CMS Issues SNF PPS Proposed Prospective System (PPS) Payment Rule Update for *FY 2019 (October 1, 2018)* and Unveils New Patient Driven Payment Model (PDPM) for SNFs Effective *FY 2020 (October 1, 2019)*

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Medicare SNF provider payment methodologies have been developed, implemented, analyzed, studied, modified, and ultimately "reformed" ever since the implementation of Medicare post-acute care provider reimbursement in 1965. CMS will now replace RUG IV with the SNF Patient-Driven Payment Model (PDPM), effective starting FY 2020. The core of PDPM is paying for SNF care based on patient clinical characteristics -- not on the amount of services provided such as rehabilitation therapy which, according to CMS, has driven reimbursement.

CMS unveiled the PDPM model through the SNF FY 2019 Update Proposed Rule issued Friday, April 27.[1] Long Term Care (LTC) pharmacy providers should take a close look at the treatment of what is referred to as the non-therapy ancillary (NTA) component of the PPS rate which encompasses payment for drugs. It was strengthened in RCS-1 and again in PDPM and should enable SNFs to take far more clincially complex patients than ever before. [2] CMS encourages comments, questions, or thoughts on this proposed rule and will accept comments until June 26, 2018.

A. SNF PPS Payment Rates for FY 2019 (Still Based on RUG Model)

The FY 2019 SNF market basket update is 2.4% as required by the Bipartisan Budget Act of 2018. CMS estimates that the FY 2019 aggregate impact will be an increase of $850 million in Medicare payments to SNFs. Absent the application of this statutory requirement, the FY 2019 market basket update factor would have been 1.9 percent which reflects the SNF FY 2019 market basket index of 2.7 percent, reduced by the multifactor productivity adjustment of 0.8 percent. This 1.9 percent update would have resulted in an estimated aggregate increase of $670 million in Medicare payments to SNFs instead of $850 million.

B. The PDPM Model

1. Predecessor RCS-1

The PDPM is, according to CMS, a refined and improved Resident Classification Sytsem-1 (RCS-1) unveiled in 2017 after a lengthy research and review process.[3] Over the years, CMS feared that the current system, (RUG IV) was failing to achieve its goal of appropriate payment for appropriate services. The system was not functioning as intended and, according to CMS, providers were using the inherent weaknesses in great part to chiefly maximize reimbursement. A variety of

concerns had also been raised with the current SNF PPS RUG-IV model by MedPAC and the OIG.

CMS believed that the RCS-I model offered a significant revision in that it represented a substantial improvement over the RUG-IV model; it would better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS. To better ensure that resident care decisions appropriately reflect each resident's actual care needs, CMS expressed the belief that it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from objective resident characteristics. [4]

The thrust of the public comments appeared not to be so much a challenge to the principle of paying according to clinical characteristics but rather to the various aspects of the proposed model that providers felt to be inaccurate, not fully thought out, administratively burdensome to an unacceptable degree, and based on insufficient data. Thus, many comments went to the complexity of RCS-1, complexity that the providers feared would benefit neither residents nor providers.

When and how would CMS fix the RCS-1 flaws noted by commenters? How would facilities manage such a complex system? Would CMS implement RCS-I effective FY 2019 or delay for FY 2020 or maybe even FY 2021? Or even, *mirabile dictu*, FY 2022? Would it provide a transition period (perhaps, blended rates?) easing providers into the new model?

Meanwhile CMS continued stakeholder engagement efforts to identify and address the concerns and questions raised by commenters.[5] As a result, the agency made what it believes are significant changes to the RCS-I model and renamed it the Patient-Driven Payment Model (PDPM). CMS announced implementation for **FY 2020! Below are some highlights of the model.**

2. PDPM:

- Uses six components to determine the federal base payment rate instead of four as in RUGs IV. The case-mix components are nursing, non-therapy ancillary, physical therapy, occupational therapy, and speech language pathology. The 6th component is non-case mix.

- Significantly reduces the overall complexity of the proposed PDPM, as compared to RUG-IV or RCS-I, based on stakeholder feedback. The new system has 80% fewer groupings than RCS-I and uses some metrics already collected for quality reporting.

- Reflects updates to the data used as the basis for CMS analyses, to ensure that the results reflect the current resident population.

- Focuses on clinically relevant factors, rather than volume-based service for determining Medicare payment.

- Adjusts Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs), **which are items and services not related to the provision of therapy such as drugs and medical supplies, thereby more accurately addressing costs associated with medically complex patients**.

- Provides, as did RCS-1, a separate payment component for NTA services, as opposed to combining NTA and nursing into one component as in the RUG-IV system. This separation allows payment for NTA services to be based on resident characteristics that predict NTA resource utilization rather than nursing staff time. According to CMS, the proposed NTA case-mix groups would provide a better measure of resource utilization and lead to more accurate payments under the SNF PPS.

  CMS has especially invited comments on the approach proposed above to classify residents for NTA payment. LTC pharmacists may wish to take this opportunity to analyze and comment. CMS with the best of intentions sometimes does not perceive the nuances and implications of certain policies for facilities on the ground.

- Makes greater use, as compared to RCS-I, of certain standardized items for payment calculations, such as in using function items also used for the SNF QRP.

- Simplifies complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients.

- Further 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 – the variable per diem rate policy.

  This policy which provides for the downward shifting of rates during the stay - was emphatically questioned in the SNF /LTC Open Door Forum on May 1, 2018. The questioning concerned residents with conditions such as strokes who usually require more therapy further into a stay – days or weeks. CMS did not or could not answer the question but indicated that it would examine this issue.

- Eliminates the need of frequent patient assessments and allows clinicians to focus more time on treating the patient.

- Reflects updates to the data used as the basis for CMS analyses, to ensure that the results reflect the current resident population.

C. Related Issues

1. Budget Neutrality

CMS has always claimed that it was not under any legislative mandate to make case-mix changes budget neutral but that, in the circumstances of major changes, it has chosen as its policy to do so. Thus, as with prior system transitions, CMS will implement the proposed PDPM case-mix system, along with the other PDPM policy changes, in a budget neutral manner through application of a parity adjustment to the case-mix weights.

This means that CMS does not intend to change the aggregate amount of Medicare payments to SNFs. Rather, CMS' aim is to utilize a case-mix methodology to classify residents in such a manner as to best ensure that payments made for specific residents are an accurate reflection of resource utilization without introducing potential incentives which could encourage inappropriate care delivery, as it believes may exist under the current case-mix methodology.

2. Impact

While PDPM is intended to be budget neutral overall, CMS expects a significant shift in payments which would redirect payments away from residents who are receiving very high amounts of therapy under the current SNF PPS, which strongly incentivizes the provision of therapy, to residents with more complex clinical needs.

For example, CMS projects that for residents whose most common therapy level is RU (ultra-high therapy)--the highest therapy level, there would be a reduction in associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent. Other resident types for which there may be higher relative payments under the proposed PDPM are: residents who have high NTA costs, receive extensive services, are dually enrolled in Medicare and Medicaid, use IV medication, have ESRD, diabetes, or a wound infection, receive amputation/prosthesis care, and/or have longer prior inpatient stays.

3. Rehabilitation Therapy

CMS believes that there should be some limit on the amount of group and concurrent therapy that is provided to residents in order to ensure that residents receive an appropriate amount of individual therapy that is tailored to their specific needs. The agency proposes a combined 25 percent limit on group and concurrent therapy which it believes would provide sufficient assurance that at least a majority of each resident's therapy would be provided on an individual basis, consistent with our position that individual therapy is generally the best way of providing therapy to SNF residents because it is most tailored to their care needs.

4. CMS Rejects Transition Options

When making major system changes, CMS often considers possible transition options for providers and other stakeholders between the former system and the new system. For example, when CMS updated OMB delineations used to establish a provider's wage index under the SNF PPS in FY 2015, CMS utilized a blended rate in the first year of implementation, whereby 50 percent of the provider's payment was derived from their former OMB delineation and 50 percent from their new OMB delineation. (79 FR 45644 – 45646).

The agency has declined to provide a transition period.[6] CMS explains that due to the fundamental nature of the change from the current RUG-IV case mix model to the proposed PDPM, which includes differences in resident assessment, payment algorithms, and other policies, it believes that proposing a blended rate for the whole system (that would require two full case-mix systems (RUG-IV and the proposed PDPM) to run concurrently).

Specifically, CMS and providers would be required to manage both the RUG-IV payment model and proposed PDPM simultaneously, creating significant burden and undue complexity for all involved parties. Furthermore, providers would be required to follow both sets of MDS assessment rules, each of which carries with it its own level of complexity. CMS would also be required to process assessments and claims under each system, which would entail a significant amount of resources and burden for CMS, MACs, and providers.

CMS concluded that no transition strategy was for implementing the proposed PDPM, due to the significant administrative and logistical issues that would be associated with such a transition strategy.

5. Effective Date

CMS considered implementing the proposed PDPM case-mix model effective beginning in FY 2019, but concluded that this would not permit sufficient time for providers and other stakeholders, including CMS, to make the necessary preparations for this magnitude of a change in the SNF PPS. It also believes that such a quick transition would not be in keeping with how similar types of SNF PPS changes have been implemented in the past.

CMS also considered implementing PDPM more than one year after being finalized, such as implementing the proposed PDPM effective beginning October 1, 2020 (FY 2021). However, CMS believes that setting the effective date of PDPM this far out is not necessary, based on its prior experience with similar SNF PPS changes.

[1] Published in the Federal Register on May 8, 2018. 83 Fed. Reg. 21018, at https://www.gpo.gov/fdsys/pkg/FR-2018-05-08/pdf/2018-09015.pdf

[2] To support commenters in evaluating the proposed PDPM, CMS also released a *Technical Report* on the development of the PDPM, along with a number of other materials to support the development of comments on the proposed rule, which are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html, *Fact Sheet* at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html. See also, *SNF PPS Payment Model Research, Patient Driven Payment Model* at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

[3] The ANPRM was published in the Federal Register at 82 Federal Register 20980, May 4, 2017. See https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08519.pdf
See also LTC Pharmacy News May 6, 2017: *CMS Proposes to Revise SNF PPS Case-Mix Methodology for FY 2019*, for a discussion n explanation of RCS-1, comparison to RUG IV, and discussion of potential impact.

[4] 83 Fed.Reg at 21036.

[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html

[6] 83 Fed.Reg at 21079.