The End and the New Beginning, October 1, 2019
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On August 31, 2019 the SNF Prospective Payment System (PPS) that was in place for over 21 years, RUGs, with a long array of legislative fixes and regulatory changes culminating with RUG IV, comes to an end – perhaps somewhat abruptly, given the fact that there is no transition period.

For much of those years, experts such as the GAO and OIG/HHS researchers, MedPAC, leading health analytic entities such as the Urban Institute researchers, and an infinite variety of university health care payment researchers and institutes, all warned that something was very wrong with the basic RUG model. They demonstrated that the incentives built into the RUGs enabled SNFs to provide care based on quantity and not need. They argued that such an incorrect impetus led to provider overpayment, basically driven by rehabilitation therapy.

On October 1, 2019, PDPM commences. CMS has issued the proposed rule for FY 2020.[1] Comments are due on June 18. Even though CMS offers no transition period, it did offer a rather long gestation period for PDPM with innumerable Technical Expert Panel (TEP) Meetings – starting in 2016. The TEPs involved SNF representatives and experts in all the various services involved in SNF care. CMS also issued a possible new payment model, Resident Classification System, Version 1 (RCS-1) on May 4, 2017. Based on public reaction and extensive comments to RCS-1, CMS went back to the drawing board and came up with the PDPM which it showcased in the proposed rule of FY 2019, but scheduled to start on October 1, 2019, the fiscal year for 2020.

We have kept you apprised on all these developments, perhaps to the point of seeming redundancy. But the illusion of redundancy was indeed due in part to the extensive outreach efforts of CMS, outlined above, to examine and analyze the extensive professional input in the modeling. CMS kept revising and modifying.

What next? No more iteration of models. Despite the comment period provided, the PDPM model is essentially locked in. And no more major changes in the PDPM model – at least for now. Thus, we provide below a brief accounting of the proposed payments for FY 2020, a few changes that CMS did make to the PDPM in the FY 2020 proposed rule, and CMS' updating of the value-based purchasing program (VBP) and the quality reporting program (QRP).

The PDPM Proposed Rule Published in the Federal Register on April 25, 2019

1. Update for SNF Aggregate Payments

CMS projects aggregate payments to SNFs will increase by $887 million, or 2.5 percent, for FY 2020 compared to FY 2019. This estimated increase is attributable to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment. CMS estimates that estimates that in FY 2020 under PDPM, SNFs in urban and rural areas will experience, on average, a 1.8 percent increase and 6.4 percent increase, respectively, in estimated payments compared with FY 2019. Providers in the urban outlying regions will experience the largest estimated increase in payments of approximately 61.3 percent. Providers in the urban Middle Atlantic region will experience the largest estimated decrease in payments of 0.8 percent.

As discussed in the SNF Proposed rule for FY 2019[2] and the March 2019 *LTC Pharmacy Newsletter* CMS finalized the implementation of PDPM in a budget neutral manner. The total estimated payments under PDPM would be adjusted to be equal to what the total actual payments under RUG-IV would have been.

2. Align SNF PPS Group Therapy Definitions with **Other** *PAC Settings*

Various PAC settings permit therapists to furnish therapy to their patients in three different modes: individual, concurrent, and group. Under the current SNF PPS, group therapy is defined as consisting of exactly four patients. Other payment systems, such as the IRF PPS, define group therapy as including as few as two patients. For more fair and consistent therapy definitions across care settings, CMS is proposing to adopt the definition of group therapy that is used in the IRF PPS: group therapy consists of two to six patients doing the same or similar activities. CMS believes aligning the group therapy definition serves to improve the agency's consistency in payment policies across PAC settings, and to create opportunities for site neutral payments.

3. Sub-Regulatory Process for International Classification of Diseases, Tenth Version (ICD-10) Codes Revisions:

PDPM utilizes ICD-10 codes to classify SNF patients into certain payment groups. Each year, the ICD-10 codes and guidelines are revised in a variety of so-called non-substantive ways, such as a single code being split into two more specific codes. To help ensure SNFs have the most up-to-date ICD-10

code information as soon as possible, in the clearest and most useful format, CMS proposes a subregulatory process for making what it refers to as nonsubstantive changes to the list of ICD-10 codes used to classify patients into clinical categories under the PDPM.

CMS makes the point that this subregulatory process aligns with similar policies in the SNF PPS and the Inpatient Rehabilitation Facility (IRF) PPS. For example, the SNF PPS already uses a subregulatory process to make nonsubstantive updates to the list of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to consolidated billing. And, the IRF PPS uses a similar subregulatory updating process for the IRF tier comorbidities list and for updating the ICD-10 code lists used for the IRF presumptive compliance methodology.

CMS makes all this sound painless and eminently reasonable. And so, it may be, but an endless list of federal court cases attest to the fact that there has been disagreement over the years as to what is or isn't a "substantive change" in policy, one which requires notice and comment (e.g. a proposed rule followed by a final rule); as opposed to a non-substantive change which does not require this process.

Why is this so crucial? It is crucial because a subregulatory process is one which forgoes notice and comment in the issuance of policy changes. So the industry, e.g. health provider category such as SNFs or hospitals or IRFs etc. **gets no say in the "subregulatory"change**. I am not asserting that this process for the ICD-10 changes discussed in this proposed rule is questionable. That is for SNFs to weigh in on or not. But it bears watching.

4. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

SNF QRP is authorized by legislation and applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Under the SNF QRP, CMS must reduce by 2 percentage points the annual market basket percentage update in the case of a SNF that does not submit required quality data.

CMS proposes to adopt two new quality measures in FY 2020 to assess how health information is shared. The two proposed measures are: 1) Transfer of Health Information from the SNF to another Provider, and 2) Transfer of Health Information from the SNF to the Patient.

In addition, CMS proposes to adopt a number of standardized patient assessment data elements that assess cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, or social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy,

transportation, or social isolation). Finally, CMS proposes updates to specifications for the Discharge to Community PAC SNF QRP measure to exclude baseline nursing home residents.

5. SNF Value-Based Purchasing Program (VBP)

The SNF VBP Program began rewarding SNFs with incentive payments based on their quality measure performance on October 1, 2018. The program currently scores SNFs on an all-cause measure of hospital readmissions, and in the future, will transition to a measure of potentially preventable hospital readmissions. As required by statute, the program reduces SNFs' Medicare payments by two percentage points, then redistributes 60% of those funds as incentive payments.

In the FY 2020 SNF PPS proposed rule, the SNF VBP Program is changing the name of the program's measure to the "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge" measure. The measure will retain the same abbreviation (SNFPPR). The proposed rule also includes an update to the public reporting requirements to ensure that CMS publishes accurate performance information for low-volume SNFs.

Where do LTC pharmacists belong in all of this?

SNFs are facing a sea change in their payment system and in their overall clinical assessment. They will provide care pursuant to the clinical needs of the patients. The clinical needs and the subsequent payment rates will be determined through the ICD-10 coding system and the revised MDS. As we have discussed before, as opposed to RUG-IV, in which a resident's classification into a single group determines the case-mix indexes and per-diem rates for all case-mix adjusted components, PDPM classifies residents into a separate group for each of the case-mix adjusted components, which each have their own associated case-mix indexes and per diem rates. The classification process is challenging but if done correctly will greatly benefit the beneficiary and the provider.

My colleague, Paul Baldwin, in the March issue of the *LTC Pharmacy Newsletter,* provided his observations on the challenge and opportunities for LTC pharmacies with the advent of PPDM. I provide a copy of Paul's comments below, which bear repeating, followed by my own two cents.

1. Paul' comments:

- ***PDPM has changed the incentives:*** The payment system will no longer reward SNFs for focusing on therapy but will reward SNFs for caring for medically-complex residents. The new incentives correct a huge flaw in the various RUG iterations,

including RUG IV that, in effect crippled care for complex medical patients! Consultant pharmacists are the recognized masters of rationalizing drug therapy for complex medical conditions.

- ***The NTA payment index rewards vigilance:*** CMS has determined that NTA (mostly drug costs) are much higher in the early days of the admission and has tripled the NTA multiplier for the first three days of care, and then reduces the scoring to one for the remainder of the stay. Consultant pharmacists that demonstrate the ability to get prescription drug therapy optimized have a strong selling point with SNF operators.

- ***Smart operators need smart pharmacies:*** With incentives for admitting complex residents arriving in 2019, SNFs will likely reward pharmacies and consultant pharmacists who understand the new system and can advise medical directors, directors of nursing, attending physicians and administrators how to best manage a population they may not be fully experienced in serving.

2. Elise's Recommendation:

My advice is that LTC Pharmacists should print out a copy of *CMS'* ***"PDPM Calculation Worksheet for SNFs."*** It can be found in draft form at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MDS_Manual_Ch_6_PDPM_508.pdf

By studying this document, you will learn the steps CMS is taking in trying to pay pursuant to need. You will see step by step how they expect to go about the process. ***The section on NTAS (mostly drugs) is invaluable. See page 18 of the document.***

[1] https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08108.pdf CMS Annual Payment Update Proposed Rule, 84 Federal Register 17620, April 25, 2019.
[2] Ibid.