NASL PDPM Questions Submitted to CMS + CMS' Answers Reported on the SNF PDPM Update Call, 12.11.18

When does CMS anticipate issuing all of the final Item Sets, Specifications, *RAI Manual* and other guidance regarding PDPM?

CMS' SNF Team Lead, John Kane, indicated that CMS would issue these resources as soon as feasible; however, he would commit to only "by early 2019" as his official response.

Given the changes to I0020A and B, along with the J200 categories, for example, CMS again must update the technical specifications available to IT vendors. Likewise, the Grouper must be updated. Callers requested that CMS flag the webpage where the current grouper is posted to reflect that the posted grouper has yet to be updated with the latest information.

NASL has repeatedly explained to CMS that IT vendors need this information in order to program, test and deploy the necessary changes and for providers to train on and use the new software in order to be fully prepared for the transition to PDPM.

Will CMS highlight the change from I8000A to a new item I0020B during this call? NASL understands that it is listed incorrectly as I0200B in several places for PT/OT clinical category assignment.

CMS covered I8000A and I0020B during the call, although we did not hear an acknowledgment of incorrect listings. CMS emphasized that only items coded into Item I0020B (New Item) will be used for determining patient diagnosis for admission.

NASL requests clarification on exactly how patients assigned to a RUG category on September 30, 2019 will be re-assigned to a PDPM category beginning October 1, 2019? Will CMS review what the process is during the call? Also, when will specific guidance on this process be issued?

CMS did address the process for re-assigning patients from RUGs to PDPM. On page 85 of the PDPM slide deck, CMS states, "There is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be *administratively infeasible* for providers and CMS." The slide continues to note that RUG-IV billing ends September 30, 2019
and PDPM billing begins October 1, 2019.

Perhaps it would have been more straightforward for CMS to say that it is not feasible for the agency to run two systems – although CMS acknowledges in its *CMCS Informational Bulletin* that the agency will no longer support RUG-III and RUG-IV case-mix methodologies via the Minimum Data Set (MDS) as of October 1, 2020. It is not clear how CMS expects the states to respond to this directive.

NASL understands that the CMIs were published by component in the final rule. We have not seen a single list of all of the components. Will CMS release one and if so, when?

We did not hear a response to this question. We will update the Committee when we receive CMS' response to our submitted question.

Additional Questions Raised by CMS' SNF PDPM Update Call, 12.11.18

For patients admitted on/after Friday, September 27, 2019, who do not meet the Short Stay criteria, there appears to be no way to meet the service criteria for payment of the High, Very High or Ultra High Rehab RUG categories. The transition process explained during the December 11 call indicates that CMS will maintain its expectation for ongoing and clinically appropriate care for patients needing extensive rehabilitation without a means for providers to meet the criteria and be reimbursed for those services.

How will CMS mitigate this discrepancy with its policy to ensure that SNFs do not incur long term compliance, quality and/or payment issues due to the fluctuation in service delivery for certain types of patients?

As CMS indicated on the December 11 educational call, none of the current regulatory requirements are being changed to accommodate PDPM, to include the rule on Administrative Presumption. As referenced and explained by CMS staff leading the call, Administrative Presumption requires that the majority of patients placed in a SNF be classified for SNF-level of care. On slide 73 of the PDPM slide deck, CMS lists the classifications that are "presumed" to need pre-determined levels of care. For example, CMS lists the following therapy groups designated under Administrative Presumption – groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO (for PT & OT) and groups SC, SE, SF, SH, SI, SJ, SK, and SL (for SLP).

Does this guidance reflect CMS' expectation that patients falling outside of the listed classifications will need SNF-level care, if only on a temporary basis?

Will there be consequence in terms of a provider's status under SNF VBP and/or Five Star if he/she provides services to beneficiaries that fall outside the listed classifications for Administrative Presumption?

CMS has explained that an Interim Payment Assessment (IPA) is to be completed within the first seven days of October 2019 for all established patients that transition from RUG-IV to PDPM. Operationally, this could mean that providers would need to complete an MDS assessment for each patient with an ARD during the last week of September in addition to completing an Admission MDS for all patients admitted during this same period. The next week (October 1 – 7, 2019), each of these patients would need to be re-assessed via an IPA, which does not need to be submitted, but must be completed within the first seven days of October 2019.

So, it appears that the need to complete such additional assessments could significantly challenge existing staff in the provision of ongoing care. CMS has made no accommodation to the SNF for the staffing and resource utilization needed to meet compliance with this isolated payment policy rule. Is CMS considering ways to address this undue burden on providers as well as for expensing this type of transition plan that CMS is imposing?

How might this transition plan impact the SNF's CMS quality status and/or compliance with Medicare's Requirements for Participation given that completing such additional patient assessments likely would not be considered medically necessary?