SNF PPS
FY 2016 Final Rule

Rochelle Archuleta & Akin Demehin
AHA Policy

August 19, 2015

SNF PPS

Final Rule for FY 2016:

- ***Payment Update***
- ***Quality Reporting Program***
- ***Discussion***

American Hospital Association

FY 2016 Payment Provisions

Payment Update

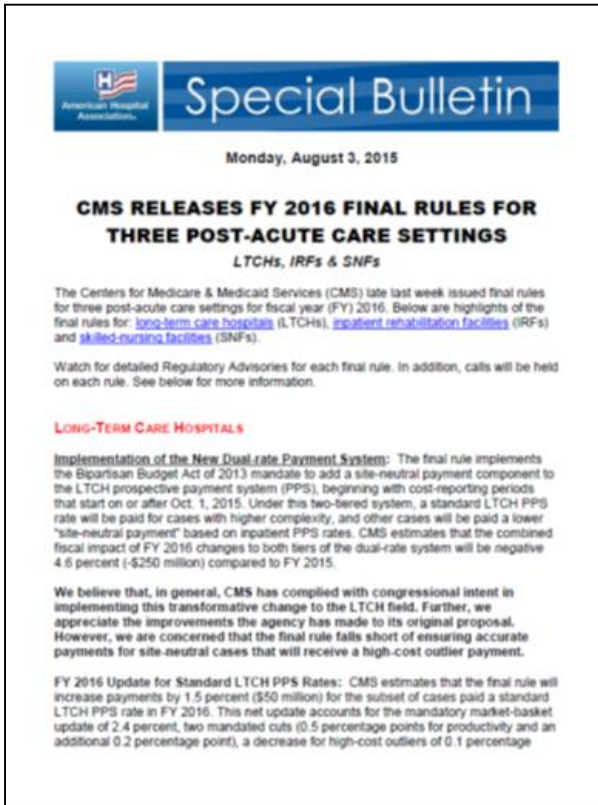
- SNF Market basket: +2.3%
- ACA productivity cut: -0.5%
- M.B. forecast error: -0.6%
- NET UPDATE: +1.2% ($430m)

Other Changes

- Labor related share: 69.1% (69.18 in FY 2015)
- ICD-10 for AIDs cases

Policy Clarifications

- HIT
- Consolidated billing
- Swing Beds
- Admin presumption



Special Bulletin

Monday, August 3, 2015

CMS RELEASES FY 2016 FINAL RULES FOR THREE POST-ACUTE CARE SETTINGS

LTCHs, IRFs & SNFs

The Centers for Medicare & Medicaid Services (CMS) late last week issued final rules for three post-acute care settings for fiscal year (FY) 2016. Below are highlights of the final rules for: long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and skilled-nursing facilities (SNFs).

Watch for detailed Regulatory Advisories for each final rule. In addition, calls will be held on each rule. See below for more information.

LONG-TERM CARE HOSPITALS

Implementation of the New Dual-rate Payment System: The final rule implements the Bipartisan Budget Act of 2013 mandate to add a site-neutral payment component to the LTCH prospective payment system (PPS), beginning with cost-reporting periods that start on or after Oct. 1, 2015. Under this two-tiered system, a standard LTCH PPS rate will be paid for cases with higher complexity, and other cases will be paid a lower "site-neutral payment" based on inpatient PPS rates. CMS estimates that the combined fiscal impact of FY 2016 changes to both tiers of the dual-rate system will be negative 4.6 percent (-$250 million) compared to FY 2015.

We believe that, in general, CMS has complied with congressional intent in implementing this transformative change to the LTCH field. Further, we appreciate the improvements the agency has made to its original proposal. However, we are concerned that the final rule falls short of ensuring accurate payments for site-neutral cases that will receive a high-cost outlier payment.

FY 2016 Update for Standard LTCH PPS Rates: CMS estimates that the final rule will increase payments by 1.5 percent ($50 million) for the subset of cases paid a standard LTCH PPS rate in FY 2016. This net update accounts for the mandatory market-basket update of 2.4 percent, two mandated cuts (0.5 percentage points for productivity and an additional 0.2 percentage point), a decrease for high-cost outliers of 0.1 percentage

Evolving SNF Quality Landscape

Nursing Home Quality Initiative (NHQI)	SNF Quality Reporting Program (SNF QRP)	SNF Value-Based Purchasing (SNF VBP)
Began 2002	Mandated by IMPACT Act	Mandated by PAMA of 2014
Uses MDS data	Pay-for-reporting	Pay-for-performance (2.0 percent withhold)
Basis of *Nursing Home Compare*	Non-reporting penalty (2.0%) starts FY 2018	Program starts in FY 2019

Long-term policy question:

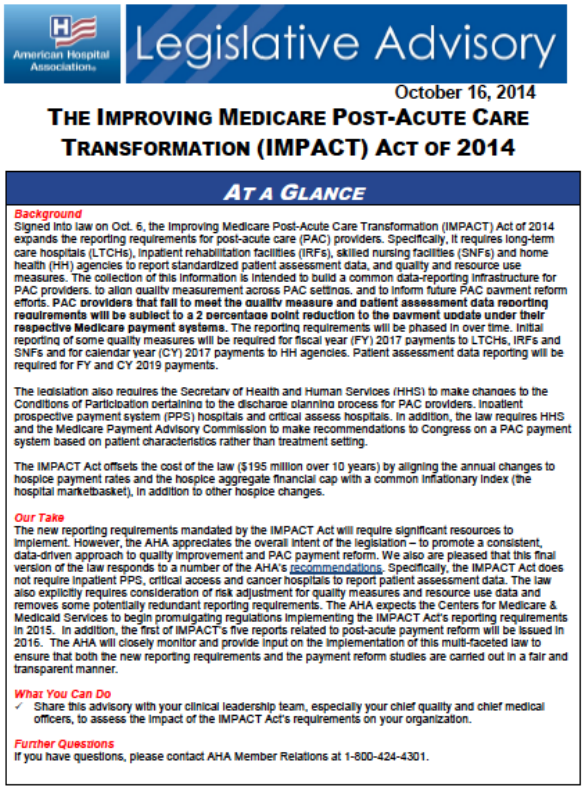
Do these programs work as an integrated whole?

American Hospital Association

= Addressed in FY 2016 SNF PPS Rule

Post-Acute Reporting Changes: IMPACT Act

- Signed into law Oct. 6, 2014
- Framed as creating "building blocks" of post-acute care reform through collection and reporting of "standardized and "interoperable":
  - Patient assessment data
  - Quality measures
- Expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HHAs
  - Payment penalties for non-reporting
- Significant regulatory activity in 2015



American Hospital Association Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to allow quality measurement across PAC settings, and to inform future PAC payment reform efforts. **PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers. Inpatient prospective payment system (PPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation -- to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

American Hospital Association

IMPACT Act – Patient Assessment Data Domains

To be addressed in future rulemaking

- **Functional status** (e.g., mobility, self care)
- **Cognitive function and mental status** (e.g., depression, ability to understand)
- **Special services, treatments, and interventions** (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- **Medical condition** (e.g., diabetes, CHF, comorbidities such as severe pressure ulcers)
- **Impairments** (e.g., incontinence, impaired and an impaired ability to hear, see, or swallow.
- Other categories deemed necessary and appropriate by the Secretary of HHS

American Hospital Association

IMPACT Act: Quality Measures

Measures must address following topics:

- **Functional Status**
- **Skin integrity**
- **Major falls**

Addressed in FY 2016 SNF PPS Final Rule

- Medication reconciliation
- Patients preferences
- Resource use, including at a minimum:
  - Medicare spending per beneficiary
  - Discharges to community
  - Potentially preventable admissions and readmissions

American Hospital Association

FY 2018 SNF QRP Measures: Functional Status

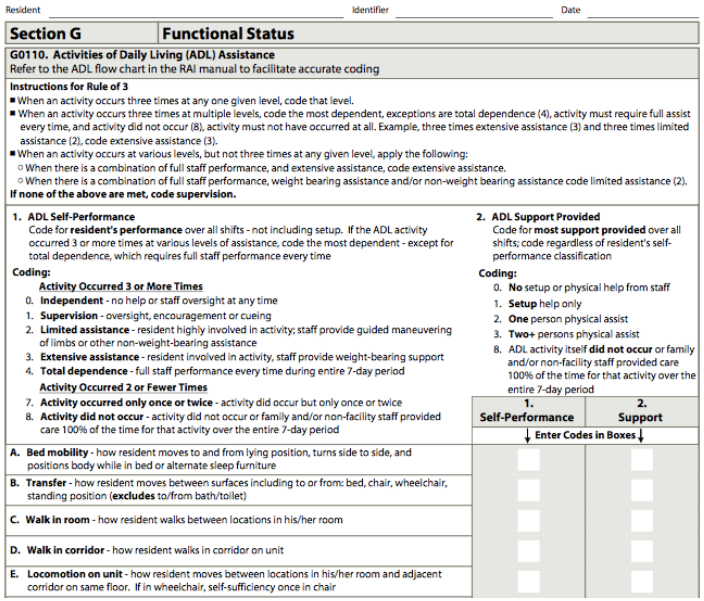
- Assesses the percentage of SNF residents who have functional status assessments completed on admission and discharge and that have care plan assessing function
  - **Does not measure functional status change, just completion of assessments**

- New items (n=26) will be added to the MDS to capture measure information
  - Clinicians score level of independence on self-care, mobility items on 6-level scale
  - To demonstrate a care plan “assesses function, at least one assessment item needs a numerical “goal”

- Data collection begins Oct. 1, 2016

American Hospital Association

FY 2018 SNF QRP Measure Proposals: Functional Status



Resident _____ Identifier _____ Date _____

Section G | **Functional Status**

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

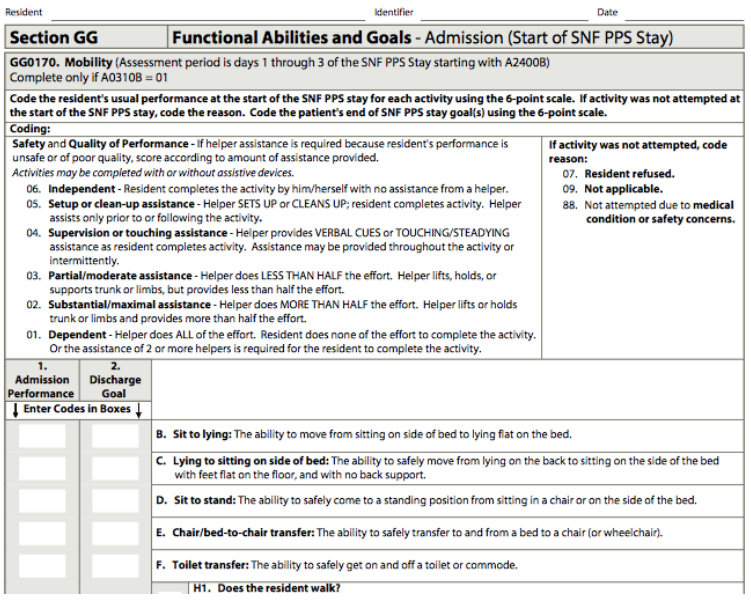
Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		
C. **Walk in room** - how resident walks between locations in his/her room		
D. **Walk in corridor** - how resident walks in corridor on unit		
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		

&



Resident _____ Identifier _____ Date _____

Section GG | **Functional Abilities and Goals** - Admission (Start of SNF PPS Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. **Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to safely get on and off a toilet or commode.
		H1. **Does the resident walk?**

- Measure data collected in addition to (not in place of) activities of daily living (ADLs) section of the MDS
- CMS would add SNF PPS discharge assessment
- **Area of concern:**
  - **Resource intensive (duplicative?) to collect and report**

American Hospital Association

FY 2018 SNF QRP Measures: Falls and Pressure Ulcers

- **Falls**
  - Assesses percentage of residents experiencing one or more falls with major injury
  - SNF QRP version of measure will reflect only SNF Part A covered patients (i.e., “short stay” patients)

- **Pressure Ulcers:** Assesses percentage of residents with one or more pressure ulcers new or worsened

- **Collected using MDS**
  - Measures already part of the NHQI, *Nursing Home Compare*, etc.
  - Addition of SNF discharge items to the MDS

American Hospital Association

FY 2018 SNF QRP: Other Programmatic Issues

- Addition of Part A Discharge (End of PPS Stay) items for measures

- Administrative processes
  - Measure retention / removal
  - Process for measure changes
  - Reconsideration process
  - Extraordinary circumstances exception

American Hospital Association

SNF Value-Based Purchasing: Finalized Measure

- SNF VBP program begins FY 2019
  - CMS must select measure of either all-cause readmissions or "potentially avoidable readmissions"
  - 2.0 percent withhold to create pool (but only 50-70 percent of funds paid back, and only those scoring above 40th percentile eligible for any incentive

- Measure
  - All-cause, unplanned hospital readmissions for SNF residents within 30 days discharge from IPPS hospital, CAH, IPF)
  - Only includes patients directly admitted to SNF (i.e., SNF admission must be within one day of prior proximal acute hospitalization)
    - However, also includes patients who may have already been discharged from SNF within the 30-day timeframe
  - Risk adjusted, **but lacks sociodemographic adjustment**

American Hospital Association

SNF Value-Based Purchasing: Issues to be addresses in future rulemaking

- Performance standards
- Scoring approach
- Measuring improvement
- Approach to public reporting / previewing of data

American Hospital Association

Questions
&
Discussion

American Hospital Association