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MDS Alert

Don't Expect COVID-19 Relief in 2021 Final Rule

CMS says that much is beyond the scope of rulemaking.

Although COVID-19 is a major focus of nursing facility staff (and residents) as the pandemic rages on, the recently finalized rule, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021," is mostly "business as usual."

Final Rule Reflects Current Challenges

However, the Centers for Medicare & Medicaid Services (CMS) says this final rule is a bit more bare bones than other years, in acknowledgement of the circumstances surrounding COVID-19.

"In recognition of the significant impact of the COVID-19 public health emergency, and limited capacity of health care providers to review and provide comment on extensive proposals, CMS has limited annual SNF rulemaking required by statute to essential policies including Medicare payment to SNFs," CMS says in a press release about the final rule.

One example: Several commenters on the proposed rule requested "excluding services from consolidated billing that would not otherwise qualify for such exclusion," CMS says. The agency responded in the final rule, saying that, while they recognize the "unique circumstances" surrounding the COVID-19 PHE, "excluding services from SNF consolidated billing that would not otherwise meet the statutory conditions for exclusion would require congressional action."

Some good news: CMS says it will increase aggregate Medicare program payments to SNFs by $750 million, a 2.2 percent increase over FY 2020. However, some facilities may be juggling lower wage index calculations if their urban or rural status changed due to the Office of Management and Budget's revised geographic delineations. However, there's a 5 percent cap on any provider wage index decreases, CMS assures.

However, and somewhat unrelatedly, CMS is making fewer or delaying changes to the minimum data set and Resident Assessment Instrument (RAI) Manual than some other years.

Note These ICD-10-Related Changes to PDPM Clinical Categories

Some changes outlined in the proposed rule that have been finalized include adjustments to some clinical category mapping that will affect how some residents' clinical categories are mapped according to the Patient- Driven Payment Model (PDPM). The adjustments mostly affect MDS item I0020B (I0020: Indicate the resident's primary medical condition category, ICD Code) and items J2100 (Recent Surgery Requiring Active SNF Care) and J2300-J5000 (Recent Surgeries Requiring Active SNF Care). The update means that some residents who had certain major surgical procedures within a particular timeframe may have their clinical category eligible to become surgical, instead, which pays higher reimbursement.

Some ICD-10 codes reflecting certain cancer diagnoses will also map differently, in acknowledgement by CMS that some cancer care is more intensive and should entail more reimbursement. There are two additional clinical category options now, "May Be Eligible for the Non-Orthopedic Surgery Category" or "May Be Eligible for One of the Two Orthopedic Surgery Categories," which these cancer diagnoses will map to, in reflection of the potential effect on the amount of care affected residents require.

Read the full final rule here: www.govinfo.gov/content/pkg/FR-2020-08-05/pdf/2020-16900.pdf.

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