CMS Medicare Update Proposal for FY 2018
Payment & Policy Changes for Skilled Nursing Facilities for FY 2018

Overview

On April 27, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule outlining proposed Fiscal Year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs).[1] According to CMS, the proposed rule proposes policies that continue a commitment to shift Medicare payments from volume to value, with continued implementation of the SNF Value-based Purchasing (VBP) program. CMS simultaneously released a Request for Information which is to be found on page 21090 of the proposed rule.

Major provisions of the proposed rule include proposals for the SNF Value-Based Purchasing Program, and the SNF Quality Reporting Program. The proposed rule also includes the Request for Information (RFI), a proposal for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP), and other key elements. The major FY 2018 proposals discussed in the rule are summarized below.

CMS will accept comments on the proposed rule until June 26, 2017. CMS will not respond to RFI comment submissions in the final rule, but rather will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

A. Changes to Payment Rates Under the SNF Prospective Payment System (SNF PPS)

Based on proposed changes contained within the proposed rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by $390 million, or 1.0 percent, from payments in FY 2017.

Pursuant to statutory mandate, CMS must establish and apply a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, CMS has developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2014 (78 FR 47939 through 47946), CMS revised and rebased the market basket index, which included updating the base year from FY 2004 to FY 2010.

For FY 2018, CMS is proposing to rebase and revise the SNF market basket, updating the base year from FY 2010 to 2014. This action would have resulted in an increase in the SNF market basket increase of 2.3%. However, Section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires a 1.0 percent market basket increase in post acute care provider updates. Thus, CMS is held to an update of 1percent. The SNF PPS payment update of 1% is disappointing. It comes MedPAC has determined an all-payer margin for SNFs of 1.6%; thus, 1% comes too close to the quick!.

Cynthia Morton, Executive Vice-President of the National Association for the Support of Long Term Care (NASL), commented that the 1% was not unexpected because of MACRA's limit on the update, an offset for paying for part of MACRA. But that did not make it good news. She added that it should be recognized that this rule like the one last year, represents **more costs** for providers who have to continue to report quality measures as required by the IMPACT Act's Quality Reporting Program.

[1] The proposed rule was published in the Federal Register on May 4, 2017, 82 **Federal Register 21014**, May 4, 2017. CMS-1679-P].

B. SNF Quality Reporting Program (QRP)

Under the SNF QRP, as required by the IMPACT Act, 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. In the FY 2018 proposed rule, CMS is proposing to replace the current pressure ulcer measure with an updated version of that measure and to adopt four new measures that address functional status for FY 2020. Proposed changes are as follows:

1. Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
2. Four outcome-based functional measures on resident functional status to align with the IRF QRP for FY2020:
    a. Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
    b. Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
    c. Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
    d. Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

Further, CMS is also proposing to begin publically reporting six new measures for display by fall 2018.

Beginning with the FY 2019 SNF QRP, SNFs must also report standardized patient assessment data. CMS proposes to satisfy this requirement for the FY 2019 SNF QRP using the data submitted on the existing pressure ulcer measure. For the FY 2020 program year, CMS is proposing that SNFs begin reporting standardized patient assessment data with respect to 5 specified patient assessment categories required by law that include:

1. Functional status;
2. Cognitive function;
3. Special services, treatments and interventions;
4. Medical conditions and co-morbidities; and
5. Impairments.

C. SNF Value-Based Purchasing Program (VBP)

CMS reports that the SNF VBP Program has adopted scoring and operational policies for its first year (FY 2019) and has specified measures and program features as required by statute. The FY 2018 SNF PPS proposed rule includes additional Program proposals, including a payment exchange function approach to implement value-based incentive payment adjustments beginning October 1, 2018. Scoring & Operational Updates: The SNF VBP Program's scoring and operational policies for its first year (FY 2019) include:

- The Program is limited to one readmission measure for each year.
- The Program requires the Secretary to reduce the total amount of Medicare payments to SNFs in a fiscal year by 2 percent reduction to fund the value-based incentive payments for that fiscal year.
- The total amount of value-based incentive payments that can be made to SNFs in a fiscal year is statutorily limited to between 50 percent and 70 percent of the total amount of the reduction to

SNF Medicare payments for that fiscal year.

- The Program must pay SNFs ranked in the lowest 40 percent less than the amount they would otherwise be paid in the absence of the SNF VBP.
- Both public and confidential facility performance reporting will be conducted.

In addition to the proposed logistical exchange function, SNF VBP Program proposed policies in the FY 2018 proposed rule include performance and baseline periods for the FY 2020 Program year, updated values for performance standards for FY 2020, additional details for the Review and Correction process for SNFs' performance information to be made public on Nursing Home Compare, and revising the previously-adopted rounding policy for SNF performance scores. Public comments on these proposals will be accepted through June 26, 2017.

D. End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act to require CMS to establish an ESRD QIP that selects measures, establishes performance standards, specifies a performance period for each payment year (PY), assesses the total performance of each facility, applies an appropriate payment reduction to each facility that does not meet a minimum TPS, and publicly reports the results.

The ESRD QIP is intended to promote high-quality care by dialysis facilities treating beneficiaries with ESRD. This program changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality measures. The ESRD QIP will reduce payments by up to two percent to ESRD facilities that do not meet or exceed a minimum total performance score (TPS).

E. Request for Information (RFI) at 82 Federal Register at 21090

As already indicated in addition to the proposed rule, CMS released a Request for Information (RFI) for continued feedback on the Medicare Program. CMS expresses the desire to start a national conversation about improving the health care delivery system and about how Medicare can contribute to making the delivery system less bureaucratic and complex. This includes reducing burden for clinicians, providers and patients in a way that increases quality of care and decreases costs – and thereby making the health care system more effective, simple and accessible while maintaining program integrity and preventing fraud.

CMS will not respond to RFI comment submissions in the final rule, but rather will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

F. Possible Burden Reduction in the Long-Term Care Requirements and Potential Center for Medicare and Medicaid Innovation MMI Models, and CMS Flexibilities and Efficiencies.

CMS is also soliciting comments on potential changes to the finalized Requirements for Long-Term Care Facilities that would result in a burden reduction if modified or eliminated; potential CMMI models or other demonstration projects that would reduce cost and increase quality of care for SNF, or more generally post-acute care patients, and ideas for CMS flexibility and efficiency.