and about 1.6 million fee-4 for-service beneficiaries used these services. Fee-for-5 service spending was $28.4 billion. Fee-for-service Medicare makes up about 11 percent of days but 19 percent of revenues.

Key questions MedPAC considered in its assessment:

- Are Medicare payments for skilled nursing facility (SNF) care adequate?
- How should Medicare's payments change for fiscal year 2020?

Staff used the Commission's payment adequacy framework to discuss the payment update for SNF services for 2020. This framework considers: beneficiary access to

care (including the supply of providers and volume of services), indicators of the quality of care furnished to beneficiaries, access to capital markets, and changes in Medicare costs and payments.

MedPAC staff found that:

- Access to SNF services is adequate.
- Regarding quality, performance was mixed with small changes from 2016.
- Regarding access to capital, capital is generally available and expected to remain so in 2019.
- The level of Medicare payments remains too high.

The following staff recommendations were provisionally approved by the Commissioners:

- Recommendation #1: The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case mix groups to maintain alignment of payments and costs.

- Recommendation #2: The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

- ***MedPAC supports the PDPM***

In the first recommendation above, MedPAC supported the PDPM with the proviso of CMS recalibrating weights to maintain alignment of payments and costs over time. MedPAC staff observed that a revised PPS should reduce the variation in Medicare margins across providers. "The impact on individual providers will depend on their mix of cases and their current practice patterns."

Staff opined that there will be some redistribution; they suspect that the difference between for-profits and nonprofits will narrow, and between freestanding and hospital-based. So the distribution will be narrowed but not eliminated.

[1] https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-12-11-SNF-PPS-PDPM.pdf
[2] Paul
[3] http://www.medpac.gov/docs/default-source/default-document-library/december-2018-transcript.pdf?sfvrsn=0