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Medicare Proposes Fiscal Year 2019 Payment & Policy Changes for Skilled Nursing Facilities

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a **proposed** rule [CMS-1696-P] outlining proposed Fiscal Year (FY) 2019 Medicare payment updates and proposed quality program changes for skilled nursing facilities (SNFs). CMS has proposed a 2.4% increase in SNF payment rates for Fiscal Year 2019. Based on changes contained within this proposed rule, CMS indicates aggregate payments to SNFs will increase in FY 2019 by $850 million from payments in FY 2018. At the same time, the overall impact of the SNF Value-Based Purchasing (VBP) program is an estimated reduction of $211 million in aggregate payments to SNFs during FY 2019. CMS has proposed minor changes to the Quality Reporting Program (QRB) VBP and asked for input on interoperability.

The CMS fact sheet discusses three major provisions of the proposed rule: the proposed changes to the case-mix classification system used under the SNF Prospective Payment System (PPS), the SNF Value-Based Purchasing Program (VBP), and the SNF Quality Reporting Program (QRP).

Modernizing the SNF PPS Case-mix Classification System

In May 2017, CMS released an Advanced Notice of Proposed Rulemaking (ANPRM) which outlined a new case-mix model, called the Resident Classification System, Version I (RCS-I), that it was considering to replace the existing Resource Utilization Group, Version IV (RUG-IV) case-mix model, used to classify residents in a covered Part A stay into payment groups under the SNF PPS. Since the ANPRM, CMS continued stakeholder engagement efforts to identify and address the concerns and questions raised by commenters. As a result, CMS has made significant changes to the RCS-I model, which resulted in renaming this model to the **SNF Patient-Driven Payment Model (PDPM).**

The proposed new model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time. CMS also significantly reduced the overall complexity of the proposed PDPM, as compared to RUG-IV or RCS-I. The proposed new case-mix classification system (the PDPM) would be effective October 1, 2019. The improved structure of this proposed model would move Medicare towards a more value-based, unified post-acute care payment system that puts the unique care needs of the patient first while also reducing significantly the administrative burden associated with the SNF PPS.

The proposed new case-mix model, PDPM, would focus on clinically relevant factors, rather than volume-based service for determining Medicare payment. PDPM would adjust Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs), which are items and services not related to the provision of therapy such as drugs and medical supplies, thereby more accurately addressing costs associated with medically complex patients. It would further adjust the SNF per diem payments to reflect varying costs throughout the stay and incorporate safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals.

The proposed SNF PDPM would reflect an approximately 80 percent reduction in the number of payment group combinations compared to the RCS-I. Additionally, it would reflect updates to the data used as the basis for CMS analyses, to ensure that the results reflect the current resident population. PDPM, as compared to RCS-I, would also make greater use of certain standardized items for payment calculations, such as in using function items also used for the SNF QRP. Finally, PDPM would simplify complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients.

The proposed new case-mix classification system (the PDPM) would be effective **October 1, 2019**.

SNF Quality Reporting Program (QRP)

The SNF QRP is authorized by section 1888(e)(6) of the Social Security Act and applies to freestanding SNFs, SNFs affiliated with acute care facilities, and swing-bed rural hospitals except for critical access hospitals. Under the SNF QRP, SNFs that fail to submit the required quality data to CMS will be subject to a 2-percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year.

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CMS reviewed the SNF QRP's measure set in accordance with the Meaningful Measures Initiative, and they are working to identify how to move the SNF QRP forward in the least burdensome manner possible while continuing to incentivize improvement in the quality of care provided to patients. Specifically, the goals of the SNF QRP and the measures used in the program cover most of the Meaningful Measures Initiative priorities, including making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

Currently, all measures adopted in the SNF QRP meet the requirements and are in satisfaction of the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT) Act. CMS is not proposing to adopt any new measures for the SNF QRP in this proposed rule.
In this proposed rule, CMS is proposing to adopt an additional factor to consider when evaluating measures for removal from the SNF QRP measure set. This factor takes into account costs that are associated with a measure and weighs them again the benefit of its continued use in the program. CMS is also proposing to publicly display the four SNF QRP assessment-based quality measures, and increase the number of years of data used to display two claims-based SNF QRP measures, Discharge to the Community and Medicare Spending per Beneficiary, from 1 year to 2 years. CMS is also proposing to codify policies that have been finalized under the SNF QRP.

SNF Value-Based Purchasing Program (VBP)

Beginning October 1, 2018 services, the SNF VBP Program will apply either positive or negative incentive payments to skilled nursing facilities based on their performance on the program's readmissions measure. The single claims-based all cause 30-day hospital readmissions measure aims to improve individual outcomes through rewarding providers that take steps to limit the readmission of their patients to a hospital. This single measure does not require SNFs to report information in addition to the information they already submit as part of their claims because CMS uses existing Medicare claims information to calculate the measure.

Public comments on the FY 2019 SNF PPS proposed rule will be accepted until June 26, 2018.

For a complete copy of the FY 2019 SNF PPS Proposed Rule; http://polaris-group.com/news_releases.asp

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