FY 2020 SNF PPS Final Rule

On Tuesday, July 30, 2019, CMS released the **FY 2020 SNF PPS Final Rule**. In this rule, CMS finalized a **2.4% payment update for FY 2020 (an increase of $851 million)**, and reiterated their decision to implement the Patient-Driven Payment Model (PDPM) on October 1, 2019.

FY 2020 PDPM Per Diem Rates

In the proposed rule, the SNF PPS payment update was slated at 2.5%; it has now been finalized at 2.4% (2.8% market basket increase and -0.4% multifactor productivity adjustment). Therefore, *the unadjusted urban and rural federal per diem rates have decreased slightly for each PDPM component, compared to what was published in the proposed rule*. The final rates are listed below:

TABLE 3: FY 2020 Unadjusted Federal Rate – URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$60.75	$56.55	$22.68	$105.92	$79.91	$94.84

TABLE 4: FY 2020 Unadjusted Federal Rate – RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$69.25	$63.60	$28.57	$101.20	$76.34	$96.59

CMS also finalized the PDPM Health Insurance Prospective Payment System (HIPPS) code structure:

- the first character represents the PT and OT groups (e.g., case-mix group, or CMG, TA = A),
- the second character represents SLP (e.g., CMG SB = B),
- the third character represents Nursing,
- the fourth NTA, and
- the fifth represents the assessment used to generate the HIPPS code.

In Tables 6 and 7 below (taken directly from the final rule), column one represents the character in the HIPPS code associated with a given PDPM component, with the specific component case-mix index (CMI) and rates listed in each subsequent column. The rates in these tables do not reflect any adjustments related to the SNF Quality Reporting Program (QRP), the SNF Value-based Purchasing (VBP) program, or the PDPM variable per diem adjustment (VPD). In addition, the wage index adjustment based on location or core-based statistical area (CBSA) is not included. Again, note that these rates are slightly lower across the board than the rates published in the proposed rule.

TABLE 6: PDPM Case-Mix Adjusted Federal Rate and Associated Indexes - URBAN

PDPM Group	PT CMI	PT ($) Rate	OT CMI	OT ($) Rate	SLP CMI	SLP ($) Rate	Nursing CMG	Nursing CMI	Nursing ($) Rate	NTA CMI	NTA ($) Rate
A	1.53	92.95	1.49	84.26	0.68	15.42	ES3	4.06	430.04	3.24	258.91
B	1.70	103.28	1.63	92.18	1.82	41.28	ES2	3.07	325.17	2.53	202.17
C	1.88	114.21	1.69	95.57	2.67	60.56	ES1	2.93	310.35	1.84	147.03
D	1.92	116.64	1.53	86.52	1.46	33.11	HDE2	2.40	254.21	1.33	106.28
E	1.42	86.27	1.41	79.74	2.34	53.07	HDE1	1.99	210.78	0.96	76.71
F	1.61	97.81	1.60	90.48	2.98	67.59	HBC2	2.24	237.26	0.72	57.54
G	1.67	101.45	1.64	92.74	2.04	46.27	HBC1	1.86	197.01	-	-
H	1.16	70.47	1.15	65.03	2.86	64.86	LDE2	2.08	220.31	-	-
I	1.13	68.65	1.18	66.73	3.53	80.06	LDE1	1.73	183.24	-	-
J	1.42	86.27	1.45	82.00	2.99	67.81	LBC2	1.72	182.18	-	-
K	1.52	92.34	1.54	87.09	3.70	83.92	LBC1	1.43	151.47	-	-
L	1.09	66.22	1.11	62.77	4.21	95.48	CDE2	1.87	198.07	-	-
M	1.27	77.15	1.30	73.52	-	-	CDE1	1.62	171.59	-	-
N	1.48	89.91	1.50	84.83	-	-	CBC2	1.55	164.18	-	-
O	1.55	94.16	1.55	87.65	-	-	CA2	1.09	115.45	-	-
P	1.08	65.61	1.09	61.64	-	-	CBC1	1.34	141.93	-	-
Q	-	-	-	-	-	-	CA1	0.94	99.56	-	-
R	-	-	-	-	-	-	BAB2	1.04	110.16	-	-
S	-	-	-	-	-	-	BAB1	0.99	104.86	-	-
T	-	-	-	-	-	-	PDE2	1.57	166.29	-	-
U	-	-	-	-	-	-	PDE1	1.47	155.70	-	-
V	-	-	-	-	-	-	PBC2	1.22	129.22	-	-
W	-	-	-	-	-	-	PA2	0.71	75.20	-	-
X	-	-	-	-	-	-	PBC1	1.13	119.69	-	-
Y	-	-	-	-	-	-	PA1	0.66	69.91	-	-

TABLE 7: PDPM Case-Mix Adjusted Federal Rate and Associated Indexes - RURAL

PDPM Group	PT CMI	PT ($) Rate	OT CMI	OT ($) Rate	SLP CMI	SLP ($) Rate	Nursing CMG	Nursing CMI	Nursing ($) Rate	NTA CMI	NTA ($) Rate
A	1.53	105.95	1.49	94.76	0.68	19.43	ES3	4.06	410.87	3.24	247.34
B	1.70	117.73	1.63	103.67	1.82	52.00	ES2	3.07	310.68	2.53	193.14
C	1.88	130.19	1.69	107.48	2.67	76.28	ES1	2.93	296.52	1.84	140.47
D	1.92	132.96	1.53	97.31	1.46	41.71	HDE2	2.40	242.88	1.33	101.53
E	1.42	98.34	1.41	89.68	2.34	66.85	HDE1	1.99	201.39	0.96	73.29
F	1.61	111.49	1.60	101.76	2.98	85.14	HBC2	2.24	226.69	0.72	54.96
G	1.67	115.65	1.64	104.30	2.04	58.28	HBC1	1.86	188.23	-	-
H	1.16	80.33	1.15	73.14	2.86	81.71	LDE2	2.08	210.50	-	-
I	1.13	78.28	1.18	75.05	3.53	100.85	LDE1	1.73	175.08	-	-
J	1.42	98.34	1.45	92.22	2.99	85.42	LBC2	1.72	174.06	-	-
K	1.52	105.26	1.54	97.94	3.70	105.71	LBC1	1.43	144.72	-	-
L	1.09	75.48	1.11	70.60	4.21	120.28	CDE2	1.87	189.24	-	-
M	1.27	87.95	1.30	82.68	-	-	CDE1	1.62	163.94	-	-
N	1.48	102.49	1.50	95.40	-	-	CBC2	1.55	156.86	-	-
O	1.55	107.34	1.55	98.58	-	-	CA2	1.09	110.31	-	-
P	1.08	74.79	1.09	69.32	-	-	CBC1	1.34	135.61	-	-

TABLE 7: PDPM Case-Mix Adjusted Federal Rate and Associated Indexes – RURAL (Continued)

PDPM Group	PT CMI	PT ($) Rate	OT CMI	OT ($) Rate	SLP CMI	SLP ($) Rate	Nursing CMG	Nursing CMI	Nursing ($) Rate	NTA CMI	NTA ($) Rate
Q	-	-	-	-	-	-	CA1	0.94	95.13	-	-
R	-	-	-	-	-	-	BAB2	1.04	105.25	-	-
S	-	-	-	-	-	-	BAB1	0.99	100.19	-	-
T	-	-	-	-	-	-	PDE2	1.57	158.88	-	-
U	-	-	-	-	-	-	PDE1	1.47	148.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	123.46	-	-
W	-	-	-	-	-	-	PA2	0.71	71.85	-	-
X	-	-	-	-	-	-	PBC1	1.13	114.36	-	-
Y	-	-	-	-	-	-	PA1	0.66	66.79	-	-

TABLE 8: Labor-Related Relative Importance, FY 2019 & FY 2020 *(change from Proposed Rule noted)*

	Relative importance, labor-related, FY 2019 18:2 forecast	**Relative importance, labor-related, FY 2020 19:1 forecast**
Wages and salaries	50.2	50.6
Employee benefits	10.1	10.0
Professional Fees: Labor-Related	3.7	3.7
Administrative & facilities support services	0.5	0.5
Installation, Maintenance & Repair Services	0.6	0.6
All Other: Labor Related Services	2.5	***2.6***
Capital-related (0.391)	2.9	2.9
Total	**70.5**	***70.9***

CMS states since the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and given the sheer volume of possible combinations of these components, it is not feasible for them to provide tables of total rate, labor and non-labor portion per "category" as they have done in the past under RUG-IV. Instead, to help providers understand the effect of the wage index on the SNF per diem rate calculation, *CMS has provided a revised hypothetical rate calculation* based on the updated per diem rates.

The example displays rate calculations prior to any adjustments related to the SNF QRP or VBP programs for a hypothetical patient in a hypothetical SNF XYZ located in Frederick, MD (Urban CBSA 43524). This patient is classified into the various PDPM CMGs such that the patient's PDPM HIPPS code is NHNC1 (PT/OT = TN, SLP = SH, Nursing CBC2, NTA = NC) on the 5-day MDS assessment.

TABLE 9: PDPM Case-Mix Adjusted Rate Computation Example

Per Diem Rate Calculation				
Component	**Component Group**	**Component Rate**	**VBP Adj Factor**	**VPD Adj Rate**
PT	TN	89.91	1.00	89.91
OT	TN	84.83	1.00	84.83
SLP	SH	64.86	-	64.86
Nursing	CBC2	164.18	-	164.18
NTA	NC	147.03	3.00	441.09
Non-Case-Mix	-	94.84	-	94.84
Total PDPM Case-Mix Adjusted Per Diem				$939.71

TABLE 10: Wage Index Adjusted Rate Computation Example

PDPM Wage Index Adjustment Calculation						
HIPPS Code	**PDPM Case-Mix Adj Per Diem**	**Labor Portion**	**Wage Index**	**Wage Index Adj Rate**	**Non-Labor Portion**	**Total Case Mix & Wage Index Adj Rate**
NHNC1	$939.71	$666.25	0.9839	$655.53	$273.46	$928.98

To obtain the Labor Portion of the rate, the Total PDPM Case-Mix Adjusted Per Diem rate ($939.71) is multiplied by the Labor Percentage (See Table 8 – 70.9% or 0.709) = $666.25. This Labor Portion is then multiplied by the Wage Index (specific to each location/CBSA) to obtain the Wage Index Adjusted Rate = $655.53. Wage Index Adj Rate + Non-Labor Portion = Total Case Mix and Wage Index Adj Rate, or $928.98.

This per diem rate applies for the first 3 days of the stay, when the NTA VPD adjustment is 3.00. Beginning day 4, the NTA VPD drops to 1.00, and the daily per diem becomes $638.28 for days 4-20. Beginning day 21, the PT and OT VPD decreases 2% to 0.98, and the daily rate drops to $634.83. Beginning day 28, the PT/OT VPD drops to 0.96, and so on. CMS completes these calculations for a 30-day stay in Table 11 of the final rule. Based on the example provided by CMS, the total payment to the SNF for this patient (HIPPS NHNC1) for a 30-day stay would be $19,975.62.

Group Therapy

CMS finalized the change to the definition of **Group Therapy** to align with the definition in the Inpatient Rehab Facility (IRF) setting: **The treatment of 2-6 patients at the same time who are performing the same or similar activities.** CMS expects the decision on group size will be made by "qualified therapists and therapy assistants" and that this decision will be made based on sound clinical rationale and "not financial gain."

CMS reiterates the expectation that documentation must be present in the plan of care to support group (vs. individual or concurrent) – such as outlining the benefits of group to the particular patient, how the prescribed type and amount of group will meet the patient's needs, and how it will assist the patient in reaching the documented goals.

CMS clarified in the final rule that these documentation requirements are not new. CMS states if there is a "change in the need for group therapy after a plan of care is completed," this should be "reflected in the medical record with whatever progress notes a facility requires to adequately capture the clinical status of the patient." CMS goes on to state they expect therapists to document the "use of group therapy for each patient they treat in a group in a way that clearly shows that group therapy is the most appropriate mode of therapy to be used in each case."

Policies regarding the use of students in the SNF under Medicare Part A are not changing under PDPM. CMS states that because therapy minutes are used as part of calculating compliance with the 25% cap on group and concurrent therapy, policies that account for students as an extension of the supervising therapist ensure an appropriate comparison between RUG-IV and PDPM. Also, CMS states these policies reflect the responsibility of the supervising therapist for the actions and treatments furnished by the student.

In response to stakeholder comments regarding possible penalties or negative consequences to exceeding the 25% group/concurrent cap, CMS states they plan to monitor the usage of group and concurrent therapy and will look at clinical outcomes. If the results of this monitoring indicate "substantial noncompliance" with the 25% limit, CMS may consider "taking additional action in future rulemaking."

ICD-10 Code Mapping and Update Process for PDPM

To ensure ICD-10 code lists used under PDPM (for Clinical Group and Comorbidity Adjustments) are up-to-date, **CMS finalized its decision to update ICD-10 code mappings, lists, and the Grouper through a "subregulatory process,"** which will consist of CMS publishing updated code mappings and lists on their website following the same timeline for implementation as current ICD-10 code updates (i.e., new diagnosis codes become effective October 1st each year). CMS will post ICD-10 code updates for FY 2020 prior to October 1, 2019.

This new process will be applied for "non-substantive changes" to ICD-10 codes, which CMS goes on to describe as "changes necessary to maintain consistency with the most current ICD-10 code set." Substantive changes, defined as changes that "go beyond the intention of maintaining consistency," would be proposed and finalized through notice and comment rulemaking. For example, a change that constitutes a change in policy, including changes to PDPM clinical category assignments or to the assignment of a code to the list of comorbidities, would be "substantive." A non-substantive change would be a clarification of an existing codes to give greater specificity or detail (like adding "R" or "L" to a knee pain code). This process aligns with the process already in place in the IRF for case-mix group assignment and for consolidated billing requirements in the SNF.

CMS states they will issue a Medicare Learning Network (MLN) article to alert providers and stakeholders to updates to the ICD-10 mappings and lists, and they will update the educational resources on the PDPM website to ensure providers are aware and able to understand the implications of such updates.

MDS Assessments Under PDPM – Changes to Regulatory Text

CMS finalized the decision to refer to the 5-day assessment as the "Initial Medicare Assessment," (vs. the "initial *patient* assessment" verbiage in the proposed rule) to avoid confusion with the interim payment assessment (IPA) beginning with the implementation of PDPM. And, they clarified that the ARD for the initial Medicare assessment must be "set for a date that is no later than the 8th day of posthospital SNF care (in other words, the facility cannot designate Day 9 or later as this assessment's ARD)." The timeliness requirements for assessment completion and submission remain the same as they are currently. CMS is finalizing changes to regulatory text to reflect these changes and clarifications.

In the final rule, CMS clarifies that the IPA is not an assessment that should be used solely to reflect changes in payment, but that, although it is "indeed optional," the intent is to allow SNFs to capture changes in the patient's clinical condition during the Medicare Part A stay. CMS also outlines changes to current regulatory text to distinguish the IPA from the Significant Change in Status assessment (SCSA), an assessment that is not limited to Medicare Part A/PPS.

SNF Quality Reporting Program (QRP) Updates

Background: The SNF QRP applies to all freestanding SNFs, SNFs affiliated with acute care hospitals, and all non-CAH swing bed rural hospitals. SNFs that fail to submit quality data to CMS will be subject to a 2% reduction in the annual market basket update. The policy regarding data submission remains the same going into FY 2020: SNFs must submit 100% of the required data elements (for ALL measures in the program) on at least 80% of the MDS assessments submitted to CMS to be compliant with the SNF QRP requirements for a program year.

CMS finalized the addition of two new process measures to the SNF QRP for FY 2022 (i.e., these measures impact payment in FY 2022 based on data collected 10/1/2020 thru 12/31/2020):

1. **Transfer of Health Information to the Provider – Post-Acute Care: Assesses** whether or not a current reconciled medication list is given to the subsequent provider when a patient is discharged from the current post-acute setting. Calculated as the proportion of resident stays with a DC assessment indicating a current reconciled medication list was provided to the subsequent provider at the time of discharge.

   The content (and "completeness") of the *current reconciled medication list* is left up to the provider, but may include the following:

   - Known medication and other allergies
   - Known drug sensitivities and reactions
   - Each medication, including name, strength, dose, and route of medication administration
   - Reason for holding a medication or when a medication should resume

   Subsequent provider includes the following, as indicated in the DC Destination item on the MDS:
   - Acute hospital
   - Another SNF
   - Intermediate care (developmental or intellectual disabilities providers)

- Home under the care of an organized home health service organization or hospice
- IRF
- Long-term acute care hospital (LTCH)
- Inpatient psychiatric facility
- Critical access hospital (CAH)
- Medicaid nursing facility

2. **Transfer of Health Information to the Patient – Post-Acute Care:** Assesses whether or not a current reconciled medication list was provided to the patient, family, or caregiver when the patient is discharged to a private home/apartment, board and care home, assisted living facility, group home, transitional living, or home under the care of a home health agency or hospice. Calculated as the proportion of resident stays with a DC assessment indicating a current reconciled medication list was provided to the patient, family, or caregiver at the time of discharge.

CMS finalized the update to the specifications of the DC to Community measure to exclude baseline nursing facility (NF) residents. Baseline NF resident is defined as a resident who had a long-term NF stay in the 180 days preceding the qualifying hospital and SNF stay without an intervening community discharge between the NF stay and the hospitalization.

Standardized Patient Assessment Data Elements (SPADEs) for the FY 2022 SNF QRP:

In the proposed rule, CMS discussed collecting multiple new SPADEs as part of the SNF QRP in its continued effort to obtain meaningful data that is assessed, collected, and measured in the same way across all post-acute care venues. **CMS finalized SPADEs in five categories for the FY 2022 SNF QRP**. CMS clarified that the data collection period for the new FY 2022 SNF QRP SPADEs will be 10/1/2020 thru 12/31/2020; for FY 2023, data collection will be CY 2021; for FY 2024, CY 2022.

The following SPADEs are to be collected/reported for all patients discharged on or after October 1, 2020, upon admission and discharge, unless otherwise noted below:

1. Cognitive Function and Mental Status:
   - Brief Interview of Mental Status (BIMS)
   - Confusion Assessment Method (CAM) to assess delirium
   - PHQ-2 to 9 (Patient Health Questionnaire) to assess depression

2. Special Services, Treatments, and Interventions:
   1) Cancer treatment: Chemotherapy (IV, Oral, Other)
   2) Cancer treatment: Radiation
   3) Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High Concentration Oxygen Delivery Systems)
   4) Respiratory Treatment: Suctioning (Scheduled, As Needed)
   5) Respiratory Treatment: Tracheostomy Care
   6) Respiratory Treatment: Non-invasive Mechanical Ventilation (BiPAP, CPAP)
   7) Respiratory Treatment: Invasive Mechanical Ventilator
   8) IV Medications: (Antibiotics, Anticoagulants, Vasoactive Medications, Other)

9) Transfusions
10) Dialysis (Hemodialysis, Peritoneal Dialysis)
11) IV Access (Peripheral IV, Midline, Central Line)
12) Nutritional Approach: Parenteral/IV Feeding
13) Nutritional Approach: Feeding Tube
14) Nutritional Approach: Mechanically Altered Diet
15) Nutritional Approach: Therapeutic Diet
16) High Risk Drug Classes: Use and Indications
    - Anticoagulants
    - Antiplatelets
    - Hypoglycemics (including insulin)
    - Opioids
    - Antipsychotics
    - Antibiotics

3. Medical Condition and Comorbidity Data: Pain Interference
   - Pain Effect on Sleep
   - Pain Interference with Therapy Activities
   - Pain Interference with Day-to-Day Activities

4. Impairment Data
   - Hearing (collected on admission only)
   - Vision (collected on admission only)

5. Social Determinants of Health (SDOH)
   1) Race (collected on admission only)
   2) Ethnicity (collected on admission only)
   3) Preferred Language – *finalized w/ modification; to be collected on admission only*
   4) Interpreter Services – *finalized w/ modification; to be collected on admission only*
   5) Health Literacy
   6) Transportation
   7) Social Isolation

Submitting Quality Data Regardless of Payer:

CMS states "…after careful consideration of public comments…**we have decided not to finalize the proposal to expand the reporting of SNF quality data to include all patients, regardless of payer, at this time."**

Public Display of QRP Data:

CMS finalized their proposal to begin publicly displaying data for the *Drug Regimen Review Conducted with Follow-Up for Identified Issues – Post Acute Care (PAC) SNF QRP* measure beginning CY 2020, or as soon as technically feasible.

SNF Value-based Purchasing Program (VBP)

To avoid confusion with the current SNF QRP readmission measure, CMS finalized its proposal to change the name of the *SNF VBP Potentially Preventable Readmissions* measure to the **Skilled Nursing Facility Potentially Preventable Readmissions After Hospital Discharge** measure. CMS states they will continue to abbreviate this as the *SNFPPR*.

Note: This measure is not in use in the SNF VBP currently, and no date has been suggested to change from the SNF All Cause Readmission (SNFRM) measure to the SNFPPR measure in this program. In the final rule, CMS states they will assess when to transition once the SNFPPR has been submitted to the National Quality Forum (NQF) for endorsement.

TO CLARIFY:

- The SNF QRP readmission measure is consistent with the readmission measures in the IRF QRP and the HH QRP and measures potentially preventable hospital readmissions *within 30 days of discharge from the SNF.*
- The SNF VBP readmission measure measures potentially preventable hospital readmissions *within 30 days of discharge from the hospital* (this includes an acute (IPPS) hospital, CAH, or psychiatric hospital).

The performance period for the SNF VBP in FY 2022 is FY 2020 (beginning 10/1/2019); the baseline period is FY 2018.

Table 15: Final FY 2022 SNF VBP Program Performance Standards (based on the FY 2018 baseline period)

Measure ID	Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-day All Cause Readmission Measure (NQF #2510)	0.79025	0.82917

This Achievement Threshold corresponds to a readmission rate of 20.98%; the Benchmark to a readmission rate of 17.08%. The SNF VBP program's achievement threshold is defined at the 25th percentile of SNFs' performance during the baseline period, not the mean of SNFs' performance during the baseline period. There are no updates to SNF VBP scoring policies in the final rule.

REMINDER: Scoring in the SNF VBP is based on 2 parameters:

- Improvement, which compares the facility's performance in the baseline year and performance year, and
- Achievement, which compares the facility's performance in the performance year to the performance of all SNFs nationally during the baseline year.

SNFs who improve their own score from the baseline year to the performance year receive "improvement points." SNFs who meet and exceed the Achievement Threshold receive "achievement points." The highest score of the 2 determines the SNF's performance score, it's "rank," and incentive payment.

CMS also finalized changes to the public reporting of SNF Performance Scores, Achievement and Improvement Scores, and Ranking based on the number of eligible stays (25 or more are "required") in

the baseline vs. performance period to allow display of sufficient, meaningful data that can be accurately interpreted.

CMS estimates the SNF VBP reductions to be $527.4 million in FY 2020.

Overall Impact to the SNF PPS for FY 2020

Using the most recently available data (i.e., FY 2018), CMS applies the current FY 2019 wage index and labor-related share value to the number of payment days to simulate FY 2019 payments. Then, using the same FY 2018 data, the FY 2020 wage index and labor-related share is applied to simulate FY 2020 payments and estimate the impact to providers of various types and locations.

Table 18: Impact to the SNF PPS for FY 2020 *(part of the table has been reproduced below)*

	Number of Facilities FY 2020	PDPM Impact	Update Wage Data	Total Change
Group				
Total	15,078	0.0%	0.0%	2.4%
Urban	10,951	-0.7%	0.0%	1.7%
Rural	4,127	3.7%	0.2%	6.2%
Hospital-based urban	380	9.9%	0.1%	12.4%
Freestanding urban	10,571	-1.0%	0.0%	1.4%
Hospital-based rural	245	20.4%	0.3%	23.1%
Freestanding rural	3,882	3.1%	0.2%	5.6%
Ownership				
For profit	10,729	-0.6%	0.0%	1.8%
Non-profit	3,469	1.5%	0.0%	3.9%
Government	880	4.5%	0.1%	7.0%

Access the Final Rule **here**.

Access CMS's Fact Sheet **here**.