



An Informational Bulletin Brought To You By Polaris Group

## SNF Value-Based Purchasing Program

On July 31, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule outlining fiscal year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs). In that rule, CMS finalized some key components of the SNF Value Based Purchasing (VBP) program, which impact reimbursement.

Beginning on October 1, 2018 for FY 2019, CMS will adjust Medicare payments to providers based on how well they manage hospital readmissions, based on performance in this calendar year (CY) 2017 compared to CY 2015. Some SNFs will see some sort of payment reduction, which can be as high as two percent for all of their Part A Medicare payments for an entire fiscal year. However, there is a potential for some SNFs who achieve low re-hospitalization rates to see an increase in reimbursement.

### Key Components to the SNF VBP Program:

#### Starting in FY 2019

- **Size of incentive pool** - CMS will calculate two percent of all SNF Part A payments and use 60 percent of that figure to calculate the payment adjustment for SNFs. CMS is mandated to use between 50 and 70 percent.
- **Method to link re-hospitalization rates to your payment** - CMS elected to utilize a logistic exchange function to translate a provider's performance in the SNF Readmission Measure (SNFRM) into a value-based incentive payment multiplier.
- **SNF VBP scores will be rounded to five significant digits** -To measure providers as precisely as possible and minimize tied rankings, CMS will round SNF VBP scores to no more than five significant digits.

#### Starting in FY 2020

- **New achievement and benchmark rates** - CMS finalized the Achievement and Benchmark rates used in the determination of a SNF's VBP score for the second year of the VBP program, which will impact payment in FY 2020. SNFs with SNFRM re-hospitalization rates greater than the Achievement rate of 19.8 percent will receive no points and will lose two percent of their Medicare payments, while providers with re-hospitalization rates less than the Benchmark rate of 16.3 percent, will receive 100 points and are likely to have net positive payments.

- **Switching performance and baseline periods to fiscal years from calendar years** - CMS is switching the measurement windows to fiscal years in the second year of the program to ensure timely notification to providers of their value-based incentive payment adjustments no later than 60 days prior to the start of a fiscal year. Switching to a fiscal year will allow CMS an extra three months for data collection, measure calculation and reporting. This means the baseline period for the second year of the program will be FY 2016 (Oct. 2015 - Sept. 2016) and the performance period will be FY 2018 (Oct. 2017 - Sept. 2018). Additionally, this means the fourth quarter of 2017 (Oct. 2017 - Dec. 2017) will count towards the performance period of both the first and second year of the program.

To read the complete FY 2018 SNF PPS Final Rule: [http://polaris-group.com/news\\_releases.asp](http://polaris-group.com/news_releases.asp)

## CMS Proposes to Cancel Major Bundled Payment Initiatives

The Centers for Medicare & Medicaid Services (CMS) announced a proposed rule to reduce the number of mandatory geographic areas participating in the Center for Medicare and Medicaid Innovation's Comprehensive Care for Joint Replacement (CJR) model from 67 to 34. In addition, CMS proposes to allow CJR participants in the 33 remaining areas to participate on a voluntary basis. In this rule, CMS also proposes to make participation in the CJR model voluntary for all low volume and rural hospitals in all of the CJR geographic areas.

CMS also is proposing through this rule to cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model, which were scheduled to begin on January 1, 2018. Moving forward, CMS expects to increase opportunities for providers to participate in voluntary initiatives rather than large mandatory episode payment model efforts.

To read the complete proposed rule: [http://polaris-group.com/news\\_releases.asp](http://polaris-group.com/news_releases.asp)



## Targeted Probe and Educate Medical Review Strategy Expansion

The Centers for Medicare & Medicaid Services (CMS) utilizes Medicare Administrative Contractors (MAC) to review clinical documentation in order to prevent improper payments. MACs choose claims for review based on many factors such as the service specific improper payment rate, data analysis and billing patterns of the provider.

In 2014, CMS began a program that combined a review of a sample of claims with education to help reduce errors in the claims submission process. CMS called this medical review strategy, Probe and Educate. CMS is now further improving this strategy by moving from a broad Probe and Educate program to a more targeted one. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers within the service rather than all provider/suppliers billing a particular service.

TPE involves the review of 20-40 claims per provider, per item or service, per round, for up to three rounds of review. Each round of 20-40 claim reviews is referred to as a probe. This term is intended to convey that the number of claims reviewed is relatively small in comparison with previous provider specific reviews where the number of claims reviewed for an individual provider may have been much larger. After each round, providers are offered individualized education based on the results of their reviews.

This program began as a pilot in one MAC jurisdiction in June 2016 and was expanded to three additional MAC jurisdictions in July 2017. As a result of the successes demonstrated during the pilot, including an increase in the acceptance of provider education as well as a decrease in appealed claims decisions, CMS has decided to expand to all MAC jurisdictions later in 2017.

The MACs included in the TPE pilot, and future nationwide program, will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate. MACs will focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers. These providers/suppliers and specific items/services are identified by the MAC through data analysis. TPE claim selection is different from that of previous probe and educate programs. Whereas previously the first round of reviews were of all providers for a specific service, the TPE claim selection is provider/supplier specific from the onset. This eliminates burden to providers who, based on data analysis, are already submitting claims that are compliant with Medicare policy.

Providers/suppliers with continued high error rates after three rounds of TPE may be referred to CMS for additional action,

which may include 100%, prepay review, extrapolation, referral to a Recovery Auditor, or other action. Providers/supplier may be removed from the review process after any of the three rounds of probe review, if they demonstrate low error rates or sufficient improvement in error rates, as determined by CMS.

## Web-Based SNF QRP Web-Based Training Module Now Available

The Centers for Medicare & Medicaid Services (CMS) is offering a refresher web-based training module addressing those areas that generated the most questions during the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Provider Trainings held in June and August of 2016. This training is designed to be used on demand anywhere you can access a browser and includes interactive exercises that allow you to test your knowledge in real life scenarios.

Specific topics include:

- Lesson 1: Scheduling the Part A PPS Discharge Assessment when Medicare Coverage Ends and the Resident Remains in the SNF
- Lesson 2: Determining Planned and Unplanned Discharges on the MDS 3.0
- Lesson 3: Combining Part A PPS Discharge Assessments with Other Assessment Types
- Lesson 4: Use of a Dash on the MDS 3.0 and the Impact on the SNF QRP
- Lesson 5: SNF QRP Data Collection Periods, including data submission requirements associated with the Annual Payment Update

Questions related to Section GG were excluded from these modules and will be addressed in a separate web-based training in the near future.





**Polaris Group Solution Center  
Hotline Q&A  
“Where No Question Goes Unanswered!”**

**Question:**

What is the timeframe that a resident has to appeal to the Quality Improvement Organization (QIO) when the facility decides to take them off Medicare Part A?

**Answer:**

For an expedited review, the resident has until noon the day before the Effective Date identified on the NOMNC. For an untimely request, which is after noon on the day before the Effective Date, they would have up to 60 days from the effective date. The Medicare Claims Processing Manual, Chapter 30, Section 260.4.3 - Untimely Requests for Review says, “Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request”.

**Question:**

I received a claim that was rejected and CMS said to cancel the claim by using a D5 or a D6. According to my information, a D5 is for canceling a claim to correct HICN/ Provider ID and D6 is for canceling a claim only to repay duplicate or OIG Overpayment. Neither of these codes apply. Should I use indicator code D9 instead for any other changes?

**Answer:**

No use indicator code D6. This is used when canceling a claim.



**2017 WEBINAR TRAININGS**  
Polaris Group is pleased to offer the following **CEU approved** live Webinars

	<u>Date</u>
<b><u>New Survey Process Training</u></b> New Survey Process - November 2017 *New Topic	9/28
<b><u>Focus on Phase 2 &amp; New Appendix PP Training</u></b> *Hot Topic Focus on Phase 2 & New Appendix PP (2-Part Training)	9/21 & 22
<b><u>QAPI Training Series</u></b> Preparing for QAPI Initiative - Part 1	9/18
Quality Assurance (QA) Skill Building QAPI - Part 2	9/20
Process Improvement (PI) Skill Building - Part 3	9/27

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Comprehensive 3-day training workshops to implement a compliant and successful Medicare program

**Training Workshops for LTC  
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<b><u>Advanced Billing for SNFs</u></b> November 14-16 Tampa, FL	<b><u>SNF Billing - Basics &amp; More</u></b> September 19-21 Orlando, FL
<b><u>Surviving MAC/RAC/ZPIC Audits</u></b> November 8-9 Orlando, FL	

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**Contributors:**  
Debora Glatfelter, RN, RAC-CT  
Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA  
Marty Pachciarz, RN, RAC-CT  
Cynthia Wilkins, RN, MSN, LNHA  
Wendy Erickson, BSN, RN, RAC-CT, CCA

**Editor:**  
Chuck Cave, BS, CHC

**Production Manager:**  
Mica Meadows