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)


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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 %, 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:** Certain episodes will be excluded:
o Any episode triggered by a SNF claim outside the 50 states, DC, Puerto Rico, and U.S. Territories.
o 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.
o 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.
o Any episode where a beneficiary has a primary payer other than Medicare.
o 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.