Medicare Skilled Nursing Facility Prospective Payment System

Payment Rule Brief — FINAL RULE

Program Year: FFY 2016

Overview and Resources

On August 4, 2015, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 final payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

A copy of the final rule *Federal Register* (FR) and other resources related to the SNF PPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.
An online version of the final rule is available at https://federalregister.gov/a/2015-18950.

Program changes by CMS will be effective for discharges on or after October 1, 2015, unless otherwise noted.
CMS estimates the overall economic impact of this final rule to be $430 million, an increase of 1.2%, in aggregate payments to SNFs in FFY 2016 over FFY 2015.

SNF Payment Rates

FR pages 46,393-46,405

Incorporating the finalized updates with the effect of a budget neutrality adjustment, the table below shows the adopted urban and rural SNF federal per-diem payment rates for FFY 2016 compared to the rates currently in effect:

Rate Component	Urban SNFs			Rural SNFs		
	Final FFY 2015	Final FFY 2016	Percent Change	Final FFY 2015	Final FFY 2016	Percent Change
Nursing Case-Mix	**$169.28**	**$171.17**	**+1.12%**	**$161.72**	**$163.53**	**+1.12%**
Therapy Case-Mix	**$127.51**	**$128.94**		**$147.02**	**$148.67**	
Therapy Non-Case-Mix	**$16.79**	**$16.98**		**$17.94**	**$18.14**	
Non-Case-Mix	**$86.39**	**$87.36**		**$87.99**	**$88.97**	

CMS will continue the 128% add-on to the per-diem payment for patients with Acquired Immune Deficiency Syndrome (AIDS).

The table below provides details of the final updates to the SNF payment rates for FFY 2016:

	SNF Rate Updates and Budget Neutrality Adjustment
Marketbasket (MB) Update	**+2.3%** ***(proposed at +2.6%)***
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	**-0.5 percentage points** ***(proposed at -0.6 percentage points)***
Forecast Error Adjustment	**-0.6 percentage points**
Wage Index/Labor-Related Share Budget Neutrality	**-0.08 percentage points**
Overall Rate Change	***+1.12%***

Effect of Sequestration

FR page reference not available

While the final rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by Congress and currently in effect through FFY 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

Wage Index and Labor-Related Share

FR pages 46,400-46,405

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the SNF rates that CMS considers to be labor-related. For FFY 2016, CMS will begin to report and apply the SNF PPS labor-related rounded to a tenth of a percentage point, rather than a thousandth of a percent. This adjustment will bring reporting of the SNF PPS labor share in line with other payment systems; resulting in a change in labor-related share from 69.180% for FFY 2015 to 69.1% for FFY 2016 (proposed at 69.2%).

FFY 2016 is the second year of a two-year transition to new CBSA delineations. Last year, CMS applied a blended wage index for any SNFs experiencing a change that was solely due to the new CBSA delineations (21% of SNFs). For FFY 2016, all SNFs will receive the wage index as determined according to the new CBSAs, with no mitigation of the impact.

A complete list of the wage indexes to be used for payment in FFY 2016 is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

RUGS-IV

FR pages 43,397-46,400

CMS classifies residents into resource utilization groups (RUGs) that are reflective of the different resources required to provide care to SNF patients. The RUGs classification reflects resident characteristic information, relative resource use, resident assessment, and the need for skilled nursing care and therapy. RUGs-IV, the current version, was implemented beginning FFY 2011. The patient assessment tool, the Minimum Data Set (MDS) 3.0, is used to assigned patients to RUG-IV categories. Each of the 66 RUGs recognized under the SNF PPS have associated nursing and/or therapy case-mix indexes (CMIs). These CMIs are applied to the federal per-diem rates. CMS will not make any changes to the RUGs for FFY 2016 and will maintain the current RUGs-IV groupings and case-mix weights. The RUG-IV case-mix adjusted federal rates and associated indexes for both urban and rural SNFs are listed in Tables 4 and 5 on FR pages 46,398-46,400.

SNF Value-Based Purchasing Program

FR Pages 46409-46,476

Background: For FFYs 2019 and beyond, CMS is required by the Protecting Access to Medicare Act of 2014 (PAMA) to implement a VBP (Value-Based Purchasing) program for SNFs under which value-based incentive payments are made to the SNFs. The PAMA also requires CMS to specify a SNF all-cause all-condition hospital readmission measure no later than October 1, 2015, and for CMS to replace this measure and specify an all-condition, risk-adjusted potentially preventable hospital readmission rate resource use measure by October 1, 2016. Under the PAMA, CMS must apply this readmission measure to the VBP program and replace it with the resource use measure in FFY 2017.

SNF Readmission Measure (SNFRM)

FR Pages 46,411-46,416

CMS will adopt the Skilled Nursing Facility 30-Day All-Cause Readmission Measure, (SNFRM) (NQF #2510), as the sole measure to be used in the SNF VBP Program. The SNFRM calculates the risk-standardized rate of all-cause, all-condition, unplanned, inpatient hospital readmissions for SNF Medicare beneficiaries within 30 days of their prior proximal short-stay acute hospital discharge. This measure is claims-based, requiring no additional data collection or submission burden for SNFs.

The SNFRM is calculated based on a standardized risk ratio (SRR) for each SNF of the number of all-cause, unplanned readmissions to an IPPS or CAH that occurred within 30 days of discharge from the prior proximal hospitalization, to the estimated number of risk-adjusted predicated unplanned inpatient hospital readmissions for the same patients treated at the average SNF. The SRR is then multiplied by the overall national raw readmission rate for all SNF stays resulting in the risk-standardized readmission rate (RSRR).

Ratio Value	Indication
> 1.0	**Higher than expected readmission rate; lower level of quality**
< 1.0	**Lower than expected readmission rate; higher level of quality**

Inclusion/Exclusion Criteria

FR Pages 46,416-46,418

An eligible SNF admission is considered to be in the 30-day risk window from the date of discharge from the proximal acute hospitalization until the 30-day period ends or the patient is readmitted to an IPPS or CAH.

The patient population includes SNF patients who had:

- A prior hospital discharge (IPPS, CAH or psychiatric hospital) within 1 day of their admission to a SNF;
- At least 12 months of Medicare Part A, FFS coverage prior to their discharge date from the prior proximal hospitalization; and
- Medicare Part A, FFS coverage during the 30 days following their discharge date from the prior proximal hospitalization.

SNF stays excluded from the measure include:

- Patients whose prior hospitalization was for the medical treatment for cancer;
- Planned readmissions;
- If the patient had one or more intervening post-acute care (PAC) admissions which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge but before readmission, within the 30-day risk window;
- If a gap or greater than 1 day exists between discharge from the prior proximal hospitalization and the SNF admission;
- SNF stays in which the patient was discharged from the SNF against medical advice (AMA);
- SNF stays in which the principal diagnosis for the prior proximal hospitalization was for rehabilitation care; fitting of prostheses and for the adjustment of devices;
- If the prior proximal hospitalization was for pregnancy; and
- If data is missing on any variable used in the SNFRM construction.

Performance Standards and Scoring

FR Pages 46,418; 46,419-46,425

Background: CMS is required by the PAMA to establish performance standards for the SNF VBP Program that include levels of achievement and improvement which must be established and announced no later than 60 days prior to the beginning of the performance period for the FY involved. Beginning in FY 2019, the SNF VBP program will provide incentive payments to SNFs with higher levels of performance on the readmission measure, and penalties to lower-performing SNFs.

CMS is considering several health care programs and demonstration projects such as the Hospital VBP (HVBP) program, the Hospital Acquired Conditions Reduction (HAC) Program, the Hospital Readmissions Reduction (HRR) Program, and the End-Stage Renal Disease Quality Incentive (ESRD QIP) Program, as prototypes for the SNF VBP program and the scoring methodology.

Under the PAMA, the SNF VBP program will take the higher of achievement and improvement scores in calculating the SNF performance score.

One year of data is used to calculate the SNFRM measure rate, shown in the table below:

Baseline period	Performance Period	Payment Period
FY prior to performance period, same duration as and seasonally aligned with the performance period	**Considering a one year period, prior to payment period**	**FY 2019**

* A baseline period that is shorter than the performance period may occasionally be adopted in order to meet operational timelines

Also in consideration is the adoption of an exchange function to translate SNF performance scores into value-based incentive payments under the SNF VBP Program during the applicable FY, similar to the linear exchange function of the HVBP Program. CMS must consider the appropriate form and slope of the exchange function to determine how best to reward high performance.

Value-based incentive payment percentage calculation methods are not yet determined. However, the total amount of value-based incentive payments for all SNFs for a FY must be greater than or equal to 50% but no more than 70% of total amount of reductions to payments for the FY as required by the PAMA.

Reporting/Review, Correction and Appeals Process

FR Pages 46,419; 46,425-46427

Beginning October 1, 2016, CMS is required by PAMA to provide quarterly feedback reports to SNFs on their performance on the readmission or resource use measure on the *Nursing Home Compare* website or its successor. CMS intends to address how to notify SNFs of the adjustments to their PPR payments based on their performance scores and ranking under the SNF VBP Program in future rulemaking.

SNF Quality Reporting Program

FR Pages 46,427-46,461

The Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act mandates the implementation of a quality reporting program for SNFs. Beginning in FY 2018, the IMPACT requires a 2 percent penalty for those SNFs that fail to submit required quality data to CMS.

For the FY 2018 SNF QRP and subsequent years, CMS is adopting three measures addressing three quality domains identified in the IMPACT Act: (1) skin integrity and changes in skin integrity; (2) incidence of major falls; and (3) functional status, cognitive function, and changes in function and cognitive function. The three measures satisfy the IMPACT Act requirement for standardized data reporting across the four post-acute care settings, including: home health agencies; inpatient rehabilitation facilities; skilled nursing facilities; and long term care hospitals. The measures are identified in the table below.

Summary Table of Domains and Measures for the FFY 2018 SNF Quality Reporting Program:

Domain	Measures	Collection Period	Submission Deadline for FY 2018 Payment Determination
Skin Integrity and Changes in Skin Integrity	Outcome Measure: Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)*	October 1, 2016 – December 31, 2016	May 15, 2017
Incidence of Major Falls	Outcome Measure: Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)		
Functional Status, Cognitive Function, and Changes in Function and Cognitive Function	Process Measure: Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; endorsed on July 23,2015)		

*CMS is considering a future update to the numerator of this measure which would require providers to report the development of unstageable pressure ulcers, including the suspected deep tissue injuries (sDTIs).

CMS is also considering these SNF QRP measures for future years:

Domain	Proposed Measures
Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates	(NQF #2510): Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2512; NQF #2502): Application of the LTCH/IRF All-Cause Unplanned Readmission measure for 30 Days Post Discharge from LTCHs/IRFs
Resource Use, including total estimated Medicare spending per beneficiary	(NQF #2158): Application of the Payment Standardized Medicare Spending Per Beneficiary (MSPB)
Discharge to community	Percentage residents/patients at discharge assessment, who are discharged to a higher level of care or to the community. Measure assesses if the patient/resident went to the community and whether they stayed there. Ideally, this measure would be paired with the 30-day all-cause readmission measure.

Staffing Data Collection

FR Pages 46,462-46,472

CMS has finalized the requirement that Long Term Care (LTC) facilities must electronically submit direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format beginning on July 1, 2016. The information submitted must specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel), include resident census data and information on resident case mix, be reported on a regular schedule and include information on employee turnover and tenure and on the hours of care provided by each category of certified employee per resident per day. The information with respect to agency and contract staff must be kept separate from information on employee staffing.

Information about the new process for submission, called PBJ reporting system, is posted on CMS' PBJ website, including a PBJ Draft Policy Manual with general background and information about submission requirements, including sample submission screens, deadlines, definitions of job categories, and how to electronically submit staffing data, either through a payroll vendor or manually.

Due to comments received by CMS, the definition of "direct care staff" was added to this section of the IMPACT Act along with the adjective "uniform" to describe the formation requirement for data format. CMS defines "direct care staff" as *"those individuals who, through interpersonal contact with residents or resident care management, provide care and services to residents to allow them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility"*.

####