Final fiscal year 2017 payment and policy changes for Medicare Skilled Nursing Facilities (CMS-1645-F)

The Centers for Medicare & Medicaid Services (CMS) Final Rule: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Final Rule for FY 2017; SNF Value-Based Purchasing Program; SNF Quality Reporting Program (8/5/16)

https://www.gpo.gov/fdsys/pkg/FR-2016-08-05/pdf/2016-18113.pdf

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Payment Rates Update for FY 2017

- CMS projects that aggregate payments to SNFs will increase in FY 2017 by $920 million, or 2.4 %t, from payments in FY 2016. This estimated increase is attributable to a 2.7 % market basket increase reduced by 0.3 percentage points, in accordance with the multifactor productivity adjustment required by law.

SNFVBP

- The SNF VBP Program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals.
- The final rule implements requirements for the SNFVBP including performance standards; scoring methodology, and a review and correction process for performance information to be made public.
- The VBP measures will apply to payments for services furnished on or after 10/1/18; data collection will begin 10/1/16.

All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Measure (SNFPPR)

- The already final 'SNF 30-Day All-Cause Readmission Measure (SNFRM) will be replaced "as soon as Practicable" by the All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Measure (SNFPPR) specified in this final rule.
- The SNF-PPR assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System (IPPS); a critical access hospital; or a psychiatric hospital.
- The SNFPPR is claims-based, requiring no additional data collection or submission from SNFs.
- The SNFPPR has 2 categories: (1) Within Stay; (2) Post SNF discharge to the end of the 30-day post hospital discharge.
    - The within-stay list of PPR conditions includes 4 clinical rationale groupings: (1) Inadequate management of chronic conditions; (2) Inadequate management of infections; (3) Inadequate management of other unplanned events; (4) Inadequate injury prevention.

    - The post-SNF discharge clinical rationale has 3 groupings: (1) Inadequate management of chronic conditions; (2) Inadequate management of infections; (3) Inadequate management of other unplanned events.
- The SNF-PPR is risk-adjusted for sociodemographic status (SES)/characteristics (diagnoses; hospital LOS; co-morbidities; # of prior hospitalizations over the past year.
- Benchmarking includes an achievement threshold at the 25th percentile of national SNF performance.
- Scoring is on a 0 -100 point scale for achievement; a 0-90 point scale for improvement.
- This measure is calculated using one full calendar year (CY) of data.

Performance Standards; Baseline; Incentive Payments; Feedback Reports

- Publication of Performance Standard Values: CMS will announce performance standards by 11/1/16 for CY 2017 for FY 2019.
- Proposed Baseline Period: CMS is adopting CY year 2015 claims (1/1/15 – 12/31/15) as the baseline period for FY 2019.
- SNF Performance Scores: These scores will be used as the basis for ranking SNF performance and establishing the value-based incentive payment percentage.
- SNF Value-Based Incentive Payments: The payment percentage must be based on the SNF performance score and be appropriately distributed so highest-ranked SNFs receive the highest payments; lowest-ranked receive the lowest payments; and the payment rate for services furnished by SNFs in the lowest 40% is less than would otherwise apply.
    - The total amount of value-based incentive payments must be greater than or equal to 50%, but not greater than 70% of the total amount of the reductions to payments for the FY.
- 1/4ly Confidential Provider Feedback Reports: Will be accessible via the QIES system CASPER Files.
- Corrections on any 1/4ly report will be accepted with an annual deadline
    - 2 phases:
        - Phase 1 allows SNFS to review /correct patient-level information used to calculate the measure rates;
        - Phase 2 – allows SNFs to review /correct performance scores and ranking.
- CMS will order SNF performance scores from low to high and publish rankings on the Nursing Home Compare and QualityNet Web sites.
- CMS will publish rankings for FY 2019 payment implications after 8/1/18.

SNF Quality Reporting Program (QRP)

CMS finalized 1 new assessment-based quality measure and 3 resource use claims-based measures:

- **Assessment:** 1 QM to meet the Medication Reconciliation domain:

***Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) SNF QRP* (FY2020)**

- Assesses whether providers were responsive to potential or actual significant medication issues by measuring the % of resident stays where medication is reviewed on admission and timely follow-up with a physician occurred each time clinically significant issues were identified.
- Drug regimen review is defined as "…the review of all medications or drugs the resident is taking to identify any potential clinically significant medication issues."
- This measure uses both the processes of medication reconciliation and drug regimen review in the event an actual or potential medication issue occurred.
- The calculation is based on the data collection of 3 standardized items to be included in the MDS; the 3 standardized items do not duplicate existing MDS items.
- The collection of data is obtained at admission and discharge.
- The denominator is the number of resident stays with a discharge or expired assessment during the reporting period.
- The numerator is the number of stays in the denominator where the medical record contains documentation of a drug regimen review conducted at: (1) admission; (2) discharge with a look-back through the resident stay, with all potential clinically significant medication issues identified during care and followed-up with a physician or designee by midnight of the next calendar day.
- This measure is not risk adjusted.
- Confidential feedback reports will be available to SNFs in 10/19.
- Timelines:
    - SNFs must complete the 3 added data items for submission through QIES beginning 10/1/18, affecting FY 2020 payment determinations.
        - SNFs must submit data for residents admitted on and after 10/1/18, and discharged from Part A stays up to and including 12/31/18.
    - CMS will collect a single ¼ of data FY 2020 to remain consistent with the [usual] October MDS release schedule.
    - Following the close of the reporting quarter, 10/1/18 – 12/31/18, SNFs will have 4.5 months to submit/correct submit the quality data.

- **Quality Measures Previously Finalized for Use in the SNF QRP:**
    - % of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
    - % of Residents Experiencing One or More Falls with Major Injury (Long Stay)

- Beginning with the FY 2018 payment determination, SNFs must report all data necessary to calculate the QMs on at least 80% of the MDS assessments they submit.
- Any SNF that does not meet the requirement that 80% of all MDS assessments submitted contain 100% of all data items necessary to calculate the QMs is subject to a 2 percentage point reduction to its FY 2018 market basket percentage.
    - "A SNF has reported all data necessary to calculate the QMs if the data actually can be used for purposes of calculating the QMs".
- Data collection period: 10/1/16 – 12/31/16. SNFs have 4.5 months from the end of the quarter (5/15/17) to complete submission/make corrections.
- For FY 2019 payment determinations 2nd through 4th quarter 2017 will be collected.
- Beginning with FY 2020 a full year of data will be collected.
- Each 1/4ly deadline will continue to occur 4.5 months from the end of a given calendar ¼.

- **Resource Use Measures:** CMS adopted 3 measures to meet the IMPACT Act mandated resource use and other measure domains:
    - **Medicare Spending per Beneficiary—Post-Acute Care SNF QRP (FY 2018);**
    - **Discharge to Community—Post Acute Care SNF QRP (2018);**
    - **Potentially Preventable 30-Day Post-Discharge Readmission Measure - SNF QRP (2018).**

Medicare Spending Per Beneficiary (MSPB) (FY 2018)

- Holds SNF providers accountable for the Medicare payments within an "episode of care" – "…the period during which a patient is directly under the SNF's care and a defined period after the end of the SNF care, "reflective of and influenced by services furnished by the SNF."
- Assesses Medicare Parts A and B spending within an episode.
- Episodes may begin within 30 days of discharge from an inpatient hospital as part of the trajectory from an acute to a PAC setting.
    - An episode begins at the 'episode trigger' - admission to a SNF.
    - The episode window includes a treatment period and an associated services period.
        - The treatment period - those services provided directly or reasonably managed by the SNF directly related to the beneficiary's care plan - begins at SNF admission and ends at discharge. Readmissions to the same facility within 7 days do not trigger a new episode.
        - The associated services period begins at the episode trigger and ends 30 days from the end of the treatment period.
- Exclusion Criteria: *C*ertain episodes will be excluded:

- Any episode triggered by a SNF claim outside the 50 states, DC, Puerto Rico, and U.S. Territories.
- Any episode where the claim(s) constituting the SNF provider's treatment have a standard allowed amount of zero or where the standard allowed amount cannot be calculated.
- Any episode where a beneficiary is not enrolled in Medicare FFS for the entirety of a 90-day lookback period (prior to the episode trigger) plus episode window (including where the beneficiary dies), or is enrolled in Part C for any part of the lookback period plus episode window.
- Any episode where a beneficiary has a primary payer other than Medicare.
- Any episode where the claim(s) constituting the SNF provider's treatment include at least one related condition code indicating it is not a PPS bill.

- Standardization and Risk Adjustment: MSPB must be adjusted for factors including age, sex, race, severity of illness, and other factors the Secretary determines appropriate.
- Reporting: CMS will provide initial confidential feedback to providers, prior to public reporting. A minimum of 20 episodes is required for reporting.

Discharge to Community-Post Acute Care (PAC) SNF QRP (FY 2018)

- Assesses successful discharge to the community including no unplanned rehospitalizations and no death within 31 days following discharge.
- Uses "Patient Discharge Status Codes" on FFS claims.
- Community is defined as home/self-care, including home and community-based settings such as group homes, foster care, independent living and other residential arrangements, with or without home health services, based on patient discharge codes on the Medicare FFS claim.
- Excludes residents discharged to home or facility-based hospice care /with a hospice benefit in the 31 days post-discharge.
- Will be calculated using 1 year of data; must include a minimum of 25 eligible stays in a given SNF for public reporting.
- Risk-adjusted for variables such as age and sex, principal diagnosis, comorbidities, ventilator status, ESRD status, and dialysis.
- To be reported as a ratio – with the denominator being the risk-adjusted estimate of the number of residents discharged to the community without an unplanned readmission.
- CMS will provide confidential feedback to SNFs prior to public reporting.
- CMS will report this measure using claims data from discharges in CY 2016.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP (2018)

- The QM assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries

in the 30 days post-SNF discharge. The SNF admission must have occurred within 30 days of discharge from a prior proximal hospital stay.

- Assesses potentially preventable readmission rates, accounting for demographics; principal diagnosis in the prior hospital stay; comorbidities; and other factors.
    - It is calculated for each SNF based on the ratio of the predicted number of risk-adjusted, unplanned, potentially preventable hospital readmissions that occur within 30 days after SNF discharge, including estimated facility effect, to the estimated predicted number of risk-adjusted, unplanned inpatient hospital readmissions for the same residents at the average SNF.
- A ratio above 1.0 indicates a higher than expected readmission rate; below 1.0 indicates a lower than expected rate.
- An eligible SNF stay is followed until: (1) The 30-day post-discharge period ends; or (2) the patient is readmitted to an acute care hospital. Planned readmissions are not counted in the measure rate.
- Risk adjustment estimates the effects of patient characteristics, comorbidities, and select health care variables on the probability of readmission; demographic characteristics (age, sex, original reason for Medicare entitlement), principal diagnosis during the prior proximal hospital stay, body-system-specific surgical indicators, comorbidities, LOS during the patient's prior hospital stay, intensive care unit utilization, end-stage renal disease status, and number of acute care hospitalizations in the preceding 365 days.
- The measure calculation uses 1 calendar year of FFS claims data; a minimum of 25 eligible stays is required for public reporting.
- CMS will provide confidential feedback to SNFs prior to public reporting.

- **Proposed Timeline/Data Submission Mechanisms for Claims-Based Measures for the FY 2018 Payment Determination and Subsequent Years**
    - CMS will use 1 year of claims data beginning with CY 2016 for feedback reports for SNFs; CY 2017 claims data for public reporting.