Medicare Skilled Nursing Facility
Prospective Payment System

Payment Rule Brief FINAL RULE provided by the Wisconsin Hospital Association
Program Year: FFY 2019

Overview and Resources

On July 31, 2018, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2019 final payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

The copy of final 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 Display version of the final rule is available at https://www.federalregister.gov/documents/2018/08/08/2018-16570/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, 2018, unless otherwise noted. CMS estimates the overall economic impact of this final payment rate update to be an increase of $820 million in aggregate payments to SNFs in FFY 2019 over FFY 2018 and the final SNF VBP impact to be an estimated reduction of $211 million in FFY 2019.

SNF Payment Rates

DISPLAY pages 14-25

Incorporating the final updates with the effect of a budget neutrality adjustment, the table below shows the final urban and rural SNF federal per-diem payment rates for FFY 2019 compared to the rates currently in effect:

Rate Component	Urban SNFs			Rural SNFs		
	Final FFY 2018 CN	Final FFY 2019	Percent Change	Final FFY 2018 CN	Final FFY 2019	Percent Change
Nursing Case-Mix	**$177.21**	**$181.44**	**+2.4%**	**$169.29**	**$173.34**	**+2.4%**
Therapy Case-Mix	**$133.48**	**$136.67**		**$153.92**	**$157.60**	
Therapy Non-Case-Mix	**$17.58**	**$18.00**		**$18.78**	**$19.23**	
Non-Case-Mix	**$90.44**	**$92.60**		**$92.11**	**$94.31**	

For FFY 2019, CMS is continuing the 128% add-on to the per-diem payment for patients with Acquired Immune Deficiency Syndrome (AIDS).

The Bipartisan Budget Act (BBA) of 2018 mandated the annual marketbasket update for FFY 2019, after applying the productivity adjustment, to be 2.4%.

The table below provides details of the final updates to the SNF payment rates for FFY 2019:

	SNF Rate Final Updates and Budget Neutrality Adjustment
Marketbasket Update	**+2.8%** (proposed at +2.7%)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.8 percentage points** (as proposed)
Bipartisan Budget Act of 2018 Mandated 2.4% Marketbasket Update	**+0.39%** (proposed at +0.49%)
Wage Index/Labor-Related Share Budget Neutrality	**0.9999** (proposed at 1.0002)
Overall Rate Change	***+2.4%***

Wage Index and Labor-Related Share

DISPLAY pages 32-47

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 2019 is finalized at 70.5 % (proposed at 70.7%) compared to 70.8% in FFY 2018.

On August 15, 2017, the Office of Management and Budget announced a new urban Metropolitan Statistical Area:

- Twin Falls, Idaho (CBSA 46300) – compromised of the principal city of Twin Falls, Idaho in Jerome County, Idaho, and Twin Falls County, Idaho

CMS is adopting a wage index and labor-related share budget neutrality factor of 0.9999 (proposed at 1.0002) for FFY 2019 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 adopted for payment in FFY 2019 is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Case-Mix Adjustment: RUGS-IV to PDPM

DISPLAY pages 25 -32, 65 – 336

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 RUGS-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.

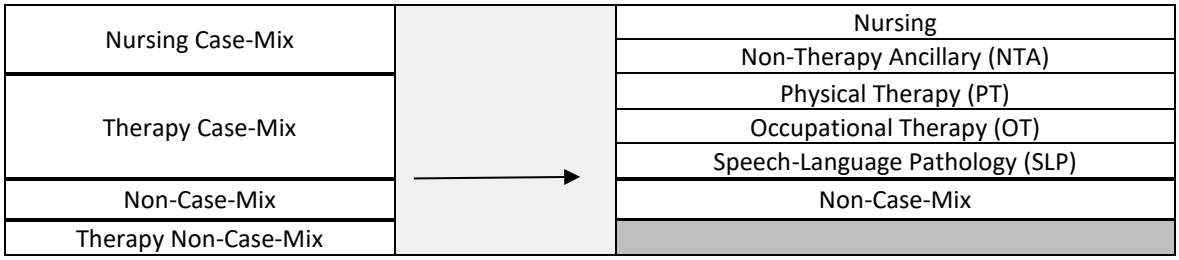
The final RUG-IV case-mix adjusted federal rates and associated indexes for both urban and rural SNFs for FFY 2019 are listed in Tables 6 and 7 on Display pages 29-32.

Since the RUG-IV was implemented in 2011, CMS has noticed many concerning trends. One of these trends is that the percentage of residents classifying into the Ultra-High therapy category has 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 has 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 better accounts 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:



The adopted 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 is classifying all residents into one of 16 PT and OT case-mix groups (Display page 153) for each of the two components, one of 12 SLP case-mix groups (Display page 165), one of 25 nursing case-mix groups (Display pages 179 - 181), and one of 6 NTA case-mix groups (Display page 198).

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. CMS adopted a variable per diem adjustment to the PT, OT, and NTA components of PDPM to account for changes in resource utilization over a stay, as detailed below. CMS did not adopt such adjustments to the SLP and nursing components because resource use tends to remain relatively constant for these components over the course of a SNF stay.

Finalized 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

Finalized 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 adopted 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 currently in effect). 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 estimated to be 1.46.

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.

The final urban and rural SNF unadjusted federal per-diem rates if the PDPM were to go into effect FFY 2019 are below:

Rate Component	Urban SNFs	Rural SNFs
Nursing Case-Mix	**$103.46**	**$98.83**
NTA Case-Mix	**$78.05**	**$74.56**
PT Case-Mix	**$59.33**	**$67.63**
OT Case-Mix	**$55.23**	**$62.11**
SLP Case-Mix	**$22.15**	**$27.90**
Non-Case-Mix	**$92.63**	**$94.34**

Additionally, CMS is finalizing that at a component level (PT, OT, SLP), when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, providers receive a non-fatal warning edit 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 is adopting a 5-day SNF PPS scheduled assessment to classify a resident under the SNF PDPM for the entirety of his or her Part A SNF stay. CMS had proposed to require providers to reclassify residents as appropriate from the initial 5-day classification using an Interim Payment Assessment (IPA) within 14 days of a change if:

- There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the PDPM or if the change results in a change in payment; or
- The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

However, based on public comment, CMS is instead making the IPA an optional assessment in which facilities will be able to determine when IPAs will be completed for their patients to address potential changes in clinical status and what criteria should be used to decide when an IPA would be necessary.

CMS is also revising the assessment reference date (ARD) criteria for an IPA as well. The 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.

The finalized PPS assessment schedule under PDPM is as follows:

Medicare Minimum Data Set (MDS) assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day 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

CMS is adopting 3 items to the Swing Bed PPS assessment to classify swing bed residents under the PDPM. CMS also is adding 18 therapy collection items to the PPS Discharge assessment to allow CMS to monitor the volume and intensity of therapy services provided under the PDPM.

CMS anticipates that, for each provider, the proposed PDPM would reduce administrative costs by approximately $12,664 and reduce the time for administrative issues by approximately 188 hours a year.

Proposed Interrupted Stay Policy

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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 is adopting 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 is adopting an interrupted stay policy 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.

SNF Value-Based Purchasing Program

DISPLAY pages 47, 361 -395

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

SNF VBP Measures

DISPLAY pages 364 - 373

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. CMS plans to submit the SNFPPR measure for NQF endorsement in 2019 upon completion of additional testing, and then plans to propose transitioning to the measure after completion of the endorsement process.

CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

Performance Standards and Scoring

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CMS will calculate rates for the SNF VBP quality measures using one year of data for each of the baseline and performance periods.

CMS is adopting the following baseline and performance periods for the FFY 2021 program year:

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

In addition, CMS is adopting its proposal that beginning FFY 2022 and for subsequent program years, CMS would adopt a performance period that is the 1 year period following the performance period from the previous program year. CMS is also finalizing this for the baseline period.

In the FFY 2018 final rule, CMS adopted the following performance standards for the SNFRM measure for the FFY 2020 program year as follows:

Measure ID	Estimated Performance Standards
SNFRM	**Achievement threshold 0.80218**
	Benchmark 0.83721

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

Measure ID	Estimated Performance Standards
SNFRM	Achievement threshold 0.79476
	Benchmark 0.83212

As previously adopted, CMS will always publish the numerical values of the achievement threshold and benchmark no later than 60 days prior to the beginning of the performance period; but if necessary, outside of notice-and-comment rulemaking will be used to accomplish this requirement. CMS is finalizing that if they discover an error in the calculations of performance standards subsequent to having published the numerical values for the performance standards for a program year, CMS would update the numerical values to correct the error. CMS is also finalizing its proposal that they would only update the numerical values one time, even if they identified a second error.

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 has decided, in the FFY 2018 final rule, to round scores on the achievement and improvement scales to the nearest ten-thousandth of a point, rather than the nearest whole number in order to avoid ties.

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.

CMS is adopting its proposal that 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.

After performance scores are calculated, they need to be converted to dollar impacts, and therefore CMS previously adopted a logistic exchange function to translate SNF performance scores into value-based incentive payments under the SNF VBP Program beginning in FFY 2019.

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.

CMS is also concerned about SNFs with fewer than 25 eligible stays (low-volume SNFs) in the performance period and therefore is adopting an adjustment to the SNF VBP methodology. 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 order to determine how value-based incentive payments will be distributed to SNFs, CMS will compare 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 that corresponds to a point on the logistic exchange function, based on its SNF performance score.

The logistic exchange function that CMS uses is:

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

Where x_i is the SNF's performance score.

CMS has not completed SNF performance score calculations for the FFY 2019 program. However, CMS did provide the range of value-based incentive payment adjustment factors applicable to the FFY 2019 program year. CMS estimates that SNFs may receive incentive payment percentages ranging from approximately -1.97% to +2.33% on a net basis.

Reporting/Review, Correction and Appeals Process

DISPLAY pages 389 - 392

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 adopting an Extraordinary Circumstances Exceptions (ECE) policy for the SNF VBP program. Specifically, if a SNF can demonstrate that an extraordinary circumstance affected the care that it provided to its patients and subsequent measure performance, CMS will exclude the calendar months during which the SNF was affected in the measure rate calculation. A SNF requesting an ECE must submit the ECE to CMS within 90 days following the extraordinary circumstance.

SNF Quality Reporting Program (QRP)

DISPLAY pages 24-25, 338 - 361

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 for those SNFs that fail to submit required quality data to CMS.

In the proposed rule, CMS stated that the 2 percentage point penalty would be applied to the standard market basket adjustment less the productivity reduction, rather than to the market basket required by the BBA of 2018. Based on comments, for FFY 2019 CMS has decided to instead apply the penalty to the BBA required market basket rather than the standard market basket.

CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

Summary Table of Domains and Measures Previously Finalized for the SNF Quality Reporting Program	
Measures	**Payment Determination Year**
Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)	FFY 2017+

Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; endorsed on July 23,2015)	FFY 2017+
Total Estimated Medicare Spending per Beneficiary (MSPB)	FFY 2018+
Discharge to Community	FFY 2018+
Potentially Preventable 30-Day Post Discharge Readmission Measure	FFY 2018+
Drug Regimen Review Conducted with Follow-Up for Identified Issues	FFY 2020+
Application of Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)	FFY 2020+
Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)	FFY 2020+
Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)	FFY 2020+
Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)	FFY 2020+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	FFY 2020+

CMS is adopting an additional factor to consider when evaluating measures for removal from the SNF QRP Program measure set: the costs associated with a measure outweigh the benefit of its continued use in the program.

Currently, CMS notifies a SNF of noncompliance with the SNF QRP requirements using the QIES ASAP system and via letter sent through the United States Post Service. CMS has adopted its proposal to notify SNFs of noncompliance with the SNF QRP requirements via a letter sent through at least once of the following methods: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

In addition, CMS is adopting its proposal to increase the number of years of data used to calculate the Medicare Spending Per Beneficiary-PAC SNF QRP and Discharge to Community-PAC SNF QRP measures for purposes of display from 1 year to 2 years starting in CY 2019. CMS is will also begin publicly displaying data in CY 2020 on the following measures:

- Application of Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633);
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634);
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

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