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CMS Proposed Rule: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017

FYI and distribution:

Following is the link to the Centers for Medicare & Medicaid Services (CMS) Proposed Rule: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research, published in the Federal Register, April 25, 2016.

www.gpo.gov/fdsys/pkg/FR-2016-04-25/pdf/2016-09399.pdf

- This proposed rule would update the payment rates under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2017.
- CMS also proposes to specify a specify a 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF Value-Based Purchasing Program (VBP); define performance standards; and adopt a scoring methodology and other policies for the VBP program aimed at implementing value-based purchasing for SNFs.
- 4 new quality and resource measures are proposed for the SNF Quality Reporting Program (SNF QRP).

- Comments are due to CMS by CoB 6/20/16.

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I. Update to payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2017.

- Based on proposed changes contained within the rule, CMS projects that aggregate payments to SNFs will increase in FY 2017 by $800 million, or 2.1 %, from payments in FY 2016.
- The estimated increase is attributable to a 2.6% market basket increase reduced by 0.5 percentage points, in accordance with the multifactor productivity adjustment required by law.

II. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) [10/1/18] [*p. 24243*]

- The SNF VBP Program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals.
- CMS initiated development of the SNF VBP Program in the FY 2016 SNF PPS final rule with adoption/finalization of the SNF 30-Day All-Cause, All-Condition Hospital Readmission Measure (SNFRM). This FY 2017 proposed rule continues the process with an 'all-condition risk-adjusted potentially preventable hospital readmission measure for SNFs', which must be specified by 10/1/16 and applied to payments for services furnished on or after 10/1/18.

- **Measures:**

SNF 30-Day All-Cause Readmission Measure (SNFRM) [Finalized: FY 2016 SNF PPS final rule]

- The SNFRM assesses the risk-standardized rate of all-cause, all-condition, unplanned inpatient hospital readmissions of Medicare fee-for-service (FFS) SNF patients within 30 days of discharge from an admission to an inpatient prospective payment system (IPPS) hospital, CAH, or psychiatric hospital.
- The measure is claims-based, requiring no additional data collection or submission burden for SNFs.

Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) [Proposed]

- The measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF residents within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital.
    - o Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable.

    - This measure is claims-based, requiring no additional data collection or submission burden for SNFs.
- The SNFPPR is consistent with the SNFRM and the 'Hospital-Wide Risk-Adjusted All-Cause Unplanned Readmission Measure'. It will use the same statistical approach, the same time window (30 days post-hospital discharge), and a similar set of risk-adjusted resident characteristics.
- The SNFPPR estimates the risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries occurring within 30 days of discharge from the prior proximal hospitalization.
- Section 1888(h)(2) of the Act requires that a single QM be implemented in the SNF VBP program at one time.
    - A within-stay only measure would "perversely incentivize the premature discharge of residents from SNFs to avoid penalty". A 30-days post-discharge only measure "would not capture readmissions occurring during the SNF stay."
- To qualify, the SNF admission must occur within 1 day of discharge from a prior proximal hospital stay.
- Definition: The definition differs based on whether the resident is admitted to the SNF ("within-stay") or in the post-SNF discharge period.
    - For resident readmissions within the SNF stay, potentially preventable readmissions (PPR) should be avoidable with sufficient medical monitoring and appropriate treatment.
        - 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; and (4) Inadequate injury prevention.
    - For individuals in the post-SNF discharge period, a potentially preventable readmission refers to readmission where the probability of occurrence could be minimized with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care.
        - There are 3 clinical rationale groupings: (1) Inadequate management of chronic conditions; (2) Inadequate management of infections; (3) Inadequate management of other unplanned events.
- Eligible SNF stays are assessed until: (1) The 30-day period ends; or (2) the patient is readmitted to an acute care hospital (IPPS or CAH).
- If the readmission is classified as unplanned and potentially preventable, it is counted as a readmission. If the readmission is planned or not preventable, the readmission is not counted in the measure rate.
- Readmission rates are risk-adjusted for case-mix characteristics "estimating the effects of patient/resident characteristics, comorbidities, and select health care variables on the probability of readmission."
    - The risk-adjustment accounts for sociodemographic characteristics (age, sex, original reason for entitlement), principal diagnosis during the prior proximal hospital stay, body system specific surgical indicators, comorbidities, length of stay during the resident's prior proximal hospital stay, intensive care utilization, end-stage renal

disease status, and number of prior acute care hospitalizations in the preceding 365 days.

- This measure is calculated using one full calendar year (CY) of data.
- CMS seeks comment on the measure itself and timing for implementation.

Proposed Achievement Performance Standard and Benchmark

- Beginning with FY 2019 CMS would define the achievement performance standard ("achievement threshold") for QMs specified under the SNF VBP program as the 25th percentile of national SNF performance on the QM during the applicable baseline period, i.e., '…an achievable standard of excellence and providing strong incentives for performance improvement.
- CMS seeks comment on whether adopting either the 50th or 15th percentiles of national SNFs' performance on the QM during the applicable baseline period should be considered and on data or other analysis that should be considered regarding the impact on SNFs' financial viability and service delivery to beneficiaries at either the higher or lower alternative standard.
    - E.G., while the 50th percentile would represent a more challenging threshold for quality improvement, it would align with the Hospital VBP and likely result in higher value-based incentive payments to top-performing SNFs. It would likely result in lower value-based incentive payments to lower-performing SNFs, which could create substantial payment disparities among participating SNFs. The 15th percentile would likely result in higher value-based incentive payments for lower-performing SNFs than other thresholds, with the corresponding result of lower value-based incentive-payments for top-performing SNFs compared to other thresholds.
- CMS would define the "benchmark" for QMs as the mean of the top decile of SNF performance on the QM during the applicable baseline period, aligning with the Hospital VBP Program.
- CMS would award points along an achievement range, the scale between the achievement threshold and the benchmark. SNFs would receive points for meeting or exceeding the achievement threshold a given measure, and could increase their score based on higher levels of performance.

Proposed Improvement Performance Standard

- Beginning with FY 2019, CMS would define the improvement performance standard ("improvement threshold") as each SNF's performance on the given QM during the applicable baseline period. CMS would measure a SNFs' performance during both the performance and baseline periods and award improvement points by comparing

performance to the improvement threshold. CMS seeks comment on this proposal.

Publication of Performance Standard Values

- CMS must establish and announce performance standards for a given SNF VBP program year not later than 60 days prior to the beginning of the performance period for the FY. CMS would establish and announce performance standards for FY 2019 by 11/1/16 and announce subsequent performance standards in the annual SNF PPS rule, effective 11/1 of each year.
- If the necessary analyses cannot be completed timely, CMS would publish the performance standards on the QualityNet Web site used by SNFs to receive VBP information no later than 60 days prior to the beginning of the performance period. CMS seeks comment on this proposal.

FY 2019 Performance Period and Baseline Period

- CMS would adopt CY 2017 (1/1/17 – 12/31/17) as the performance period for the FY 2019 SNF VBP Program, with a 90-day run out period immediately thereafter for claims processing.

Proposed FY 2019 Baseline Period

- CMS would adopt CY year 2015 claims (1/1/15 – 12/31/15) as the baseline period for the FY 2019 SNF VBP Program and use that baseline period as the basis for calculating performance standards [with a 90-day claims run out following the last date of discharge (12/31/15) before incorporating the 2015 claims into the database. CMS seeks comment on this proposal.

Proposed SNF VBP Performance Scoring

- CMS would adopt a scoring model similar to the Hospital VBP Program, with certain modifications. CMS would implement a 0 - 100 point scale for achievement scoring and a 0 - 90 point scale for improvement scoring, with the achievement threshold set at the 25th percentile of SNF national performance on the QM during the baseline period.

Proposed Scoring of SNF Performance on the SNFRM [30-day All Cause Readmission]

- SNFRM rates represent the % of qualifying residents at a facility readmitted within the risk window for the QM, i.e., "lower SNFRM rates indicate lower rates of readmission, indicating higher quality care."
- To reduce confusion, CMS proposes to calculate scores by first inverting SNFRM rates using the following:
    - *SNFRM Inverted Rate* = 1 − Facility's SNFRM Rate. "Higher SNFRM performance would reflect better performance;

incentivize improvement in a clear and understandable manner; simplify public reporting."

- ***Achievement-*** A SNF would earn a score of 0 - 100 points based on where its performance fell relative to the achievement threshold (25th percentile) and the benchmark (the mean of the top decile of SNF performance during the baseline period).
  - o If a SNF's SNFRM inverted rate was equal to or greater than the benchmark, the SNF would receive 100 points for achievement;
  - o If a SNF's SNFRM inverted rate was less than the achievement threshold (lower bound of the achievement range), the SNF would receive 0 points for achievement.
  - o If a SNF's SNFRM inverted rate was equal to or greater than the achievement threshold, but less than the benchmark, between 0 and 100 points would be awarded according to the following formula:

$$SNF\ Achievement\ Score = \left(\left[9\ x\ \left(\frac{(SNF's\ Perf.\ Period\ Inverted\ Rate - Achievement\ Threshold)}{(Benchmark - Achievement\ Threshold)}\right)\right] + .5\right) x\ 10$$

- ***Improvement-*** SNFs would earn a score of 0 - 90 points based on how much its performance during the performance period improved from its performance on the QM during the baseline period. A unique improvement range would be established for each SNF defining the distance between the SNF's baseline period score and the national benchmark for the QM (the mean of the top decile of SNF performance on the QM during the baseline period). A SNF improvement score would be calculated for each SNF depending on its performance period score.
  - o Equal to or lower than its improvement threshold, the SNF would receive 0 points for improvement.
  - o Equal to or higher than the benchmark, the SNF would receive 90 points for improvement.
  - o Greater than its improvement threshold, but less than the benchmark, the SNF would receive between 0 and 90 points for improvement according to the following formula:

$$SNF\ Improvement\ Score = \left(\left[10\ x\ \left(\frac{(SNF\ Perf.\ Period\ Inverted\ Rate - SNF\ Baseline\ Period\ Inverted\ Rate)}{(Benchmark - SNF\ Baseline\ Period\ Inverted\ Rate)}\right)\right] - .5\right) x\ 10$$

- ***Establishing SNF Performance Scores***
  - o CMS would use the higher of a SNF's achievement and improvement scores as the SNF's performance score for a given year. The SNF performance score would be used as the basis for

ranking SNF performance on the QMs and establishing the value-based incentive payment percentage.

SNF Value-Based Incentive Payments

- The value-based incentive payment percentage must be based on the SNF performance score and be appropriately distributed so the highest-ranked SNFs receive the highest payments; the lowest-ranked SNFs receive the lowest payments; and the payment rate for services furnished by SNFs in the lowest 40% be 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.
- CMS would adopt an exchange function in future rulemaking to ensure the total amount of value-based incentive payments each year meets those criteria.

Request for Comment on Exchange Function

- CMS would use a linear exchange function to translate a SNF's Total Performance Score into the percentage multiplier to be applied to each SNF Medicare discharge claim submitted during the applicable FY.

SNF VBP Reporting

- ***Confidential Feedback Reports***
  - o CMS is developing the feedback reports, operational systems, and implementation guidance related to the required reports for provision via the QIES and CASPER.
  - o *Two-Phase SNF VBP Data Review and Correction Process*
    - CMS would use 1 of the 4 reports each year to provide SNFs opportunity to review their data to be public reported, including (1) A count of readmissions; (2) number of eligible stays at the SNF; (3) the SNF's risk-standardized readmissions ratio; (4) the national SNF measure performance rate.
    - CMS would provide resident-level information used in calculating the QM rate and seeks comment on what information would be most useful to SNFs and how it should be made available.
  - *Phase Two: Review and Correction of SNF Performance Scores and Ranking* - CMS would inform each SNF of its payment adjustments linked to the SNF VBP Program not later than 60 days prior to the FY involved. The report would also include SNF performance scores and ranking. Phase 2 would be limited to corrections to the performance score calculation and the ranking.

- ***SNF VBP Public Reporting***
  - o CMS must post on *Nursing Home Compare* Web site or its successor information regarding the individual SNF performance with respect to a FY, including the performance score for each SNF and each SNF's ranking.
  - o CMS must periodically post aggregate information on the SNF VBP Program on *Nursing Home Compare* Web or its successor, including the range of SNF performance scores, and the number of SNFs receiving value-based incentive payments and the range and total amount of those payments.
  - o CMS will address this in future rulemaking, but seeks comment on the best means to display SNF-specific and aggregate performance information.

Ranking SNF Performance

- CMS would order SNF performance scores from low to high and publish those rankings on both *Nursing Home Compare* and the QualityNet Web sites.
- CMS will publish the ranking for FY 2019 SNF VBP payment implications after 8/1/18.
- CMS seeks comment on the most appropriate format and Web site for the ranking's publication.

III. SNF Quality Reporting Program (SNF QRP) [FY' 2018] (p. 24256)

- **Drug Regimen Review:** CMS would adopt 1 QM to meet the Medication Reconciliation domain: (1) Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care SNF QRP.
- **Resource Use Measures:** For FY 2018 and subsequent years, CMS would also adopt 3 measures to meet the IMPACT Act mandated resource use and other measure domains: **(1)** Medicare Spending per Beneficiary—Post-Acute Care SNF QRP; **(2)** Discharge to Community—Post Acute Care SNF QRP; **(3)** Potentially Preventable 30-Day Post-Discharge Readmission Measure - SNF QRP.

- ***Policy for Retaining SNF QRP Measures Adopted for Future Payment Determinations:*** The FY 2016 SNF PPS final rule finalized policy for QM removal and that when CMS adopts a QM for the SNF QRP for a payment determination, the QM will be automatically retained for all subsequent payment determinations absent a proposal to remove, suspend, or replace it. No new policies are proposed related to QM or removal.

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)

- CMS seeks comment on how socioeconomic and demographic factors should be used in risk adjustment for the resource use and other measures.

Resource Use: Total Estimated MSPB-PAC SNF QRP [Medicare Spending Per Beneficiary]

- CMS would adopt an MSPB-PAC SNF QRP measure for inclusion for the FY 2018 payment determination and subsequent years.
- Resource use QMs, including total estimated Medicare spending per beneficiary, for PAC providers - SNFs, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs) that are required to submit necessary data as specified by the Secretary.
- The QMs holds SNF providers accountable for the Medicare payments within an "episode of care" (episode) - 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."
- Each MSPB-PAC QM assesses Medicare Part A and Part B spending within an episode; the numerator and denominator are defined similarly for each of the measures. "Setting-specific measures allow CMS to account for differences between settings in payment policy, types of data available, and the underlying health characteristics of beneficiaries."
- MSPB-PAC episodes may begin within 30 days of discharge from an inpatient hospital as part of a patient's trajectory from an acute to a PAC setting. A SNF stay beginning within 30 days of discharge from an inpatient hospital will be included 1x in the hospital's MSPB measure, and 1x in the SNF provider's MSPB-PAC measure.

Episode Construction

- An MSPB-PAC SNF episode begins at the episode trigger - admission to a SNF. The admitting facility is the attributed provider for whom the MSPB-PAC SNF measure is calculated.
- The episode window is the time period during which Medicare FFS Part A and Part B services are counted towards the MSPB-PAC SNF episode. Because Medicare FFS claims are already reported to the Medicare program for payment purposes, SNF providers will not be required to report any additional data to CMS for calculation of this measure.

- The episode window includes a treatment period and an associated services period. The treatment period begins at the trigger (day of SNF admission) and ends on the day of discharge. Readmissions to the same facility occurring within 7 or fewer days do not trigger a new episode, and are included in the treatment period of the original episode. When 2 sequential stays at the same SNF occur within 7 or fewer days of one another, the treatment period ends on the day of discharge for the latest SNF stay.
- The treatment period includes those services provided directly or reasonably managed by the SNF directly related to the beneficiary's care plan. The associated services period is the time during which Medicare Part A and Part B services (with certain exclusions) are counted towards the episode. The associated services period begins at the episode trigger and ends 30 days after the end of the treatment period.
- An MSPB-PAC episode may begin during the associated services period of an MSPB-PAC SNF episode in the 30 days post-treatment.
    - E.G: A SNF provider discharges a beneficiary who is admitted to a HHA within 30 days. The HHA claim would be included 1x as an associated service for the attributed provider of the first MSPB-PAC SNF episode and 1x as a treatment service for the attributed provider of the second MSPB-PAC HHA episode.

Measure Calculation

- Medicare payments for Part A and Part B claims for services included in MSPB-PAC SNF episodes are used to calculate the MSPB-PAC SNF measure.
- *Exclusion Criteria:* In addition to service-level exclusions that remove some payments from individual episodes, CMS would exclude certain episodes from the MSPB-PAC SNF measure to ensure accurate reflection of resource use and meaningful comparisons between SNF providers. The proposed episode-level exclusions are:
    - 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 attributed 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 (90-day 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 for any part of the 90-day lookback period plus episode window.

- Any episode where the claim(s) constituting the attributed SNF provider's treatment include at least one related condition code indicating it is not a prospective payment system bill.

Standardization and Risk Adjustment

- MSPB-PAC QMs must be adjusted for factors including age, sex, race, severity of illness, and other factors the Secretary determines appropriate.

Measure Numerator and Denominator

- The MSPB-PAC SNF QRP measure is payment-standardized and risk-adjusted comparing a given SNF provider's Medicare spending against the Medicare spending of other SNF providers within a performance period.
- CMS would use the same payment standardization methodology as the hospital MSPB QM, i.e., removing geographic payment differences, such as wage index and geographic practice cost index (GPCI), incentive payment adjustments, and other add-on payments that support broader Medicare program goals, e.g., indirect graduate medical education.
- CMS would create mutually exclusive/exhaustive clinical case mix categories using the most recent institutional claim in the 60 days prior to the start of the MSPB-PAC SNF episode; use a regression framework with a 90-day hierarchical condition category (HCC) lookback period and covariates including the clinical case mix categories, HCC indicators, age brackets, indicators for originally disabled, ESRD enrollment, and long-term care status, and selected interactions of these covariates where sample size and predictive ability make them appropriate
- To calculate the MSPB-PAC Amount for each SNF provider, the average of the ratio of the standardized episode spending over the expected episode spending (as predicted in risk adjustment) is calculated and multiplied by the average episode spending level across all SNF providers nationally. The denominator for a SNF provider's MSPB-PAC SNF measure is the episode-weighted national median of the MSPB-PAC Amounts across all SNF providers.

- *Data Sources:* The MSPB-PAC SNF resource use measure is an administrative claims-based measure, using Part A and Part B claims from FFS beneficiaries and Medicare eligibility files.
- *Cohort:* The measure cohort includes Medicare FFS beneficiaries with a SNF treatment period ending during the data collection period.
- *Reporting:* CMS would provide initial confidential feedback to providers, prior to public reporting, based on Medicare FFS claims data from discharges in CY 2016. CMS would publicly report this measure

using claims data from discharges in CY 2017. CMS proposes a minimum of 20 episodes for reporting and inclusion in the SNF QRP.

Resource Use: Discharge to Community-Post Acute Care (PAC) SNF QRP

- CMS would adopt the QM, Discharge to Community—PAC SNF QRP, for the FY 2018 payment determination and subsequent years as a Medicare FFS claims-based measure.
- This proposed measure reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following.
    - Community would be defined as home/self-care, with or without home health services, based on patient discharge codes on the Medicare FFS claim.
- CMS would use data from Medicare FFS claims and Medicare eligibility files to calculate this QM, i.e., data from the "Patient Discharge Status Code" on Medicare FFS claims to determine discharge to a community setting and include those residents with no unplanned readmission to acute care and who remain alive during the 31 days following discharge.
- This QM would be calculated using 1 year of data; and include a minimum of 25 eligible stays in a given SNF for public reporting of the measure.
- Since Medicare FFS claims data are already reported to the Medicare program for payment and Medicare eligibility files are also available, SNFs will not be required to report any additional data to CMS for calculation.
- The denominator is the risk-adjusted expected number of discharges to community. The numerator is the risk-adjusted estimate of the number of residents who are discharged to the community; do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window; and who remain alive during the post-discharge observation window.
- The measure is risk-adjusted for variables such as age and sex, principal diagnosis, comorbidities, ventilator status, ESRD status, and dialysis, among other variables.
- CMS would provide confidential feedback to SNFs prior to public reporting based on Medicare FFS claims data from discharges in CY 2016. CMS would publicly report this measure using claims data from discharges in CY 2017.

Resource Use: Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP

- CMS must specify measures for all-condition risk-adjusted potentially preventable hospital readmission rates by SNFs, LTCHs, and IRFs by 10/1/16 and HHAs by 1/1/17. This would be a Medicare FFS claims-based measure for FY 2018 payment determination and subsequent years.
- 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 (inpatient admission to an acute care hospital [IPPS, CAH, or psychiatric hospital]).
- The measure requires no additional data collection or submission burden for SNFs.
- The measure 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 a SNF discharge, including estimated facility effect, to the estimated predicted number of risk-adjusted, unplanned inpatient hospital readmissions for the same patients treated at the average SNF.
- A ratio above 1.0 indicates a higher than expected readmission 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 (IPPS or CAH) or LTCH. If the readmission is unplanned and potentially preventable, it counts as a readmission. If the readmission is planned, it is not counted in the measure rate.
- The risk adjustment modeling 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, length of stay during the patient's prior proximal hospital stay, intensive care unit (ICU) utilization, end-stage renal disease status, and number of acute care hospitalizations in the preceding 365 days.
- The measure is calculated using 1 calendar year of FFS claims data; CMS is proposing a minimum of 25 eligible stays for public reporting.

Medication Reconciliation: Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) SNF QRP

- CMS must specify a QM to address the domain of medication reconciliation by 10/1/18 for IRFs, LTCHs and SNFs; and by 1/1/17 for HHAs.

- CMS would adopt the QM, Drug Regimen Review Conducted with Follow-Up for Identified Issues—PPAC SNF QRP, as a resident-assessment based, cross-setting QM with data collection beginning 10/1/18 for the FY 2020 payment determinations and subsequent years.
- The measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issues when such issues were identified.
- The measure reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that stay.
- 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 utilizes both the processes of medication reconciliation and a drug regimen review, in the event an actual or potential medication issue occurred.
- CMS would adopt the measure for FY 2020 payment determination and subsequent years.
- The calculation of the proposed quality measure would be based on the data collection of 3 standardized items to be included in the MDS.
- The collection of data by means of the standardized items would be obtained at admission and discharge.
- The standardized items used to calculate this measure do not duplicate existing MDS items.
- 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; and (2) discharge with a look back through the entire resident stay, with all potential clinically significant medication issues identified during the course of care and followed-up with a physician or designee by midnight of the next calendar day.
- This measure is not risk adjusted.

Form, Manner, Timing of Quality Data Submission

- New SNFs – The FY 2016 SNF PPS final rule finalized that new SNFs must begin reporting data on any QM finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, e.g., CCN on 8/28/16; 30 days are added = 9/27; the SNF must submit data for residents admitted as of 10/1/16.

Finalized Data Collection Timelines and Requirements for the FY 2018 Payment Determination and Subsequent Years

- The FY 2016 SNF PPS final rule for the FY 2018 payment determination finalized that SNFs submit data on the 3 finalized QMs for residents admitted on and after 10/1/16, and discharged up to and including 12/31/16. CMS will collect that single ¼ of data for FY 2018 to remain consistent with the usual October release schedule for the MDS.
- Following the close of the reporting 1/4, 10/1/6 - 12/31/16 for the FY 2018 payment determination, SNFs would have an additional 4.5 months to correct and/or submit their quality data; the final deadline for submitting data for the FY 2018 payment determination is 5/15/17.

Quality measure	***Data collection source***	***Data collection period***	***Data submission deadline for FY 2018 payment determination***
Percent of Patients or Residents with Pressure Ulcers that are New or Worsened	*MDS*	*10/01/16-12/31/16*	*May 15, 2017.*
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	*MDS*	*10/01/16-12/31/16*	*May 15, 2017.*
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that	*MDS*	*10/01/16-12/31/16*	*May 15, 2017.*

Quality measure	*Data collection source*	*Data collection period*	*Data submission deadline for FY 2018 payment determination*
Addresses Function			

Data Collection Timelines and Requirements for the FY 2019 Payment Determinations and Subsequent Years

- CMS proposes moving to CY reporting following the initial reporting of data from 10/1/16 – 12/31/16 for the FY 2018 payment determination, i.e., 1/4ly deadlines following each ¼ of data submission, beginning with data reporting for the FY 2019 payment determinations.
- Each 1/4ly deadline will occur approximately 4.5 months after the end of a given calendar ¼ [see Table 15 – page 24271]. The FY 2019 payment determination would be based on 12 calendar months of data reporting beginning on 1/1/17, and ending on 12/31/17.
- CMS is proposing that beginning with FY 2019 payment determination, assessment-based measures will follow a CY schedule of data reporting (beginning 1/1 – 3/31…) and 1/4ly review and correction periods and data submission deadlines (beginning 4/1 – 4/15…) [See Table 16 – page 24272] for all subsequent payment determination years unless otherwise specified.

Proposed Timeline/Data Submission Mechanisms for Claims-Based Measures for the FY 2018 Payment Determination and Subsequent Years

- CMS would use 1 year of claims data beginning with CY 2016 to inform feedback reports for SNFs, and CY 2017 claims data for public reporting for the Medicare Spending per Beneficiary—PAC SNF QRP Measure; Discharge to Community—PAC SNF QRP measure; and the Potentially Preventable 30-Day Post-Discharge Readmission Measure.

Proposed Timeline/Data Submission Mechanisms for the FY 2020 Payment Determination and Subsequent Years - SNF QRP Assessment-Based QM

- CMS proposes that SNFs complete data elements to be included in the MDS for submission through the QIES system beginning 10/1/18 for the QM, Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP, affecting FY 2020 payment determination and subsequent years.
- For the FY 2020 payment determination, CMS proposes that SNFs submit data on the assessment-based QM for residents who are admitted to the SNF on and after 10/1/18, and discharged from Part A stays (discharged from Part A stays and physically discharged) up to and including 12/31/8, using the proposed data submission schedule.
- CMS would collect a single ¼ of data for the FY 2020 payment determination to remain consistent with the [usual] October release schedule for the MDS.
- CMS proposes that following the close of the reporting quarter, 10/1/18 – 12/31/18, for the FY 2020 payment determination, SNFs would have an additional 4.5 months to correct and/or submit their quality data; the final deadline for submitting data for the FY 2020 payment determination would be 5/15/19.
- CMS would follow a CY schedule for measure and data submission requirements, including 1/4ly deadlines following each ¼ of data submission, beginning with data reporting for the FY 2021 payment determinations; each 1/4ly deadline will be approximately 4.5 months after the end of a given calendar 1/4.

SNF QRP Data Completion Thresholds for the FY 2018 Payment Determination and Subsequent Years

- The FY 2016 SNF PPS final rule finalized policies for data completion thresholds for the FY 2018 payment determination and subsequent years.
- 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 that they submit. For the FY 2018 SNF QRP, 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 SNF QRP QMs would be subject to a reduction of 2 percentage points 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. The finalized provision will affect FY 2018 payment determinations and subsequent years and is dependent upon the successful achievement of the completion threshold of the data used to calculate the measures finalized.

SNF QRP Data Validation Requirements for the FY 2018 Payment Determination and Subsequent Years

- CMS continues to explore data validation methodology that will limit the amount of burden and cost to SNFs, while allowing us to establish estimations of the accuracy of SNF QRP data.

SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent Years

- The FY 2016 SNF PPS final rule finalized submission and extension requirements for the SNF QRP for FY 2018 payment determination and subsequent years. No changes are proposed.

SNF QRP Reconsideration and Appeals Procedures for FY2018 Payment Determinations and Subsequent Years

- The FY 2016 SNF PPS final rule finalized reconsideration and appeals procedures for the SNF QRP for FY 2018 payment determination and subsequent years. No changes are proposed.

Public Display od QM Data for SNF QRP / Procedures for Opportunity to Review & Correction

- Future rulemaking - CMS will propose policy to publicly display performance information for individual SNFs on IMPACT Act QMs. As indicated above, in this rule, CMS proposes procedures to allow SNFs to review and correct their data and information on the QMs before those data are made public, including confidential feedback reports and review and correction periods.

- Assessment-based QMs: SNF Quality Measure (QM) [confidential feedback] Reports, would be available to each SNF using the CASPER System. CMS proposes monthly updates as data becomes available, viewable at both the facility- and resident-levels.
    - o CMS proposes a 30-day preview period via a CASPER preview report prior to public display for SNFs to preview performance information on their QMs that will be made public.
    - o Corrections to underlying data would not be allowed during this time, but SNFs may contest incorrect QM calculations during the 30-day preview. If CMS determines the QM has a calculation error, CMS would suppress the data on the public reporting site, recalculate the QM and publish it at the next scheduled public display date.
- Claims-based QMs – Prior to public display, CMS will make available via CASPER a confidential preview report containing claims-based measure rate calculations, e.g., facility and national rates; for feedback purposes only, not corrections. Because the claims-based

measures are calculated annually, these CASPER QM reports will be refreshed annually.
    - SNFs may request correction of QM calculation during the 30 day preview. If it is agreed the QM has a calculation error, CMS would suppress the data, recalculate, and publish it at the next scheduled public display date.
    - Beginning with data that will be publicly displayed in 2018, claims-based QMs will be calculated using claims data with at least a 90 day run off period after the last discharge date in the applicable period.

SNF QRP Quality Measures and Measure Concepts Under Consideration for Future Years

- CMS is inviting comment on the following for future inclusion in the SNF QRP:
    - Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions.
    - Transfer of health information and care preferences when an individual transitions.
    - Patient- and Caregiver-Centered Care.
    - Percent of Residents Who Self-Report Moderate to Severe Pain.
    - Application of the Change in Self-Care Score for Medical Rehabilitation Patients.
    - Application of the Change in Mobility Score for Medical Rehabilitation Patients

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