FY2020 SNF PPS PROPOSED RULE

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Your PDPM Resource

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SUMMARY PREPARED BY AEGIS THERAPIES

On Friday, April 19, 2019, the Centers for Medicare and Medicaid Services (CMS) released the FY2020 SNF PPS Proposed Rule. CMS published the proposed rule in the Federal Register April 25, 2019, and the text of this version can be accessed here. A summary of the major provisions that impact skilled nursing facilities (SNFs) with respect to PDPM can be found below. Aegis also has a summary of the complete rule available. Aegis Therapies will respond to this proposed rule and submit comments to CMS by **5:00 p.m. EST on June 18, 2019**.

Payment Update Provisions

For FY 2020, CMS proposes that the market basket update for skilled nursing facilities is 2.5 percent, which is an increase in payments of $887 million, 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.

Patient Driven Payment Model Provisions

As anticipated, the proposed rule does not make wholesale changes to the Patient Driven Payment Model (PDPM), but it does contain information in three key areas of change and/or policy clarifications and adjustments. The changes are not substantive, and PDPM is on track for the scheduled Oct. 1, 2019, implementation date.

Issues related to PDPM Implementation

The proposed rule includes three proposed changes related to PDPM. These changes include: (1) revising the definition of group therapy to "two to six" patients; (2) creating a sub-regulatory process for updating ICD-10 code mappings and lists; and (3) updating regulation text to reflect already finalized policies relating to the assessment schedule. The group therapy definition is one that Aegis advocated for in our comments to the proposed rule a year ago.

Change in the definition of Group Therapy

Currently, group therapy is defined as the practice of one therapist or therapy assistant treating four patients at the same time while patients are performing either the same or similar activities. Under this proposed rule, CMS is proposing to modify the definition of group therapy in the SNF setting to align with the inpatient rehabilitation facility (IRF) setting, and to reflect the clinical judgment of the therapist. Specifically, **CMS is proposing to define group therapy in the SNF Part A setting as "a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities." CMS is proposing that this change take effect with the implementation of PDPM Oct. 1, 2019.** Also, please note that the minutes that are coded on the MDS are unadjusted, or unallocated, minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy.

CMS notes that it continues to believe that individual therapy is the preferred mode of therapy provision and that it offers the most tailored service for patients. Additionally, CMS maintains that when group therapy is used in a SNF, therapists must explicitly document its use in order to demonstrate or justify why it is the most appropriate mode of therapy for the patient receiving it. This description should include, but need not be limited to, the specific benefits to that particular patient of including the documented type and amount of group therapy; that is, how the prescribed type and amount of group therapy will meet the patient's needs and assist the patient in reaching the documented goals. The 25 percent limit in the amount of group and concurrent therapy combined, by therapy discipline, remains as finalized last year.

Updating ICD-10 Code Mapping and Lists

CMS realizes the importance of timely updates to ICD-10 code lists and any mapping changes for PDPM but proposes to do so via a "sub-regulatory process" meaning it would be accomplished outside of the formal rule making process.

Beginning with updates for FY 2020, non-substantive changes to the ICD-10 codes included on the code mappings and lists under PDPM would be applied through the sub-regulatory process, while substantive revisions would be proposed and finalized through notice and comment rulemaking. Non-substantive changes are limited to those specific changes that are necessary to maintain consistency with the most current ICD-10 medical code data set. A substantive change would be defined simply as any change that does not fall within the category of a non-substantive change (i.e., changes that go beyond maintaining consistency with the most current ICD-10 medical code data set.

Revisions to the Regulation Text

CMS is proposing to update the regulation text to reflect changes in the assessment schedule under PDPM which were already finalized in the FY 2019 SNF PPS final rule. These changes are to reflect the policy taking effect under PDPM Oct. 1, 2019, and are related to (1) the initial payment assessment; and (2) the optional interim payment assessment. First, for the initial payment assessment, the proposed regulation changes would state that "the assessment schedule must include performance of an initial patient assessment no later than the 8th day of post-hospital SNF care." Additional proposed changes to the regulation text would reflect the optional interim payment assessment and the proposed change would amend the regulation text to require the completion of "such other interim payment assessments as the SNF determines are necessary to account for changes in the patient care needs."

Readers may be wondering about the potential impact of the first change noted above – the change in the definition of group therapy. Rather than the strict requirement currently in place that a group must be made up of 4 patients and one clinician, CMS is proposing to allow group size to vary from 2 to 6 participants with the one clinician. There are a number of considerations that may influence any impact this definition change might have. Recall that a component of

the current definition and the proposed change is that the participants in the group must be working on "the same or similar" activities. Thus, an important consideration is the number of Med A residents a facility has at any point in time that may have the same or similar activities written as part of the therapy discipline's plan of care. Patient numbers may limit a location's ability to expand the size of groups. Facility logistics also plays an important role – obviously to have any group, it requires the ability to physically bring the participants together at the same time in the same location. More participants may increase that complexity – are patients located somewhat proximate to one another or are they located in different wings or different floors of a facility; are there transport personnel available to assist or does this fall exclusively to rehab staff; successful execution of group therapy requires advance planning on the part of the rehab team and awareness and support from facility staff. We encourage open dialogue with rehab leadership regarding the best approach to group therapy for any facility.

We encourage providers to consider these and other factors that may influence group therapy options and to discuss options and plans with the rehab team. While Aegis notes the CMS belief about individual therapy being a predominant option, we also note the published evidence and our own experience with respect to the benefits of therapy delivered in group settings and note the positive response from patients to such delivery.

Questions about this information? Contact PDPM@AegisTherapies.com or visit our Resource Center for more information at AegisTherapies.com/Resources.