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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 413, and 424

[CMS-1696-P]

RIN 0938-AT24

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2019. This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG-IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) effective October 1, 2019. It also proposes revisions to the regulation text that describes a beneficiary's SNF "resident" status under the consolidated billing provision and the required content of the SNF level of care certification. The proposed rule also includes proposals for the SNF Quality Reporting Program (QRP) and the Skilled Nursing Facility Value-Based Purchasing (VBP) Program that will affect Medicare payment to SNFs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS-1696-P. Because of staff and

resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1696-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1696-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Penny Gershman, (410) 786-6643, for information related to SNF PPS clinical issues.

John Kane, (410) 786-0557, for information related to the development of the payment rates and case-mix indexes.

Kia Sidbury, (410) 786-7816, for information related to the wage index.

Bill Ullman, (410) 786-5667, for information related to level of care determinations, consolidated billing, and general information.

Mary Pratt, (410) 786-6867, for information related to skilled nursing facility quality reporting program.

Celeste Bostic, (410) 786-5603, for information related to the skilled nursing facility value-based purchasing program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that website to view public comments.

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the Internet on the CMS website. The wage index tables for this proposed rule can be accessed on the SNF PPS Wage Index home

page, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Readers who experience any problems accessing any of these online SNF PPS wage index tables should contact Kia Sidbury at (410) 786-7816.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

Table of Contents

I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for FY 2019 as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It would also respond to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register,** before the August 1 that precedes the start of each fiscal year (FY), certain specified information relating to the payment update (see section II.C. of this proposed rule). This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG-IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) effective October 1, 2019. This proposed rule also proposes updates to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) and Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP).

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5) of the Act, the federal rates in this proposed rule would reflect an update to the rates that we published in the SNF PPS final rule for FY 2018 (82 FR 36530), as corrected in the FY 2018 SNF PPS correction notice (82 FR 46163), which reflects the SNF market basket update for FY 2019, as required by section 1888(e)(5)(B)(iv) of the Act (as added by section 53111 of the Bipartisan Budget Act of 2018) . This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG-IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM). It also proposes revisions at 42 CFR 411.15(p)(3)(iv), which describes a beneficiary's SNF "resident" status under the consolidated billing provision, and 42 CFR 424.20(a)(1)(i), which describes the required content of the SNF level of care certification. Furthermore, in accordance with section 1888(h) of the Act, this proposed rule proposes, beginning October 1, 2018, to reduce the adjusted federal per diem rate determined under section 1888(e)(4)(G) of the Act by 2 percent, and to adjust the resulting rate by the value-based incentive payment amount earned by the SNF for that fiscal year under the SNF VBP Program. Additionally, this proposed rule proposes to update requirements for the SNF VBP, including requirements that would apply to the FY 2021 SNF VBP program year, changes to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception policy for the SNF VBP Program. Finally, this rule proposes to update requirements for the SNF QRP, including adopting a new quality measure removal factor and codifying in our regulations a number of requirements.

C. Summary of Cost and Benefits

TABLE 1: Cost and Benefits

Provision Description	Total Transfers
Proposed FY 2019 SNF PPS payment rate update.	The overall economic impact of this proposed rule would be an estimated increase of $850 million in aggregate payments to SNFs during FY 2019.
Proposed FY 2019 SNF VBP changes.	The overall economic impact of the SNF VBP Program is an estimated reduction of $211 million in aggregate payments to SNFs during FY 2019.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for us. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[1] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[2] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce costs including, the collection and reporting burden while producing quality measurement that is more focused on

[1] Meaningful Measures web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.

[2] See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html

meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures);
- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in Table 2:

TABLE 2: Meaningful Measures Framework Domains and Measure Areas

Quality Priority	Meaningful Measure Area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections
	Preventable Healthcare Harm
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals
	End of Life Care according to Preferences
	Patient's Experience of Care
	Patient Reported Functional Outcomes
Promote Effective Communication and Coordination of Care	Medication Management
	Admissions and Readmissions to Hospitals
	Transfer of Health Information and Interoperability
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care
	Management of Chronic Conditions
	Prevention, Treatment, and Management of Mental Health
	Prevention and Treatment of Opioid and Substance Use Disorders
	Risk Adjusted Mortality
Work with Communities to Promote Best Practices	Equity of Care

Quality Priority	Meaningful Measure Area
of Healthy Living	Community Engagement
Make Care Affordable	Appropriate Use of Healthcare
	Patient-focused Episode of Care
	Risk Adjusted Total Cost of Care

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers and promoting operational efficiencies.

E. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

The IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further interoperability in post-acute care, CMS is developing a Data Element Library to serve as a publicly available centralized, authoritative resource for standardized data elements and their

associated mappings to health IT standards. These interoperable data elements can reduce provider burden by allowing the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2018 Interoperability Standards Advisory (ISA) is available at https://www.healthit.gov/standards-advisory .

Most recently, the 21st Century Cures Act (Pub. L. 114-255), enacted in late 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, Congress directed ONC to "develop or support a trusted exchange framework, including a common agreement among health information networks nationally." This framework (https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another important provision, Congress defined "information blocking" as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, and established new authority for HHS to discourage these practices.

We invite providers to learn more about these important developments and how they are likely to affect SNFs.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997, Pub. L. 105-33, enacted on August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf.

Section 215(a) of Protecting Access to Medicare Act of 2014 (Pub. L. 113-93, enacted on April 1, 2014) (PAMA) added section 1888(g) to the Act requiring the Secretary to specify an all-cause all-condition hospital readmission measure and an all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a VBP program for SNFs. Finally, section 2(c)(4) of the IMPACT Act added section 1888(e)(6) to the Act, which requires the Secretary to implement a quality reporting program for SNFs under which SNFs report data on measures and resident assessment data.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and 1888(e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the federal case-mix adjusted rate. The transition extended through the facility's first 3 cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments for SNFs entirely on the adjusted federal per diem rates, we no longer include adjustment factors under the transition related to facility-specific rates for the upcoming FY.

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2018 (82 FR 36530), as corrected in the FY 2018 SNF PPS correction notice (82 FR 46163).

Section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** of the following:

- The unadjusted federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- The factors to be applied in making the area wage adjustment for these services.

Along with other proposed revisions discussed later in this preamble, this proposed rule would provide the required annual updates to the per diem payment rates for SNFs for FY 2019.

III. SNF PPS Rate Setting Methodology and FY 2019 Update

A. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the federal rates also incorporated a Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would have been payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for geographic variations in wages and for the costs of facility differences in case mix. In compiling the database used to compute the federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA 1997 prescribed, we set the federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas, and adjusted the portion of the federal rate attributable to wage-related costs by a wage index to reflect geographic variations in wages.

B. SNF Market Basket Update

1. SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish 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, we have 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 2018 (82 FR 36548 through 36566), we revised and rebased the market basket index, which included updating the base year from FY 2010 to 2014.

The SNF market basket index is used to compute the market basket percentage change that is used to update the SNF federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage update is adjusted by a forecast error correction, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule. For FY 2019, the growth rate of the 2014-based SNF market basket is estimated to be 2.7 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2018 forecast with historical data through fourth quarter 2017, before the multifactor productivity adjustment is applied.

However, we note that section 53111 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, enacted on February 9, 2018) (BBA 2018) amended section 1888(e) of the Act to add section 1888(e)(5)(B)(iv) of the Act. Section 1888(e)(5)(B)(iv) of the Act establishes a special rule for FY 2019 that requires the market basket percentage, after the application of the productivity adjustment, to be 2.4 percent. In accordance with section 1888(e)(5)(B)(iv) of the Act, we will use a market basket percentage of 2.4 percent to update the federal rates set forth in this proposed rule. We propose to revise §413.337(d) to reflect this statutorily required 2.4 percent market basket percentage for FY 2019. In addition, to conform with section 1888(e)(5)(B)(iii) of the Act, we propose to update the regulations to reflect the 1 percent market

basket percentage required for FY 2018 (as discussed in the FY 2018 SNF PPS final rule, 82 FR 36533). Accordingly, we are proposing to revise paragraph (d)(1) of §413.337, which sets forth the market basket update formula, by revising paragraph (d)(1)(v), and by adding paragraphs (d)(1)(vi) and (d)(1)(vii). The proposed revision to add paragraph (d)(1)(vi) would reflect section 1888(e)(5)(B)(iii) of the Act (as added by section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10)), which establishes a special rule for FY 2018 that requires the market basket percentage, after the application of the productivity adjustment, to be 1.0 percent. The proposed revision to add paragraph (d)(1)(vii) would reflect section 1888(e)(5)(B)(iv) of the Act (as added by section 53111 of BBA 2018), which establishes a special rule for FY 2019 that requires the market basket percentage, after the application of the productivity adjustment, to be 2.4 percent. These statutory provisions are self-implementing and do not require the exercise of discretion by the Secretary. In section III.B.5. of this proposed rule, we discuss the specific application of the BBA 2018-specified market basket adjustment to the forthcoming annual update of the SNF PPS payment rates. In addition, in section III.B.5 of this proposed rule, we discuss the 2 percent reduction applied to the market basket update for those SNFs that fail to submit measures data as required by section 1888(e)(6)(A) of the Act.

2. Use of the SNF Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of the previous FY to the midpoint of the current FY. Absent the addition of section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of BBA 2018, we would have used the percentage change in the SNF market basket index to compute the update factor for FY 2019. This factor is based on the IGI first quarter 2018 forecast (with historical data through the fourth quarter 2017) of the FY 2019

percentage increase in the 2014-based SNF market basket index reflecting routine, ancillary, and capital-related expenses. The estimated SNF market basket percentage is 2.7 percent for FY 2019. As discussed in sections III.B.3. and III.B.4. of this proposed rule, this market basket percentage change would be reduced by the applicable forecast error correction (as described in §413.337(d)(2)) and by the MFP adjustment as required by section 1888(e)(5)(B)(ii) of the Act. As noted previously, section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of the BBA 2018, requires us to update the SNF PPS rates for FY 2019 using a 2.4 percent market basket percentage change, instead of the estimated 2.7 percent market basket percentage change adjusted by the multifactor productivity adjustment as described below. Additionally, as discussed in section II.B. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full federal rates that started with cost reporting periods beginning in July 1998 has expired.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003 final rule (68 FR 46057 through 46059), §413.337(d)(2) provides for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule

(72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will reflect both upward and downward adjustments, as appropriate.

For FY 2017 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.7 percentage points, while the actual increase for FY 2017 was 2.7 percentage points, resulting in the actual increase being the same as the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the FY 2019 market basket percentage change of 2.7 percent would not have been adjusted to account for the forecast error correction. Table 3 shows the forecasted and actual market basket amounts for FY 2017.

TABLE 3: Difference Between the Forecasted and Actual Market Basket Increases for FY 2017

Index	Forecasted FY 2017 Increase*	Actual FY 2017 Increase**	FY 2017 Difference
SNF	2.7	2.7	0.0

*Published in **Federal Register**; based on second quarter 2016 IGI forecast (2010-based index).
**Based on the first quarter 2018 IGI forecast, with historical data through the fourth quarter 2017 (2010-based index).

4. Multifactor Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010) (Affordable Care Act) requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the multifactor productivity (MFP) adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the MFP adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the

applicable FY, year, cost-reporting period, or other annual period). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS website at http://www.bls.gov/mfp for the BLS historical published MFP data.

MFP is derived by subtracting the contribution of labor and capital inputs growth from output growth. The projections of the components of MFP are currently produced by IGI, a nationally recognized economic forecasting firm with which CMS contracts to forecast the components of the market baskets and MFP. To generate a forecast of MFP, IGI replicates the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models. For a discussion of the MFP projection methodology, we refer readers to the FY 2012 SNF PPS final rule (76 FR 48527 through 48529) and the FY 2016 SNF PPS final rule (80 FR 46395). A complete description of the MFP projection methodology is available on our website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.

a. Incorporating the MFP Adjustment into the Market Basket Update

Per section 1888(e)(5)(A) of the Act, the Secretary shall establish 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. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY,

and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding fiscal year.

The MFP adjustment, calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2019, is estimated to be 0.8 percent. Also, consistent with section 1888(e)(5)(B)(i) of the Act and §413.337(d)(2), the market basket percentage for FY 2019 for the SNF PPS would be based on IGI's first quarter 2018 forecast of the SNF market basket percentage, which is estimated to be 2.7 percent.

If not for the enactment of section 53111 of the BBA 2018, the FY 2019 update would be calculated in accordance with section 1888(e)(5)(B)(i) and (ii) of the Act, pursuant to which the market basket percentage determined under section 1888(e)(5)(B)(i) of the Act (that is, 2.7 percent) would be reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2019) of 0.8 percent, which would be calculated as described above and based on IGI's first quarter 2018 forecast. Absent the enactment of section 53111 of the BBA 2018, the resulting MFP-adjusted SNF market basket update would have been equal to 1.9 percent, or 2.7 percent less 0.8 percentage point. However, as discussed above, section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of the BBA 2018, requires us to apply a 2.4 percent market basket percentage increase in determining the FY 2019 SNF payment rates set forth in this proposed rule (without regard to the MFP adjustment described above).

5. Market Basket Update Factor for FY 2019

Sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(i) of the Act require that the update factor used to establish the FY 2019 unadjusted federal rates be at a level equal to the market basket index percentage change. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2017, through September 30, 2018 to the average market basket level for the period of October 1, 2018, through September 30, 2019. This process

yields a percentage change in the 2014-based SNF market basket of 2.7 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust the market basket percentage change by the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the difference between the forecasted FY 2017 SNF market basket percentage change and the actual FY 2017 SNF market basket percentage change (FY 2017 is the most recently available FY for which there is historical data) did not exceed the 0.5 percentage point threshold, the FY 2019 market basket percentage change of 2.7 percent would not be adjusted by the forecast error correction.

If not for the enactment of section 53111 of the BBA 2018, the SNF market basket for FY 2019 would be determined in accordance with section 1888(e)(5)(B)(ii) of the Act, which requires us to reduce the market basket percentage change by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2019) of 0.8 percent, as described in section III.B.4. of this proposed rule. Thus, absent the enactment of the BBA 2018, the resulting net SNF market basket update would equal 1.9 percent, or 2.7 percent less the 0.8 percentage point MFP adjustment. We note that our policy has been that, if more recent data become available (for example, a more recent estimate of the SNF market basket and/or MFP adjustment), we would use such data, if appropriate, to determine the SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the SNF PPS final rule.

Historically, we have used the SNF market basket, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices from one year to the next. However, section 1888(e)(5)(B)(iv) of the Act, as added by section

53111 of the BBA 2018, requires us to use a market basket percentage of 2.4 percent, after application of the MFP to adjust the federal rates for FY 2019. Under section 1888(e)(5)(B)(iv) of the Act, the market basket percentage increase used to determine the federal rates set forth in this proposed rule will be 2.4 percent for FY 2019. Tables 4 and 5 reflect the updated components of the unadjusted federal rates for FY 2019, prior to adjustment for case-mix.

TABLE 4: FY 2019 Unadjusted Federal Rate Per Diem--URBAN

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$181.50	$136.71	$18.01	$92.63

TABLE 5: FY 2019 Unadjusted Federal Rate Per Diem--RURAL

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$173.39	$157.65	$19.23	$94.34

In addition, we note that section 1888(e)(6)(A)(i) of the Act provides that, beginning with FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year involved, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket index percentage change being less than 0.0 for a fiscal year, and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act applies only with respect to the fiscal year involved, that the reduction cannot be taken into account in computing the payment amount for a subsequent fiscal year.

Accordingly, we propose that for SNFs that do not satisfy the reporting requirements for the FY 2019 SNF QRP, we would apply a 2.0 percentage point reduction to the SNF market basket percentage change for that fiscal year, after application of any applicable forecast error adjustment as specified in §413.337(d)(2) and the MFP adjustment as specified in §413.337(d)(3). For FY 2019, the application of this reduction to SNFs that have not met the requirements for the FY 2019 SNF QRP would result in a market basket index percentage change for FY 2019 that is less than zero (specifically, a net update of negative 0.1 percentage point, derived by subtracting 2 percent from the MFP-adjusted market basket update of 1.9 percent), and would also result in FY 2019 payment rates that are less than such payment rates for the preceding FY. We invite comments on these proposals.

C. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the interim final rule with comment period that initially implemented the SNF PPS (63 FR 26252, May 12, 1998), we developed the RUG-III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG-III, but also to create case-mix indexes (CMIs). The original RUG-III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the SNF PPS proposed rule for

FY 2010 (74 FR 22208), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting Resource Utilization Groups, Version 4 (RUG-IV) case-mix classification system reflected the data collected in 2006 through 2007 during the STRIVE project, and was finalized in the FY 2010 SNF PPS final rule (74 FR 40288) to take effect in FY 2011 concurrently with an updated new resident assessment instrument, version 3.0 of the Minimum Data Set (MDS 3.0), which collects the clinical data used for case-mix classification under RUG-IV.

We note that case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy services. The case-mix classification system uses clinical data from the MDS to assign a case-mix group to each patient that is then used to calculate a per diem payment under the SNF PPS. As discussed in section IV.A. of this proposed rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the time frames for MDS completion in our Resident Assessment Instrument (RAI) Manual. For an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html .

In addition, we note that section 511 of the Medicare Prescription Drug, Improvement,

and Modernization Act of 2003 (Pub. L. 108-173, enacted December 8, 2003) (MMA) amended section 1888(e)(12) of the Act to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. The MMA add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.gov/transmittals/downloads/r160cp.pdf. In the SNF PPS final rule for FY 2010 (74 FR 40288), we did not address this certification in that final rule's implementation of the case-mix refinements for RUG-IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect for the time being. (We discuss in section V.I. of this proposed rule the specific payment adjustments that we are proposing under the proposed PDPM to provide for an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents.)

For the limited number of SNF residents that qualify for the MMA add-on, there is a significant increase in payments. As explained in the FY 2016 SNF PPS final rule (80 FR 46397 through 46398), on October 1, 2015 (consistent with section 212 of PAMA), we converted to using ICD-10-CM code B20 to identify those residents for whom it is appropriate to apply the AIDS add-on established by section 511 of the MMA. For FY 2019, an urban facility with a resident with AIDS in RUG-IV group "HC2" would have a case-mix adjusted per diem payment of $453.68 (see Table 6) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted per diem payment of approximately $1,034.39.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2019 payment rates set forth in this proposed rule reflect the use of the RUG-IV case-mix classification system from October 1, 2018, through September 30, 2019. We list the proposed case-mix adjusted RUG-IV payment rates for FY 2019, provided separately for urban and rural SNFs, in Tables 6 and 7 with corresponding case-mix values. We use the revised OMB delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634) to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. Tables 6 and 7 do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the MMA, which we apply only after making all other adjustments (such as wage index and case-mix). Additionally, Tables 6 and 7 do not reflect adjustments which may be made to the SNF PPS rates as a result of either the SNF Quality Reporting Program (QRP), discussed in section VI.B. of this proposed rule, or the SNF Value Based-Purchasing (VBP) program, discussed in section VI.C. of this proposed rule.

TABLE 6: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes--URBAN

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$484.61	$255.65		$92.63	$832.89
RUL	2.57	1.87	$466.46	$255.65		$92.63	$814.74
RVX	2.61	1.28	$473.72	$174.99		$92.63	$741.34
RVL	2.19	1.28	$397.49	$174.99		$92.63	$665.11
RHX	2.55	0.85	$462.83	$116.20		$92.63	$671.66
RHL	2.15	0.85	$390.23	$116.20		$92.63	$599.06
RMX	2.47	0.55	$448.31	$75.19		$92.63	$616.13
RML	2.19	0.55	$397.49	$75.19		$92.63	$565.31
RLX	2.26	0.28	$410.19	$38.28		$92.63	$541.10
RUC	1.56	1.87	$283.14	$255.65		$92.63	$631.42
RUB	1.56	1.87	$283.14	$255.65		$92.63	$631.42
RUA	0.99	1.87	$179.69	$255.65		$92.63	$527.97
RVC	1.51	1.28	$274.07	$174.99		$92.63	$541.69
RVB	1.11	1.28	$201.47	$174.99		$92.63	$469.09
RVA	1.10	1.28	$199.65	$174.99		$92.63	$467.27
RHC	1.45	0.85	$263.18	$116.20		$92.63	$472.01
RHB	1.19	0.85	$215.99	$116.20		$92.63	$424.82
RHA	0.91	0.85	$165.17	$116.20		$92.63	$374.00
RMC	1.36	0.55	$246.84	$75.19		$92.63	$414.66
RMB	1.22	0.55	$221.43	$75.19		$92.63	$389.25
RMA	0.84	0.55	$152.46	$75.19		$92.63	$320.28
RLB	1.50	0.28	$272.25	$38.28		$92.63	$403.16
RLA	0.71	0.28	$128.87	$38.28		$92.63	$259.78
ES3	3.58		$649.77		$18.01	$92.63	$760.41
ES2	2.67		$484.61		$18.01	$92.63	$595.25
ES1	2.32		$421.08		$18.01	$92.63	$531.72
HE2	2.22		$402.93		$18.01	$92.63	$513.57
HE1	1.74		$315.81		$18.01	$92.63	$426.45
HD2	2.04		$370.26		$18.01	$92.63	$480.90
HD1	1.60		$290.40		$18.01	$92.63	$401.04
HC2	1.89		$343.04		$18.01	$92.63	$453.68
HC1	1.48		$268.62		$18.01	$92.63	$379.26
HB2	1.86		$337.59		$18.01	$92.63	$448.23
HB1	1.46		$264.99		$18.01	$92.63	$375.63
LE2	1.96		$355.74		$18.01	$92.63	$466.38
LE1	1.54		$279.51		$18.01	$92.63	$390.15
LD2	1.86		$337.59		$18.01	$92.63	$448.23
LD1	1.46		$264.99		$18.01	$92.63	$375.63
LC2	1.56		$283.14		$18.01	$92.63	$393.78
LC1	1.22		$221.43		$18.01	$92.63	$332.07
LB2	1.45		$263.18		$18.01	$92.63	$373.82
LB1	1.14		$206.91		$18.01	$92.63	$317.55
CE2	1.68		$304.92		$18.01	$92.63	$415.56

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
CE1	1.50		$272.25		$18.01	$92.63	$382.89
CD2	1.56		$283.14		$18.01	$92.63	$393.78
CD1	1.38		$250.47		$18.01	$92.63	$361.11
CC2	1.29		$234.14		$18.01	$92.63	$344.78
CC1	1.15		$208.73		$18.01	$92.63	$319.37
CB2	1.15		$208.73		$18.01	$92.63	$319.37
CB1	1.02		$185.13		$18.01	$92.63	$295.77
CA2	0.88		$159.72		$18.01	$92.63	$270.36
CA1	0.78		$141.57		$18.01	$92.63	$252.21
BB2	0.97		$176.06		$18.01	$92.63	$286.70
BB1	0.90		$163.35		$18.01	$92.63	$273.99
BA2	0.70		$127.05		$18.01	$92.63	$237.69
BA1	0.64		$116.16		$18.01	$92.63	$226.80
PE2	1.50		$272.25		$18.01	$92.63	$382.89
PE1	1.40		$254.10		$18.01	$92.63	$364.74
PD2	1.38		$250.47		$18.01	$92.63	$361.11
PD1	1.28		$232.32		$18.01	$92.63	$342.96
PC2	1.10		$199.65		$18.01	$92.63	$310.29
PC1	1.02		$185.13		$18.01	$92.63	$295.77
PB2	0.84		$152.46		$18.01	$92.63	$263.10
PB1	0.78		$141.57		$18.01	$92.63	$252.21
PA2	0.59		$107.09		$18.01	$92.63	$217.73
PA1	0.54		$98.01		$18.01	$92.63	$208.65

TABLE 7: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes--RURAL

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$462.95	$294.81		$94.34	$852.10
RUL	2.57	1.87	$445.61	$294.81		$94.34	$834.76
RVX	2.61	1.28	$452.55	$201.79		$94.34	$748.68
RVL	2.19	1.28	$379.72	$201.79		$94.34	$675.85
RHX	2.55	0.85	$442.14	$134.00		$94.34	$670.48
RHL	2.15	0.85	$372.79	$134.00		$94.34	$601.13
RMX	2.47	0.55	$428.27	$86.71		$94.34	$609.32
RML	2.19	0.55	$379.72	$86.71		$94.34	$560.77
RLX	2.26	0.28	$391.86	$44.14		$94.34	$530.34
RUC	1.56	1.87	$270.49	$294.81		$94.34	$659.64
RUB	1.56	1.87	$270.49	$294.81		$94.34	$659.64
RUA	0.99	1.87	$171.66	$294.81		$94.34	$560.81
RVC	1.51	1.28	$261.82	$201.79		$94.34	$557.95
RVB	1.11	1.28	$192.46	$201.79		$94.34	$488.59
RVA	1.10	1.28	$190.73	$201.79		$94.34	$486.86
RHC	1.45	0.85	$251.42	$134.00		$94.34	$479.76
RHB	1.19	0.85	$206.33	$134.00		$94.34	$434.67
RHA	0.91	0.85	$157.78	$134.00		$94.34	$386.12
RMC	1.36	0.55	$235.81	$86.71		$94.34	$416.86
RMB	1.22	0.55	$211.54	$86.71		$94.34	$392.59
RMA	0.84	0.55	$145.65	$86.71		$94.34	$326.70
RLB	1.50	0.28	$260.09	$44.14		$94.34	$398.57
RLA	0.71	0.28	$123.11	$44.14		$94.34	$261.59
ES3	3.58		$620.74		$19.23	$94.34	$734.31
ES2	2.67		$462.95		$19.23	$94.34	$576.52
ES1	2.32		$402.26		$19.23	$94.34	$515.83
HE2	2.22		$384.93		$19.23	$94.34	$498.50
HE1	1.74		$301.70		$19.23	$94.34	$415.27
HD2	2.04		$353.72		$19.23	$94.34	$467.29
HD1	1.60		$277.42		$19.23	$94.34	$390.99
HC2	1.89		$327.71		$19.23	$94.34	$441.28
HC1	1.48		$256.62		$19.23	$94.34	$370.19
HB2	1.86		$322.51		$19.23	$94.34	$436.08
HB1	1.46		$253.15		$19.23	$94.34	$366.72
LE2	1.96		$339.84		$19.23	$94.34	$453.41
LE1	1.54		$267.02		$19.23	$94.34	$380.59
LD2	1.86		$322.51		$19.23	$94.34	$436.08
LD1	1.46		$253.15		$19.23	$94.34	$366.72
LC2	1.56		$270.49		$19.23	$94.34	$384.06
LC1	1.22		$211.54		$19.23	$94.34	$325.11
LB2	1.45		$251.42		$19.23	$94.34	$364.99
LB1	1.14		$197.66		$19.23	$94.34	$311.23
CE2	1.68		$291.30		$19.23	$94.34	$404.87
CE1	1.50		$260.09		$19.23	$94.34	$373.66
CD2	1.56		$270.49		$19.23	$94.34	$384.06
CD1	1.38		$239.28		$19.23	$94.34	$352.85

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
CC2	1.29		$223.67		$19.23	$94.34	$337.24
CC1	1.15		$199.40		$19.23	$94.34	$312.97
CB2	1.15		$199.40		$19.23	$94.34	$312.97
CB1	1.02		$176.86		$19.23	$94.34	$290.43
CA2	0.88		$152.58		$19.23	$94.34	$266.15
CA1	0.78		$135.24		$19.23	$94.34	$248.81
BB2	0.97		$168.19		$19.23	$94.34	$281.76
BB1	0.90		$156.05		$19.23	$94.34	$269.62
BA2	0.70		$121.37		$19.23	$94.34	$234.94
BA1	0.64		$110.97		$19.23	$94.34	$224.54
PE2	1.50		$260.09		$19.23	$94.34	$373.66
PE1	1.40		$242.75		$19.23	$94.34	$356.32
PD2	1.38		$239.28		$19.23	$94.34	$352.85
PD1	1.28		$221.94		$19.23	$94.34	$335.51
PC2	1.10		$190.73		$19.23	$94.34	$304.30
PC1	1.02		$176.86		$19.23	$94.34	$290.43
PB2	0.84		$145.65		$19.23	$94.34	$259.22
PB1	0.78		$135.24		$19.23	$94.34	$248.81
PA2	0.59		$102.30		$19.23	$94.34	$215.87
PA1	0.54		$93.63		$19.23	$94.34	$207.20

D. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We propose to continue this practice for FY 2019, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF

payments. For FY 2019, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2014 and before October 1, 2015 (FY 2015 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554, enacted on December 21, 2000) (BIPA) authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the Inpatient Prospective Payment System (IPPS) wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are inpatient hospitals. Therefore, while we continue to believe that the development of such an audit process could improve SNF cost reports in such a manner as to permit us to establish a SNF-specific wage index, we do not regard an undertaking of this magnitude as being feasible within the current level of programmatic resources.

In addition, we propose to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2019 SNF PPS wage index. For rural geographic areas that do not have hospitals, and therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy.

For FY 2019, there are no rural geographic areas that do not have hospitals, and thus, this methodology would not be applied. For rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we would use the average wage indexes of all of the urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2019, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. The proposed wage index applicable to FY 2019 is set forth in Tables A and B available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the OMB Bulletin No. 03-04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB

Bulletin No. 13-01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13-01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010 in the **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15-01, which provides minor updates to and supersedes OMB Bulletin No. 13-01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15-01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15-01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), we wish to note that this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index.

On August 15 2017, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Areas (OMB Bulletin No. 17–01). The new urban CBSA is as follows:

- Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

The OMB bulletin is available on the OMB Web site at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2017/b-17-01.pdf. We note, we did not have sufficient time to include this change in the computation of the proposed

FY 2019 wage index, rate setting, and tables. This new CBSA may affect the budget neutrality factor and wage indexes, depending on the impact of the overall payments of the hospital located in this new CBSA. In this proposed rule, we are providing an estimate of this new area's wage index based on the estimated average hourly wage, unadjusted for occupational mix, for new CBSA 46300 and the national average hourly wages from the wage data for the proposed FY 2019 wage index. Currently, provider 130002 is the only hospital located in Twin Falls County, Idaho, and there are no hospitals located in Jerome County, Idaho. Thus, the proposed wage index for CBSA 46300 is calculated using the average hourly wage data for one provider (provider 130002).

Taking the estimated unadjusted average hourly wage of $35.833564813 of new CBSA 46300 and dividing by the national average hourly wage of $42.990625267 results in the estimated wage index of 0.8335 for CBSA 46300.

In the final rule, we would incorporate this change into the final FY 2019 wage index, rate setting and tables. Thus, for FY 2019, we would use the OMB delineations that were adopted beginning with FY 2015 to calculate the area wage indexes, with updates as reflected in OMB Bulletin Nos. 15-01 and 17-01. As noted above, the proposed wage index applicable to FY 2019 (without the CBSA update from OMB Bulletin No. 17-01 specified above) is set forth in Tables A and B available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Once calculated, we would apply the wage index adjustment to the labor-related portion of the federal rate. Each year, we calculate a revised labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are labor-intensive and vary with the local labor market) in the input price index. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), we finalized a proposal to revise the labor-related share to

reflect the relative importance of the 2014-based SNF market basket cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2019. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2019 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2019 in four steps. First, we compute the FY 2019 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2019 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2019 relative importance for each cost category by multiplying this ratio by the base year (2014) weight. Finally, we add the FY 2019 relative importance for each of the labor-related cost categories (Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-related services, and a portion of Capital-Related expenses) to produce the FY 2019 labor-related relative importance. Table 8 summarizes the proposed updated labor-related share for FY 2019, compared to the labor-related share that was used for the FY 2018 SNF PPS final rule.

TABLE 8: Labor-Related Relative Importance, FY 2018 and FY 2019

	Relative importance, labor-related, FY 2018 17:2 forecast[1]	**Relative importance, labor-related, FY 2019 18:1 forecast**[2]
Wages and salaries	50.3	50.3
Employee benefits	10.2	10.2
Professional Fees: Labor-Related	3.7	3.7
Administrative and facilities support services	0.5	0.5
Installation, Maintenance and Repair Services	0.6	0.6
All Other: Labor Related Services	2.5	2.5
Capital-related (.391)	3.0	2.9
Total	**70.8**	**70.7**

[1] Published in the **Federal Register**; based on second quarter 2017 IGI forecast
[2] Based on first quarter 2018 IGI forecast, with historical data through fourth quarter 2017.

Tables 9 and 10 show the proposed RUG-IV case-mix adjusted federal rates for FY 2019 by labor-related and non-labor-related components. Tables 9 and 10 do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the MMA, which we apply only after making all other adjustments (such as wage index and case-mix). Additionally, Tables 9 and 10 do not reflect adjustments which may be made to the SNF PPS rates as a result of either the SNF Quality Reporting Program (QRP), discussed in section VI.B. of this proposed rule, or the SNF Value Based-Purchasing (VBP) program, discussed in section VI.C. of this proposed rule.

TABLE 9: RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs By Labor and Non-Labor Component

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	$832.89	$588.85	$244.04
RUL	$814.74	$576.02	$238.72
RVX	$741.34	$524.13	$217.21
RVL	$665.11	$470.23	$194.88
RHX	$671.66	$474.86	$196.80
RHL	$599.06	$423.54	$175.52
RMX	$616.13	$435.60	$180.53
RML	$565.31	$399.67	$165.64
RLX	$541.10	$382.56	$158.54
RUC	$631.42	$446.41	$185.01
RUB	$631.42	$446.41	$185.01
RUA	$527.97	$373.27	$154.70
RVC	$541.69	$382.97	$158.72
RVB	$469.09	$331.65	$137.44
RVA	$467.27	$330.36	$136.91
RHC	$472.01	$333.71	$138.30
RHB	$424.82	$300.35	$124.47
RHA	$374.00	$264.42	$109.58
RMC	$414.66	$293.16	$121.50
RMB	$389.25	$275.20	$114.05
RMA	$320.28	$226.44	$93.84
RLB	$403.16	$285.03	$118.13
RLA	$259.78	$183.66	$76.12
ES3	$760.41	$537.61	$222.80
ES2	$595.25	$420.84	$174.41
ES1	$531.72	$375.93	$155.79
HE2	$513.57	$363.09	$150.48
HE1	$426.45	$301.50	$124.95
HD2	$480.90	$340.00	$140.90
HD1	$401.04	$283.54	$117.50
HC2	$453.68	$320.75	$132.93
HC1	$379.26	$268.14	$111.12
HB2	$448.23	$316.90	$131.33
HB1	$375.63	$265.57	$110.06

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
LE2	$466.38	$329.73	$136.65
LE1	$390.15	$275.84	$114.31
LD2	$448.23	$316.90	$131.33
LD1	$375.63	$265.57	$110.06
LC2	$393.78	$278.40	$115.38
LC1	$332.07	$234.77	$97.30
LB2	$373.82	$264.29	$109.53
LB1	$317.55	$224.51	$93.04
CE2	$415.56	$293.80	$121.76
CE1	$382.89	$270.70	$112.19
CD2	$393.78	$278.40	$115.38
CD1	$361.11	$255.30	$105.81
CC2	$344.78	$243.76	$101.02
CC1	$319.37	$225.79	$93.58
CB2	$319.37	$225.79	$93.58
CB1	$295.77	$209.11	$86.66
CA2	$270.36	$191.14	$79.22
CA1	$252.21	$178.31	$73.90
BB2	$286.70	$202.70	$84.00
BB1	$273.99	$193.71	$80.28
BA2	$237.69	$168.05	$69.64
BA1	$226.80	$160.35	$66.45
PE2	$382.89	$270.70	$112.19
PE1	$364.74	$257.87	$106.87
PD2	$361.11	$255.30	$105.81
PD1	$342.96	$242.47	$100.49
PC2	$310.29	$219.38	$90.91
PC1	$295.77	$209.11	$86.66
PB2	$263.10	$186.01	$77.09
PB1	$252.21	$178.31	$73.90
PA2	$217.73	$153.94	$63.79
PA1	$208.65	$147.52	$61.13

TABLE 10: RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	$852.10	$602.43	$249.67
RUL	$834.76	$590.18	$244.58
RVX	$748.68	$529.32	$219.36
RVL	$675.85	$477.83	$198.02
RHX	$670.48	$474.03	$196.45
RHL	$601.13	$425.00	$176.13
RMX	$609.32	$430.79	$178.53
RML	$560.77	$396.46	$164.31
RLX	$530.34	$374.95	$155.39
RUC	$659.64	$466.37	$193.27
RUB	$659.64	$466.37	$193.27
RUA	$560.81	$396.49	$164.32
RVC	$557.95	$394.47	$163.48
RVB	$488.59	$345.43	$143.16
RVA	$486.86	$344.21	$142.65
RHC	$479.76	$339.19	$140.57
RHB	$434.67	$307.31	$127.36
RHA	$386.12	$272.99	$113.13
RMC	$416.86	$294.72	$122.14
RMB	$392.59	$277.56	$115.03
RMA	$326.70	$230.98	$95.72
RLB	$398.57	$281.79	$116.78
RLA	$261.59	$184.94	$76.65
ES3	$734.31	$519.16	$215.15
ES2	$576.52	$407.60	$168.92
ES1	$515.83	$364.69	$151.14
HE2	$498.50	$352.44	$146.06
HE1	$415.27	$293.60	$121.67
HD2	$467.29	$330.37	$136.92
HD1	$390.99	$276.43	$114.56
HC2	$441.28	$311.98	$129.30
HC1	$370.19	$261.72	$108.47
HB2	$436.08	$308.31	$127.77
HB1	$366.72	$259.27	$107.45
LE2	$453.41	$320.56	$132.85
LE1	$380.59	$269.08	$111.51
LD2	$436.08	$308.31	$127.77
LD1	$366.72	$259.27	$107.45
LC2	$384.06	$271.53	$112.53
LC1	$325.11	$229.85	$95.26
LB2	$364.99	$258.05	$106.94
LB1	$311.23	$220.04	$91.19
CE2	$404.87	$286.24	$118.63
CE1	$373.66	$264.18	$109.48
CD2	$384.06	$271.53	$112.53
CD1	$352.85	$249.46	$103.39
CC2	$337.24	$238.43	$98.81
CC1	$312.97	$221.27	$91.70
CB2	$312.97	$221.27	$91.70
CB1	$290.43	$205.33	$85.10
CA2	$266.15	$188.17	$77.98
CA1	$248.81	$175.91	$72.90
BB2	$281.76	$199.20	$82.56
BB1	$269.62	$190.62	$79.00
BA2	$234.94	$166.10	$68.84
BA1	$224.54	$158.75	$65.79
PE2	$373.66	$264.18	$109.48
PE1	$356.32	$251.92	$104.40
PD2	$352.85	$249.46	$103.39
PD1	$335.51	$237.21	$98.30
PC2	$304.30	$215.14	$89.16
PC1	$290.43	$205.33	$85.10
PB2	$259.22	$183.27	$75.95
PB1	$248.81	$175.91	$72.90
PA2	$215.87	$152.62	$63.25
PA1	$207.20	$146.49	$60.71

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage adjustment had not been made. For FY 2019 (federal rates effective October 1, 2018), we would apply an adjustment to fulfill the budget neutrality requirement. We would meet this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2018 to the weighted average wage adjustment factor for FY 2019. For this calculation, we would use the same FY 2017 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The budget neutrality factor for FY 2019 would be 1.0002.

As discussed above, we have historically used, and propose to continue using, pre-reclassified IPPS hospital wage data, unadjusted for occupational mix and the rural and imputed floors, as the basis for the SNF wage index. That being said, we note that we have received recurring comments in prior rulemaking (most recently in the FY 2018 SNF PPS final rule (82 FR 36539 through 36541)) regarding the development of a SNF-specific wage index. It has been suggested that we develop a SNF-specific wage index utilizing SNF cost report wage data instead of hospital wage data. We have noted, in response that developing such a wage index would require a resource-intensive audit process similar to that used for IPPS hospital data, to improve the quality of the SNF cost report data in order for it to be used as part of this analysis. This audit process is quite extensive in the case of approximately 3,300 hospitals, and it would be significantly more so in the case of approximately 15,000 SNFs. As discussed previously in this rule, we believe auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in

terms of recordkeeping and completion of the cost report worksheet. We also believe that adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are hospitals. Therefore, while we continue to review all available data and contemplate the potential methodological approaches for a SNF-specific wage index in the future, we continue to believe that in the absence of the appropriate SNF-specific wage data, using the pre-reclassified, pre-rural and imputed floor hospital inpatient wage data (without the occupational mix adjustment) is appropriate and reasonable for the SNF PPS.

As an alternative to a SNF-specific wage index, it has also been suggested that we consider adopting certain wage index policies in use under the IPPS, such as geographic reclassification or rural floor. Although we have the authority under section 315 of BIPA to establish a geographic reclassification procedure specific to SNFs under certain conditions, as discussed previously, under BIPA, we cannot adopt a reclassification policy until we have collected the data necessary to establish a SNF-specific wage index. Thus, we cannot adopt a reclassification procedure at this time. With regard to adopting a rural floor policy, as we stated in the FY 2017 SNF PPS final rule (82 FR 36540), MedPAC has recommended eliminating the rural floor policy (which actually sets a floor for urban hospitals) from the calculation of the IPPS wage index (see, for example, Chapter 3 of MedPAC's March 2013 Report to Congress on Medicare Payment Policy, available at http://medpac.gov/docs/default-source/reports/mar13_ch03.pdf, which notes on page 65 that in 2007, MedPAC had ". . . recommended eliminating these special wage index adjustments and adopting a new wage index system to avoid geographic inequities that can occur due to current wage index policies (Medicare Payment Advisory Commission 2007b."). As we stated in the FY 2017 SNF PPS

final rule, if we were to adopt the rural floor under the SNF PPS, we believe that the SNF PPS wage index could become vulnerable to problems similar to those that MedPAC identified in its March 2013 Report to Congress.

Given the perennial nature of these comments and responses on the SNF PPS wage index policy, we are requesting further comments on the issues discussed above. Specifically, we request comment on how a SNF-specific wage index may be developed without creating significant administrative burdens for providers, CMS, or its contractors. Further, we request comments on specific alternatives we may consider in future rulemaking which could be implemented in advance of, or in lieu of, a SNF-specific wage index.

E. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, section 1888(h) of the Act requires the Secretary to reduce the adjusted Federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished during a fiscal year by 2 percent, and to adjust the resulting rate for a SNF by the value-based incentive payment amount earned by the SNF based on the SNF's performance score for that fiscal year under the SNF VBP Program. To implement these requirements, we propose to add a new paragraph (f) to §413.337. See section VI.C. of this proposed rule for further information regarding the SNF VBP Program, including a discussion of the methodology we would use to make the payment adjustments.

F. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ, Table 11 shows the adjustments made to the federal per diem rates (prior to application of any adjustments under the SNF QRP and SNF VBP programs as discussed above) to compute the provider's actual per diem PPS payment for FY 2019. We derive the Labor and Non-labor columns from Table 9. The wage index used in this

example is based on the proposed wage index, which may be found in Table A available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. As illustrated in Table 11, SNF XYZ's total PPS payment for FY 2019 would equal $48,801.32.

TABLE 11: Adjusted Rate Computation Example
SNF XYZ: Located in Frederick, MD (Urban CBSA 43524)
Wage Index: 0.9882
(See Proposed Wage Index in Table A)[1]

RUG-IV Group	Labor	Wage Index	Adjusted Labor	Non-Labor	Adjusted Rate	Percent Adjustment	Medicare Days	Payment
RVX	$524.13	0.9882	$517.95	$217.21	$735.16	$735.16	14	$10,292.24
ES2	$420.84	0.9882	$415.87	$174.41	$590.28	$590.28	30	$17,708.40
RHA	$264.42	0.9882	$261.30	$109.58	$370.88	$370.88	16	$5,934.08
CC2[2]	$243.76	0.9882	$240.88	$101.02	$341.90	$779.53	10	$7,795.30
BA2	$168.05	0.9882	$166.07	$69.64	$235.71	$235.71	30	$7,071.30
							100	**$48,801.32**

[1] Available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.
[2] Reflects a 128 percent adjustment from section 511 of the MMA.

IV. Additional Aspects of the SNF PPS

A. SNF Level of Care--Administrative Presumption

The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system discussed in section III.C. of this proposed rule. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the current 66-group RUG-IV case-mix classification system to assist in making certain SNF level of care determinations.

In accordance with the regulations at §413.345, we include in each update of the federal payment rates in the **Federal Register** a discussion of the resident classification system that

provides the basis for case-mix adjustment. Under that discussion, we designate those specific classifiers under the case-mix classification system that represent the required SNF level of care, as provided in §409.30. As set forth in the FY 2011 SNF PPS update notice (75 FR 42910), this designation reflects an administrative presumption under the 66-group RUG-IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG-IV groups on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) on the 5-day Medicare-required assessment.

A beneficiary assigned to any of the lower 14 RUG-IV groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 52 RUG-IV groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 14 RUG-IV groups.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html (where such designations appear in the paragraph entitled "Case Mix Adjustment"), and would publish such designations in rulemaking only to the extent that we actually intend to make changes in them. (We discuss in section V.H. of this proposed rule the modifications to the administrative level of care presumption that we are proposing in order to accommodate the case-mix

classification system under the proposed PDPM.)

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption:

> . . . is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations in which a resident's assignment to one of the upper . . . groups is itself based on the receipt of services that are subsequently determined to be not reasonable and necessary.

Moreover, we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the ARD of the 5-day assessment.

B. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA 1997) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. (Please refer to section VI.A. of this rule for a discussion of a proposed revision to the regulation text that describes a

beneficiary's status as a SNF "resident" for consolidated billing purposes.) Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297).

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf. In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, enacted on November 29, 1999) (BBRA) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual high-cost, low probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.gov/transmittals/downloads/ab001860.pdf.

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate additional, individual services for exclusion

within each of the specified service categories. In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA do not designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: they must fall within one of the four service categories specified in the BBRA; and they also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791). In this proposed rule, we specifically invite public comments identifying HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated

billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2018). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

C. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the

statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN-SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html. We refer readers to section V.E.2. of this proposed rule for a discussion of the revisions we are proposing to the MDS 3.0 swing-bed assessment effective October 1, 2019.

V. Proposed Revisions to SNF PPS Case-Mix Classification Methodology

A. Issues Relating to the Current Case-Mix System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to the per diem rates to account for case-mix. The statute specifies that the adjustment is to be based on both a resident classification system that the Secretary establishes that accounts for the relative resource use of different resident types, as well as resident assessment and other data that the Secretary considers appropriate.

In general, the case-mix classification system currently used under the SNF PPS classifies residents into payment classification groups, called RUGs, based on various resident characteristics and the type and intensity of therapy services provided to the resident. Under the existing SNF PPS methodology, there are two case-mix-adjusted components of payment: nursing and therapy. Each RUG is assigned a CMI for each payment component to reflect relative differences in cost and resource intensity. The higher the CMI, the higher the expected resource utilization and cost associated with residents assigned to that RUG. The case-mix-adjusted nursing component of payment reflects relative differences in a resident's associated nursing and non-therapy ancillary (NTA) costs, based on various resident characteristics, such as resident comorbidities, and treatments. The case-mix-adjusted therapy component of payment reflects relative differences in a resident's associated therapy costs, which is based on a combination of PT, OT, and SLP services. Resident classification under the existing therapy component is based primarily on the amount of therapy the SNF chooses to provide to a SNF resident. Under the RUG-IV model, residents are classified into rehabilitation groups, where payment is determined primarily based on the intensity of therapy services received by the resident, and into nursing groups, based on the intensity of nursing services received by the

resident and other aspects of the resident's care and condition. However, only the higher paying of these groups is used for payment purposes. For example, if a resident is classified into a both the RUA (Rehabilitation) and PA1 (Nursing) RUG-IV groups, where RUA has a higher per-diem payment rate than PA1, the RUA group is used for payment purposes. It should be noted that the vast majority of Part A covered SNF days (over 90 percent) are paid using a rehabilitation RUG. A variety of concerns have been raised with the current SNF PPS, specifically the RUG-IV model, which we discuss below.

When the SNF PPS was first implemented in 1998 (63 FR 26252), we developed the RUG-III case-mix classification model, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG-III but also to create CMIs. This initial RUG-III model was refined by changes finalized in the FY 2006 SNF PPS final rule (70 FR 45032), which included adding nine case-mix groups to the top of the original 44-group RUG-III hierarchy, which created the RUG-53 case-mix model.

In the FY 2010 SNF PPS proposed rule (74 FR 22208), we proposed the RUG-IV model based on, among other reasons, concerns that incentives in the SNF PPS had changed the relative amount of nursing resources required to treat SNF residents (74 FR 22220). These concerns led us to conduct a new Staff Time Measurement (STM) study, the Staff Time and Resource Intensity Verification (STRIVE) project, which served as the basis for developing the current SNF PPS case-mix classification model, RUG-IV, which became effective in FY 2011. At that time, we considered alternative case mix models, including predictive models of therapy payment based on resident characteristics; however, we had a "great deal of concern that by separating payment from the actual provision of services, the system, and more importantly, the

beneficiaries would be vulnerable to underutilization." (74 FR 22220) Other options considered at the time included a non-therapy ancillary (NTA) payment model based on resident characteristics (74 FR 22238) and a DRG-based payment model that relied on information from the prior inpatient stay (74 FR 22220); these and other options are discussed in detail in a CMS Report to Congress issued in December 2006 (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf).

In the years since we implemented the SNF PPS, finalized RUG-IV, and made statements regarding our concerns about underutilization of services in previously considered models, we have witnessed a significant trend that has caused us to reconsider these concerns. More specifically, as discussed in section V.E. of the FY 2015 SNF PPS proposed rule (79 FR 25767), we documented and discussed trends observed in therapy utilization in a memo entitled "Observations on Therapy Utilization Trends" (which may be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Therapy_Trends_Memo_04212014.pdf). The two most notable trends discussed in that memo were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. In that memo, we state "the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720 minute threshold for RU groups, has increased from 5 percent in FY 2005 to 33 percent in FY 2013" and this trend has continued since that time. While it might be possible to attribute the increasing share of residents in the Ultra-High therapy category to increasing acuity within the SNF population, we believe the increase in "thresholding" (that is, of providing just enough

therapy for residents to surpass the relevant therapy thresholds) is a strong indication of service provision predicated on financial considerations rather than resident need. We discussed this issue in response to comments in the FY 2015 SNF PPS final rule, where, in response to comments regarding the lack of "current medical evidence related to how much therapy a given resident should receive," we stated the following:

> With regard to the comments which highlight the lack of existing medical evidence for how much therapy a given resident should receive, we would note that…the number of therapy minutes provided to SNF residents within certain therapy RUG categories is, in fact, clustered around the minimum thresholds for a given therapy RUG category. However, given the comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest. (79 FR 45651)

In response to comments related to factors which may explain the observed trends, we stated the following:

> With regard to the comment which highlighted potential explanatory factors for the observed trends, such as internal pressure within SNFs that would override clinical judgment, we find these potential explanatory factors troubling and entirely inconsistent with the intended use of the SNF benefit. Specifically, the minimum therapy minute thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision. As discussed in Chapter 8, Section 30 of the Medicare Benefit Policy Manual (Pub. 100–02), to be covered, the services provided to a SNF resident must be "reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice." (emphasis added) Therefore, services which are not specifically tailored to meet the individualized needs and goals of the resident, based on the resident's condition and the evaluation and judgment of the resident's clinicians, may not meet this aspect of the definition for covered SNF care, and we believe that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies, or the professional judgment of clinicians. (79 FR 45651 through 45652)

In addition to this discussion of observed trends, others have also identified potential areas of concern within the current SNF PPS. The two most notable sources are the Office of the Inspector General (OIG) and the Medicare Payment Advisory Commission (MedPAC).

For the OIG, three recent OIG reports describe the OIG's concerns with the current SNF

PPS. In December 2010, the OIG released a report entitled "Questionable Billing by Skilled Nursing Facilities" (which may be accessed at https://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf). In this report, among its findings, the OIG found that "from 2006 to 2008, SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged" (OEI-02-09-00202, ii), and among other things, recommended that we should "consider several options to ensure that the amount of therapy paid for by Medicare accurately reflects beneficiaries' needs" (OEI-02-09-00202, iii). Further, in November 2012, the OIG released a report entitled "Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009" (which may be accessed at https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf). In this report, the OIG found that "SNFs billed one-quarter of all claims in error in 2009" and that the "majority of the claims in error were upcoded; many of these claims were for ultrahigh therapy." (OEI-02-09-00200, Executive Summary). Among its recommendations, the OIG stated that "the findings of this report provide further evidence that CMS needs to change how it pays for therapy" (OEI-02-09-00200, 15). Finally, in September 2015, the OIG released a report entitled "The Medicare Payment System for Skilled Nursing Facilities Needs to be Reevaluated" (which may be accessed at https://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf). Among its findings, the OIG found that "Medicare payments for therapy greatly exceed SNFs' costs for therapy," further noting that "the difference between Medicare payments and SNFs' costs for therapy, combined with the current payment method, creates an incentive for SNFs to bill for higher levels of therapy than necessary" (OEI-02-13-00610, 7). Among its recommendations, the OIG stated that CMS should "change the method of paying for therapy", further stating that "CMS should accelerate its efforts to develop and implement a new method of paying for therapy that relies on beneficiary characteristics or care needs." (OEI-02-13-00610, 12).

For MedPAC's recommendations in this area, Chapter 8 of MedPAC's March 2017 Report to Congress (available at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch8.pdf) includes the following recommendation: "The Congress should…direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities" and "…make any additional adjustments to payments needed to more closely align payment with costs." (March 2017 MedPAC Report to Congress, 220). This recommendation is seemingly predicated on MedPAC's own analysis of the current SNF PPS, where they state that "almost since its inception the SNF PPS has been criticized for encouraging the provision of excessive rehabilitation therapy services and not accurately targeting payments for nontherapy ancillaries" (March 2017 MedPAC Report to Congress, 202). Finally, with regard to the possibility of changing the existing SNF payment system, MedPAC stated that "since 2015, [CMS] has gathered four expert panels to receive input on aspects of possible design features before it proposes a revised PPS" and further that "the designs under consideration are consistent with those recommended by the Commission" (March 2017 MedPAC Report to Congress, 203).

The combination of the observed trends in the current SNF PPS discussed above (which strongly suggest that providers may be basing service provision on financial reasons rather than resident need), the issues raised in the OIG reports discussed above, and the issues raised by MedPAC, has caused us to consider significant revisions to the existing SNF PPS, in keeping with our overall responsibility to ensure that payments under the SNF PPS accurately reflect both resident needs and resource utilization.

Under the RUG-IV system, therapy service provision determines not only therapy payments but also nursing payments. This is because, as noted above, payment is based on the highest RUG category that the resident could be assigned to, so only one of a resident's assigned RUG groups, rehabilitation or nursing, is used for payment purposes. Each rehabilitation group

is assigned a nursing CMI to reflect relative differences in nursing costs for residents in those rehabilitation groups, which is less specifically tailored to the individual nursing costs for a given resident than the nursing CMIs assigned for the nursing RUGs. Given that, as mentioned above, most resident days are paid using a rehabilitation RUG, and since assignment into a rehabilitation RUG is based on therapy service provision, this means that therapy service provision effectively determines nursing payments for those residents who are assigned to a rehabilitation RUG. Thus, we believe any attempts to revise the SNF PPS payment methodology to better account for therapy service provision under the SNF PPS would need to be comprehensive and affect both the therapy and nursing case-mix components. Moreover, in the FY 2015 SNF PPS final rule, in response to comments regarding access for certain "specialty" populations (such as those with complex nursing needs), we stated the following:

> With regard to the comment on specialty populations, we agree with the commenter that access must be preserved for all categories of SNF residents, particularly those with complex medical and nursing needs. As appropriate, we will examine our current monitoring efforts to identify any revisions which may be necessary to account appropriately for these populations. (79 FR 45651)

In addition, MedPAC, in its March 2017 Report to Congress, stated that it has previously recommended that we revise the current SNF PPS to "base therapy payments on patient characteristics (not service provision), remove payments for NTA services from the nursing component, [and] establish a separate component within the PPS that adjusts payments for NTA services" (March 2017 MedPAC Report to Congress, 202). Accordingly, we note that included among the proposed revisions we discuss in this proposed rule, are revisions to the SNF PPS to address longstanding concerns regarding the ability of the RUG-IV system to account for variation in nursing and NTA services, as described in sections V.D.3.e. of this proposed rule.

In May 2017, CMS released an Advance Notice of Proposed Rulemaking with comment (82 FR 20980) (the ANPRM), in which we discussed the history of and analyses conducted

during the SNF Payment Models Research (PMR) project, which sought to address these concerns with the RUG-IV model, and sought comments on a possible replacement to the current RUG-IV model, which we called the Resident Classification System, Version I (RCS-I). This model was intended as an improvement over the RUG-IV model because it would better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS. We received many comments from stakeholders on a wide variety of aspects of the RCS-I model. After considering these comments, we made significant revisions to the RCS-I model to account for the concerns or questions raised by stakeholders, resulting in a revised case-mix classification model which we are proposing in this rule. To make clear the purpose and intent of replacing the existing RUG-IV system, the model we are proposing in this rule is called the Patient-Driven Payment Model (PDPM).

In the sections that follow, we describe the comprehensive proposed revisions to the current SNF PPS case-mix classification system and its replacement with PDPM, effective October 1, 2019. Specifically, we discuss a proposed alternative to the existing RUG-IV, called the Patient-Driven Payment Model (PDPM), effective for payments beginning October 1, 2019. As further detailed below, we believe that the PDPM represents an improvement over the RUG-IV model and the RCS-I model because it would better account for resident characteristics and care needs while reducing both systemic and administrative complexity. To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics.

B. Summary of the Skilled Nursing Facility Payment Models Research Project.

As noted above, since 1998, Medicare Part A has paid for SNF services on a per diem

basis through the SNF PPS. Currently, therapy payments under the SNF PPS are based primarily on the amount of therapy furnished to a patient, regardless of that patient's specific characteristics and care needs. Beginning in 2013, we contracted with Acumen, LLC to identify potential alternatives to the existing methodology used to pay for services under the SNF PPS. The recommendations developed under this contract, entitled the SNF PMR project, form the basis of the proposals contained in the sections below.

The SNF PMR operated in four phases. In the first phase of the project, which focused exclusively on therapy payment issues, Acumen reviewed past research studies and policy issues related to SNF PPS therapy payment and options for improving or replacing the current therapy payment methodology. After consideration of multiple potential alternatives, such as competitive bidding and a hybrid model combining resource-based pricing (for example, how therapy payments are made under the current SNF PPS) with resident characteristics, we identified a model that relies on resident characteristics rather than the amount of therapy received as the most appropriate replacement for the existing therapy payment model. As stated above, we believe that relying on resident characteristics would improve the resident-centeredness of the model and discourage resident care decisions predicated on service-based financial incentives. A report summarizing Acumen's activities and recommendations during the first phase of the SNF PMR contract, the SNF Therapy Payment Models Base Year Final Summary Report, is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Summary_Report_20140501.pdf.

In the second phase of the project, Acumen used the findings from the Base Year Final Summary Report as a guide to identify potential models suitable for further analysis. During this phase of the project, in an effort to establish a comprehensive approach to Medicare Part A SNF payment reform, we expanded the scope of the SNF PMR to encompass other aspects of the SNF

PPS beyond therapy. Although we always intended to ensure that any revisions specific to therapy payment would be considered as part of an integrated approach with the remaining payment methodology, we believed it was prudent to examine potential improvements and refinements to the overall SNF PPS payment system as well.

During this phase of the SNF PMR, Acumen hosted four Technical Expert Panels (TEPs), which brought together industry experts, stakeholders, and clinicians with the research team to discuss different topics within the overall analytic framework. In February 2015, Acumen hosted a TEP to discuss questions and issues related to therapy case-mix classification. In November 2015, Acumen hosted a second TEP focused on questions and issues related to nursing case-mix classification, as well as to discuss issues related to payment for NTAs. In June 2016, Acumen hosted a third TEP to provide stakeholders with an outline of a potential revised SNF PPS payment structure, including new case-mix adjusted components and potential companion policies, such as variable per diem payment adjustments. Finally, in October 2016, Acumen hosted a fourth TEP, during which Acumen presented the case-mix components for a potential revised SNF PPS, as well as an initial impact analysis associated with the potential revised SNF PPS payment model. The presentation slides used during each of the TEPs, as well as a summary report for each TEP, is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

In the third phase of the contract, we tasked Acumen to assist in developing supporting language and documentation, most notably a technical report (the SNF PMR technical report), related to an earlier version of the alternative SNF PPS case-mix classification model we were considering, which we named the Resident Classification System, Version I (RCS-I). The SNF PMR technical report associated with the ANPRM is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-

Payment/SNFPPS/therapyresearch.html.

The final phase of the project, which began in October 2017, was focused on refinements to the alternative model. We received a large number of comments in response to the ANPRM introducing the RCS-I model. During the revision phase, Acumen conducted additional analyses based on the comments received and made a number of modifications to the payment model. The resulting case-mix classification model is the PDPM we are proposing. During the final phase of the project, Acumen produced a second technical report that presents the analyses and results that were used to develop the proposed revised payment model described in this proposed rule (the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

In the sections below, we outline each aspect of the proposed PDPM, as well as additional revisions to the SNF PPS which we are proposing along with the proposed implementation of the PDPM. We invite comments on any and all aspects of the proposed PDPM, including the research analyses described in this proposed rule, the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) and the SNF PMR technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

C. Revisions to SNF PPS Federal Base Payment Rate Components

1. Background on SNF PPS Federal Base Payment Rates and Components

Section 1888(e)(4) of the Act requires that the SNF PPS per diem federal payment rates be based on FY 1995 costs, updated for inflation to the first effective period of the PPS. These base rates are then required to be adjusted to reflect differences among facilities in patient case-mix and in average wage levels by area. In keeping with this statutory requirement, the base per

diem payment rates were set in 1998 and reflect average SNF costs in a base year (FY 1995), updated for inflation to the first period of the SNF PPS, which was the 15-month period beginning on July 1, 1998. The federal base payment rates were calculated separately for urban and rural facilities and based on allowable costs from the FY 1995 cost reports of hospital-based and freestanding SNFs, where allowable costs included all routine, ancillary, and capital-related costs (excluding those related to approved educational activities) associated with SNF services provided under Part A, and all services and items for which payment could be made under Part B prior to July 1, 1998.

In general, routine costs are those included by SNFs in a daily service charge and include regular room, dietary, and nursing services, medical social services and psychiatric social services, as well as the use of certain facilities and equipment for which a separate charge is not made. Ancillary costs are directly identifiable to residents and cover specialized services, including therapy, drugs, and laboratory services. Lastly, capital-related costs include the costs of land, building, and equipment and the interest incurred in financing the acquisition of such items. (63 FR 26253)

There are four federal base payment rate components which may factor into SNF PPS payment. Two of these components, "nursing case-mix" and "therapy case-mix," are case-mix adjusted components, while the remaining two components, "therapy non-case-mix" and "non-case-mix," are not case-mix adjusted. While we discuss the details of the proposed PDPM and justifications for certain associated policies we are proposing throughout section V of this proposed rule, we note that, as part of the PDPM case-mix model, we propose to bifurcate the "nursing case-mix" component of the federal base payment rate into two case-mix adjusted components and separate the "therapy case-mix" component of the federal base payment rate into three case-mix adjusted components, thereby creating five case-mix adjusted components of

the federal base per diem rate. More specifically, we propose to separate the "therapy case-mix" rate component into a "Physical Therapy" (PT) component, "Occupational Therapy" (OT) component, and a "Speech-Language Pathology" (SLP) component. Our rationale for separating the therapy case-mix component in this manner is presented in section V.D.3.b. of this proposed rule. Based on the results of the SNF PMR, we also propose to separate the "nursing case-mix" rate component into a "Nursing" component and a "Non-Therapy Ancillary" (NTA) component. Our rationale for proposing to bifurcate the nursing case-mix component in this manner is presented in section V.D.3.d. of this proposed rule. Given that all SNF residents under PDPM would be assigned to a classification group for each of the three proposed therapy-related case-mix adjusted components as further discussed below, we propose eliminating the "therapy non-case-mix" rate component under PDPM and distributing the dollars associated with this current rate component amongst the proposed PDPM therapy components. The existing non-case-mix component would be maintained as it is currently constituted under the existing SNF PPS. Although the case-mix components of the proposed PDPM case-mix classification system would address costs associated with individual resident care based on an individual's specific needs and characteristics, the non-case-mix component addresses consistent costs that are incurred for all residents, such as room and board and various capital-related expenses. As these costs are not likely to change, regardless of what changes we might make to the SNF PPS, we propose to maintain the non-case-mix component as it is currently used.

In the next section, we discuss the methodology used to create the proposed PDPM case-mix adjusted components, as well as the data sources used in this calculation. The proposed methodology does not calculate new federal base payment rates but simply proposes to modify the existing base rate case-mix components for therapy and nursing. The methodology and data used in this calculation are based on the data and methodology used in the calculation of the

original federal payment rates in 1998, as further discussed below.

2. Data Sources Utilized for Proposed Revision of Federal Base Payment Rate Components

Section II.A.2. of the interim final rule with comment period that initially implemented the SNF PPS (63 FR 26256 through 26260) provides a detailed discussion of the data sources used to calculate the original federal base payment rates in 1998. Except as discussed below, we propose to use the same data sources (that is, cost information from FY 1995 cost reports) to determine the portion of the therapy case-mix component base rate that would be assigned to each of the proposed therapy component base rates (PT, OT, and SLP). We believe that using the same data sources, to the extent possible, that were used to calculate the original federal base payment rates in 1998 results in base rates for the components that resemble as closely as possible what they would have been had these components initially been established in 1998. The portion of the nursing component base rate that corresponds to NTA costs was already calculated using the same data source used to calculate the federal base payment rates in 1998. As explained below, we used the previously calculated percentage of the nursing component base rate corresponding to NTA costs to set the NTA base rate and verified this calculation with the analysis described in section V.C.3. of this proposed rule. Therefore, the steps described below address the calculations performed to separate out the therapy base rates alone.

The percentage of the current therapy case-mix component of the federal base payment rates that would be assigned to the three proposed therapy components (PT, OT, and SLP) of the federal base payment rates was determined using cost information from FY 1995 cost reports, after making the following exclusions and adjustments: First, only settled and as-submitted cost reports for hospital-based and freestanding SNFs for periods beginning in FY 1995 and spanning 10 to 13 months were included. This set of restrictions replicates the restrictions used to derive the original federal base payment rates as set forth in the 1998 interim final rule with comment

period (63 FR 26256). Following the methodology used to derive the SNF PPS base rates, routine and ancillary costs from as-submitted cost reports were adjusted down by 1.31 and 3.26 percent, respectively. As discussed in the 1998 interim final rule with comment period, the specific adjustment factors were chosen to reflect average adjustments resulting from cost report settlement and were based on a comparison of as-submitted and settled reports from FY 1992 to FY 1994 (63 FR 26256); these adjustments are in accordance with section 1888(e)(4)(A)(i) of the Act. We used similar data, exclusions, and adjustments as in the original base rates calculation so the resulting base rates for the components would resemble as closely as possible what they would have been had they been established in 1998. However, there were two ways in which the PT, OT, and SLP percentage calculations deviate from the 1998 base rates calculation. First, the 1998 calculation of the base rates excluded reports for facilities exempted from cost limits in the base year. The available data do not identify which facilities were exempted from cost limits in the base year, so this restriction was not implemented. We do not believe this had a notable impact on our estimate of the PT, OT, and SLP percentages, because only a small fraction of facilities were exempted from cost limits. Consistent with the 1998 base rates calculation, we excluded facilities with per diem costs more than three standard deviations higher than the geometric mean across facilities. Therefore, facilities with unusually high costs did not influence our estimate. Second, the 1998 calculation of the base rates excluded costs related to exceptions payments and costs related to approved educational activities. The available cost report data did not identify costs related to exceptions payments nor indicate what percentage of overall therapy costs or costs by therapy discipline were related to approved educational activities, so these costs are not excluded from the PT, OT, and SLP percentage calculations. Because exceptions were only granted for routine costs, we believe the inability to exclude these costs should not affect our estimate of the PT, OT, and SLP percentages as exceptions would not

apply to therapy costs. Additionally, the data indicate that educational costs made up less than one-hundredth of 1 percent of overall SNF costs. Therefore, we believe that the inability to exclude educational costs should have a negligible impact on our estimates.

In addition to Part A costs from the cost report data, the 1998 federal base rates calculation incorporated estimates of amounts payable under Part B for covered SNF services provided to Part A SNF residents, as required by section 1888(e)(4)(A)(ii) of the Act. In calculating the PT, OT, and SLP percentages, we also estimated the amounts payable under Part B for covered SNF services provided to Part A residents. All Part B claims associated with Part A SNF claims overlapping with FY 1995 cost reports were matched to the corresponding facility's cost report. For each cost center (PT, OT, and SLP) in each cost report, a ratio was calculated to determine the amount by which Part A costs needed to be increased to account for the portion of costs payable under Part B. This ratio for each cost center was determined by dividing the total charges from the matched Part B claims by the total charges from the Part A SNF claims overlapping with the cost report. The 1998 interim final rule (63 FR 26256) states that to estimate the amounts payable under Part B for covered SNF services provided to Part A SNF residents, CMS (then known as HCFA) matched 100 percent of Part B claims associated with Part A covered SNF stays to the corresponding facility's cost report. Part B allowable charges were then incorporated at the facility level by the appropriate cost report center. Although the interim final rule does not provide further detail on how Part B allowable charges were incorporated at the facility level, we believe that our methodology reasonably approximates the methodology described in the interim final rule, and provides a reasonable estimate of the amounts payable under Part B for covered SNF services provided to Part A residents for purposes of calculating the PT, OT, and SLP percentages. Therefore, we believe it is reasonable to use this methodology to calculate the PT, OT, and SLP percentages of the therapy case-mix

component.

Finally, the 1998 federal base rates calculation standardized the cost data for each facility to control for the effects of case-mix and geographic-related wage differences, as required by section 1888(e)(4)(C) of the Act. When calculating the PT, OT and SLP shares of the current therapy base rate, we replicated the method used in 1998 to standardize for wage differences, as described in the 1998 interim final rule with comment period (63 FR 26259 through 26260). We applied a hospital wage index to the labor-related share of costs, estimated at 75.888 percent, and used an index composed of hospital wages from FY 1994. The PT, OT, and SLP percentage calculations did not include the case-mix adjustment used in the 1998 calculation because the 1998 adjustment relied on the obsolete RUG-III classification system. In the 1998 federal base rates calculation, information from SNF and inpatient claims was mapped to RUG-III clinical categories at the resident level to case-mix adjust facility per diem costs. However, the 1998 interim final rule did not document this mapping, and the data used as the basis for this adjustment are no longer available, and therefore, this step could not be replicated. We believe that the inability to apply the case-mix adjustment likely has a small impact on our estimate of the PT, OT, and SLP percentages. The 1998 interim final rule indicates that the case-mix adjustment was applied by dividing facility per diem costs for a given component by average facility case mix for that component; in other words, multiplying by the inverse of average facility case mix. As long as average facility case-mix values are within a relatively narrow range, adjustment for facility case mix should not have a large impact on the estimated PT, OT, and SLP percentages. Because the RUG-III case-mix indexes shown in the 1998 interim final rule are within a relatively narrow range (for example, therapy indexes range from 0.43 to 2.25), we do not expect the inability to apply the case-mix adjustment to facility per diem costs to have a large influence on the estimated PT, OT, and SLP percentages. These data sources are

described in more detail in section 3.10. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

We invite comments on the data sources used to determine the PT, OT, and SLP rate components, as discussed above.

3. Methodology Used for the Calculation of Proposed Federal Base Payment Rate Components

As discussed previously in this section, we are proposing to separate the current therapy components into a PT component, an OT component, and an SLP component. To do this, we calculated the percentage of the current therapy component of the federal base rate that corresponds to each of the three proposed PDPM therapy components (PT, OT, and SLP) in accordance with the methodology set forth below.

The data described in section V.C.2. of this proposed rule (primarily, cost information from FY 1995 cost reports) provides cost estimates for the Medicare Part A SNF population for each cost report that met the inclusion criteria. Cost reports stratify costs by a number of cost centers that indicate different types of services. For instance, costs are reported separately for each of the three therapy disciplines (PT, OT, and SLP). Cost reports also include the number of Medicare Part A utilization days during the cost reporting period. This allows us to calculate both average total therapy costs per day and average therapy costs by discipline in the facility during the cost reporting period. Therapy costs are defined as the sum of costs for the three therapy disciplines.

The goal of this methodology is to estimate the fraction of therapy costs that corresponds to each of the three therapy disciplines. We use the facility-level per-diem costs developed from 1995 cost reports to derive average per diem amounts for both total therapy costs and for PT,

OT, and SLP costs separately. To do this, we followed the methodology outlined in section II.A.3. of the 1998 interim final rule with comment period (63 FR 26260), which was used by CMS (then known as HCFA) to create the federal base payment rates:

(1) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we computed the mean based on data from freestanding SNFs only. This mean was weighted by the total number of Medicare days of the facility.

(2) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we computed the mean based on data from both hospital-based and freestanding SNFs. This mean was weighted by the total number of Medicare days of the facility.

(3) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we calculated the arithmetic mean of the amounts determined under steps (1) and (2) above.

In section 3.10.3. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), we show the results of these calculations.

The three steps outlined above produce a measure of costs per day by therapy discipline and a measure of total therapy costs per day. We divided the discipline-specific (PT, OT, SLP) cost measure by the total therapy cost measure to obtain the percentage of the therapy component that corresponds to each therapy discipline. We believe that following a methodology to derive the discipline-specific therapy percentages that is consistent with the methodology used to determine the base rates in the 1998 interim final rule with comment period is appropriate because a consistent methodology helps to ensure that the resulting base rates for the components resemble what they would be had they been established in 1998. We found that PT, OT, and SLP costs correspond to 43.4 percent, 40.4 percent, and 16.2 percent of the therapy component of the federal per diem rate for urban SNFs, and 42.9 percent, 39.4 percent, and 17.7 percent of

the therapy component of the federal per diem rate for rural SNFs. Under the proposed PDPM, the current therapy case-mix component would be separated into a Physical Therapy component, an Occupational Therapy component, and a Speech-Language Pathology component using the percentages derived above. This process would be done separately for urban and for rural facilities. In the appendix of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) we provide the specific cost centers used to identify PT, OT, and SLP costs.

In addition, we propose to separate the current nursing case-mix component into a nursing case-mix component and an NTA component. Similar to the therapy component, we calculated the percentage of the current nursing component of the federal base rates that corresponds to each of the two proposed PDPM components (NTA and nursing). The 1998 reopening of the comment period for the interim final rule (63 FR 65561, November 27, 1998) states that NTA costs comprise 43.4 percent of the current nursing component of the urban federal base rate, and the remaining 56.6 percent accounts for nursing and social services salary costs. These percentages for the nursing component of the federal base rate for rural facilities are 42.7 percent and 57.3 percent, respectively (63 FR 65561). Therefore, we propose to assign 43 percent of the current nursing component of the federal base rates to the proposed new NTA component of the federal base rates and assign the remaining 57 percent to the new nursing component of the federal base rates to reflect what the base rates would have been for these components if they had been separately established in 1998.

We verified the 1998 calculation of the percentages of the nursing component federal base rates that correspond to NTA costs by developing a measure of NTA costs per day for urban and rural facilities. We used the same data (that is, cost information from 1995 cost reports) and

followed the same methodology described above to develop measures of PT, OT, and SLP costs per day and total therapy costs per day. The measure of NTA costs per day produced by this analysis is $47.70 for urban facilities and $47.30 for rural facilities. The original 1998 federal base rates for the nursing component, which relied on a similar methodology, were $109.48 for urban facilities and $104.88 for rural facilities. Therefore, our measure of NTA costs in urban facilities was equivalent to 43.6 percent of the urban 1998 federal nursing base rate, and our measure of NTA costs in rural facilities was equivalent to 45.1 percent of the rural 1998 federal nursing base rate. These results are similar to the estimates published in the 1998 reopening of the comment period for the interim final rule (63 FR 65561, November 27, 1998), which we believe supports the validity of the 43 percent figure stated above.

For illustration purposes, Tables 12 and 13 set forth what the unadjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5. These are derived by dividing the proposed FY 2019 SNF PPS base rates according to the percentages described above. Tables 12 and 13 also show what the unadjusted federal per diem rates for the non-case-mix component would be, which are not affected by the change in case-mix methodology from RUG-IV to PDPM. We use these unadjusted federal per diem rates in calculating the impact analysis discussed in section V.J. of this proposed rule.

TABLE 12: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Urban[3]

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

TABLE 13: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Rural

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

We invite comments on the proposed data sources and proposed methodology for calculating the unadjusted federal per diem rates that would be used in conjunction with the proposed PDPM effective October 1, 2019.

4. Proposed Updates and Wage Adjustments of Revised Federal Base Payment Rate Components

In section III.B. of this proposed rule, we describe the process used to update the federal per diem rates each year. Additionally, as discussed in section III.B.4 of this proposed rule, SNF PPS rates are adjusted for geographic differences in wages using the most recent hospital wage index data. Under PDPM, we propose to continue to update the federal base payment rates and adjust for geographic differences in wages following the current methodology used for such updates and wage index adjustments under the SNF PPS. Specifically, we propose to continue the practice of using the SNF market basket, adjusted as described in section III.B. of this proposed rule to update the federal base payment rates and to adjust for geographic differences in

3 The rates shown in Tables 12 and 13 illustrate what the unadjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5.

wages as described in section III.B.4. of this proposed rule.

D. Proposed Design and Methodology for Case-Mix Adjustment of Federal Rates

1. Background on Proposed PDPM

Section 1888(e)(4)(G)(i) of the Act requires that the Secretary provide an appropriate adjustment to account for case mix and that such an adjustment shall be based on a resident classification system that accounts for the relative resource utilization of different patient types. The current case-mix classification system uses a combination of resident characteristics and service intensity metrics (for example, therapy minutes) to assign residents to one of 66 RUGs, each of which corresponds to a therapy CMI and a nursing CMI, which are indicative of the relative cost to a SNF of treating residents within that classification category. However, as noted in section V.A. of this proposed rule, incorporating service-based metrics into the payment system can incentivize the provision of services based on a facility's financial considerations rather than resident needs. To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics that are patient, and not facility, centered. To that end, the proposed PDPM was developed to be a payment model which derives payment classifications almost exclusively from verifiable resident characteristics.

Additionally, the current RUG-IV case-mix classification system reduces the varied needs and characteristics of a resident into a single RUG-IV group that is used for payment. As of FY 2017, of the 66 possible RUG classifications, over 90 percent of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs, with over 60 percent of covered SNF PPS days billed using one of the three Ultra-High Rehabilitation RUGs. The implication of this pattern is that more than half of the days billed under the SNF PPS effectively utilize only a

resident's therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payment for all aspects of a resident's care. Both of these metrics, more notably a resident's therapy minutes, may not derive so much from the resident's own characteristics, but rather, from the type and amount of care the SNF decides to provide to the resident. Even assuming that the facility takes the resident's needs and unique characteristics into account in making these service decisions, the focus of payment remains centered, to a potentially great extent, on the facility's own decision making and not on the resident's needs.

While the RUG-IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG-IV group, the proposed PDPM would separately identify and adjust for the varied needs and characteristics of a resident's care and combine this information together to determine payment. We believe that the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care. For these reasons, we propose that, effective October 1, 2019, SNF residents would be classified using the PDPM, as further discussed below. As discussed in section V.J. below, we propose to implement the PDPM on October 1, 2019 to allow all stakeholders adequate time for systems updates and staff training needed to assure smooth implementation.

2. Data Sources Utilized for Developing Proposed PDPM

To understand, research, and analyze the costs of providing Part A services to SNF residents, we utilized a variety of data sources in the course of research. In this section, we discuss these sources and how they were used in the SNF PMR in developing the proposed PDPM. A more thorough discussion of the data sources used during the SNF PMR is available in section 3.1. of the SNF PDPM technical report (available at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

a. Medicare Enrollment Data

Beneficiary enrollment and demographic information was extracted from the CMS enrollment database (EDB) and Common Medicare Environment (CME). Beneficiaries' Medicare enrollment was used to apply restrictions to create a study population for analysis. For example, beneficiaries were required to have continuous Medicare Part A enrollment during a SNF stay. Demographic characteristics (for example, age) were incorporated as being predictive of resource use. Furthermore, enrollment and demographic information from these data sources were used to assess the impact of the proposed PDPM on subpopulations of interest. In particular, the EDB and CME include indicators for potentially vulnerable subpopulations, such as those dually-enrolled in Medicaid and Medicare.

b. Medicare Claims Data

Medicare Parts A and B claims from the CMS Common Working File (CWF) were used to conduct claims analyses as part of the SNF PMR. SNF claims (CMS-1450 form, OMB control number 0938-0997), including type of bill (TOB) 21x (SNF Inpatient Part A) and 18x (hospital swing bed), were used to identify Medicare Part A stays paid under the SNF PPS. Part A stays were constructed by linking claims that share the same beneficiary, facility CMS Certification Number (CCN), and admission date. Stays created from SNF claims were linked to other claims data and assessment data via beneficiary identifiers.

Acute care hospital stays that qualified the beneficiary for the SNF benefit were identified using Medicare inpatient hospital claims. The dates of the qualifying hospital stay listed in the span codes of the SNF claim were used to connect inpatient claims with those dates listed as the admission and discharge dates. Although there are exceptions, the claims from the

preceding inpatient hospitalization commonly contain clinical and service information relevant to the care administered during a SNF stay. Components of this information were used in the regression models predicting therapy and NTA costs and to better understand patterns of post-acute care (PAC) referrals for patients requiring SNF services. Additionally, the most recent hospital stay was matched to the SNF stay, which often (though not always) was the same as the preceding inpatient hospitalization, and used in the regression models.

Other Medicare claims, including outpatient hospital, physician, home health, hospice, durable medical equipment, and drug prescriptions, were incorporated, as necessary, into the analysis in one of three ways: (1) to verify information found on assessments or on SNF or inpatient claims; (2) to provide additional resident characteristics to test outside of those found in assessment and SNF and inpatient claims data; and (3) to stratify modeling results to identify effects of the system on beneficiary subpopulations. These claims were linked to SNF claims using beneficiary identifiers.

c. Assessment Data

Minimum Data Set (MDS) assessments were the primary source of resident characteristic information used to explain resource utilization in the SNF setting. The data repositories include MDS assessments submitted by SNFs and swing-bed hospitals. MDS version 2.0 assessments were submitted until October 2010, at which point MDS version 3.0 assessments began. MDS data were extracted from the Quality Improvement Evaluation System (QIES). MDS assessments were then matched to SNF claims data using the beneficiary identifier, assessment indicator, assessment date, and Resource Utilization Group (RUG).

d. Facility Data

Facility characteristics, while not considered as explanatory variables when modeling service use, were used for impact analyses. By incorporating this facility-level information, we

could identify any disproportionate effects of the proposed case-mix classification system on different types of facilities.

Facility-level characteristics were taken from the Certification and Survey Provider Enhanced Reports (CASPER). From CASPER, we draw facility-level characteristics such as ownership, location, facility size, and facility type. CASPER data were supplemented with information from publicly available data sources. The principal data sources that are publicly available include the Medicare Cost Reports (Form 2540-10, 2540-96, and 2540-92) extracted from the Healthcare Cost Report Information System (HCRIS) files, Provider-Specific Files (PSF), Provider of Service files (POS), and Nursing Home Compare (NHC). These data sources have information on facility costs, payment, and characteristics that directly affect PPS calculations.

3. Proposed Resident Classification under PDPM

a. Background

As noted above, section 1888(e)(4)(G)(i) of the Act requires that the Secretary provide for an appropriate adjustment to account for case mix and that such an adjustment shall be based on a resident classification system that accounts for the relative resource utilization of different patient types. The proposed PDPM was developed to be a payment model which derives almost exclusively from resident characteristics. The proposed PDPM would separately identify and adjust five different case-mix components for the varied needs and characteristics of a resident's care and then combine these together with the non-case-mix component to form the full SNF PPS per diem rate for that resident.

As with any case-mix classification system based on resident characteristics, the proposed predictors that would be part of case-mix classification under PDPM are those which our analysis identified as associated with variation in costs for the given case-mix component.

The proposed federal per diem rates discussed above serve as "base rates" specifically because they set the basic average cost of treating a typical SNF resident. Based on the presence of certain needs or characteristics, caring for certain residents may cost more or less than that average cost. A case-mix system identifies certain aspects of a resident or of a resident's care which, when present, lead to average costs for that group being higher or lower than the average cost of treating a typical SNF resident. For example, if we found that therapy costs were the same for two residents regardless of having a particular condition, then that condition would not be relevant in predicting increases in therapy costs. If, however, we found that, holding all else constant, the presence of a given condition was correlated with an increase in therapy costs for residents with that condition over those without that condition, then this could mean that this condition is indicative, or predictive, of increased costs relative to the average cost of treating SNF residents generally.

In the subsections that follow, we describe each of the five proposed case-mix adjusted components under the proposed PDPM and the basis for each of the proposed predictors that would be used within the proposed PDPM to classify residents for payment purposes.

b. Proposed Physical and Occupational Therapy Case-Mix Classification

A fundamental aspect of the proposed PDPM is to use resident characteristics to predict the costs of furnishing similarly situated residents with SNF care. Costs derived from the charges on claims and cost-to-charge ratios (CCRs) on facility cost reports were used as the measure of resource use to develop the proposed PDPM. Costs better reflect differences in the relative resource use of residents as opposed to charges, which partly reflect decisions made by providers about how much to charge payers for certain services. Costs derived from charges are reflective of therapy utilization as they are correlated to the therapy minutes recorded for each therapy discipline. Under the current RUG-IV case-mix model, therapy minutes for all three

therapy disciplines (PT, OT, SLP) are added together to determine the appropriate case-mix classification for the resident. However, as shown in section 3.3.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), when we began to investigate resident characteristics predictive of therapy costs for each therapy discipline, we found that PT and OT costs per day are only weakly correlated with SLP costs per day (correlation coefficient of 0.04). The set of resident characteristics from the MDS that predicted PT and OT utilization was different than the set of characteristics predicting SLP utilization. Additionally, many predictors of high PT and OT costs per day predicted lower SLP costs per day, and vice versa. For example, residents with cognitive impairments receive less physical and occupational therapy but receive more speech-language pathology. As a result of this analysis, we found that basing case-mix classification on total therapy costs per day obscured differences in the determinants of PT, OT, and SLP utilization.

In contrast, the correlation coefficient between PT and OT costs per day was high (0.62). Additionally, regression analyses found that predictors of high PT costs per day were also predictive of high OT costs per day. For example, the analyses found that late-loss ADLs are strong predictors of both PT and OT costs per day. We then used a range of resident characteristics to predict PT and OT costs per day separately and we found that the coefficients in both models followed similar patterns. Finally, resident characteristics were found to be better predictors of the sum of PT and OT costs per day than for either PT or OT costs separately. These analyses used a variety of items from the MDS as independent variables and used PT, OT, and SLP costs per day as dependent variables. More information on these analyses can be found in section 3.3.1. of the SNF PMR technical report that accompanied the ANPRM available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-

Payment/SNFPPS/therapyresearch.html.

Given the results of this analytic work as well as feedback from multiple stakeholders, we propose three separate case-mix adjusted components, one corresponding to each therapy discipline: PT, OT, and SLP. In the original RCS-I model presented in the ANPRM, we stated that we were considering addressing PT and OT services through a single component, given the strong correlation between PT and OT costs and our finding that very similar predictors explained variation in the utilization of both therapy disciplines. However, commenters on the ANPRM stated that having a single combined PT and OT component could encourage providers to inappropriately substitute PT for OT and vice versa. This belief comports with feedback received from professional organizations and other stakeholders during technical expert panels (TEPs). The TEP commenters stated that PT and OT services should be addressed via separate components given the different aims of the two therapy disciplines and differences in the clinical characteristics of the resident subpopulations for which PT or OT services are warranted. For example, clinicians consulted during development of PDPM advised that personal hygiene, dressing, and upper extremity motion may bear a closer clinical relationship to OT utilization, while lower extremity motion may be more closely related to PT utilization. While we do not believe that RCS-I, which included two separate components for PT/OT and SLP, contained stronger incentives for substitution across therapy disciplines compared to RUG-IV, which reimburses all three therapy disciplines through a single therapy component, we concur with the TEP commenters that PT and OT have different aims and that there are clinically relevant differences between residents who could benefit from PT, residents who could benefit from OT, and residents who could benefit from both disciplines. For the foregoing reasons, we decided to separate the combined PT/OT component presented in the ANPRM into two separate case-mix adjusted components in the proposed PDPM. Because of the strong correlation between the

dependent variables used for both components and the similarity in predictors, we decided to maintain the same case-mix classification model for both components. In practice, this means that the same resident characteristics will determine a resident's classification for PT and OT payment. However, each resident will be assigned separate case-mix groups for PT and OT payment, which correspond to separate case-mix indexes and payment rates. We believe that providing separate case-mix-adjusted payments for PT and OT may allay concerns about inappropriate substitution across disciplines and encourage provision of these services according to clinical need. As clinical practices evolve independently of incentives created by the current RUG-IV payment model, we would re-evaluate the different sets of resident characteristics that are predictive of PT and OT utilization after the proposed PDPM is implemented. If based on this re-evaluation we determine that different sets of characteristics are predictive of PT and OT resource utilization, we can consider revising the payment model to better reflect clinical differences between residents who receive PT services and those who receive OT services.

After delineating the three separate case-mix adjusted therapy components, we continued our analysis by identifying resident characteristics that were best predictive of PT and OT costs per day. To accomplish this, we conducted cost regressions with a host of variables from the MDS assessment, the prior inpatient claims, and the SNF claims that were believed to be potentially predictive of relative increases in PT and OT costs. The variables were selected with the goal of being as inclusive as possible with respect to characteristics related to the SNF stay and the prior inpatient stay. The selection also incorporated clinical input. These initial costs regressions were exploratory and meant to identify a broad set of resident characteristics that are predictive of PT and OT resource utilization. The results were used to inform which variables should be investigated further and ultimately included in the payment system. A table of all of the variables considered as part of this analysis appears in the appendix of the SNF PMR

technical report that accompanied the ANPRM available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. Based on our regression analyses, we found that the three most relevant categories of predictors of PT and OT costs per day were the clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment. More information on this analysis can be found in section 3.4.1. of the SNF PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Under the RUG-IV case-mix model, residents are first categorized based on being a rehabilitation resident or a non-rehabilitation resident, then categorized further based on additional aspects of the resident's care. Under the proposed PDPM, for the purposes of determining the resident's PT and OT groups and, as will be discussed below, the resident's SLP group, the resident would first be categorized based on the clinical reasons for the resident's SNF stay. Empirical analyses demonstrated that the clinical basis for the resident's stay (that is, the primary reason the resident is in the SNF) is a strong predictor of therapy costs. For example, all of the clinical categories (described below) developed to characterize the primary reason for a SNF stay (except the clinical category used as the reference group) were found to be statistically significant predictors of therapy costs per day. More detail on these analyses can be found in section 3.4.1. of the SNF PMR technical report that accompanied the ANPRM (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). In consultation with stakeholders (industry representatives, beneficiary representatives, clinicians, and payment policy experts) at multiple technical expert panels (TEPs), we created a set of ten inpatient clinical categories that we believe capture the range of general resident types which may be found in a SNF. These

proposed clinical categories are provided in Table 14.

TABLE 14: Proposed PDPM Clinical Categories

Major Joint Replacement or Spinal Surgery	Cancer
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Non-Orthopedic Surgery

We propose to categorize a resident into a PDPM clinical category using item I8000 on the MDS 3.0. Providers would use the first line in item I8000 to report the ICD-10-CM code that represents the primary reason for the resident's Part A SNF stay. This code would be mapped to one of the ten clinical categories provided in Table 14. The mapping between ICD-10-CM codes and the ten clinical categories is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. The mapping indicates that in some cases, a single ICD-10-CM code maps to more than one clinical category because the care plan for a resident with this diagnosis may differ depending on the inpatient procedure history. In these cases, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the immediately preceding inpatient stay that relates to the primary reason for the Part A SNF stay and typically requires extensive post-surgical rehabilitation or nursing care. If the resident did not receive a related surgical procedure during the prior inpatient stay that typically requires extensive post-surgical rehabilitation or nursing care, the resident may be categorized into a non-surgical clinical category. For example, certain wedge compression fractures that were treated with an invasive surgical procedure such as a fusion during the prior inpatient stay would be categorized as Major Joint Replacement or Spinal Surgery, but if these cases were not treated with a surgical procedure they would be categorized

as Non-Surgical Orthopedic/Musculoskeletal. For residents who received a related surgical procedure during the prior inpatient stay, a provider would need to indicate the type of surgical procedure performed for the resident to be appropriately classified under PDPM. Thus, in these cases we are proposing to require providers to record the type of inpatient surgical procedure performed during the prior inpatient stay so that residents can be appropriately classified into a PDPM clinical category for purposes of PT, OT, and SLP classification. We propose that providers record the type of surgical procedure performed during the prior inpatient stay by coding an ICD-10-PCS code that corresponds to the inpatient surgical procedure in the second line of item I8000 in cases where inpatient surgical information is required to appropriately categorize a resident under PDPM. If we were to use the second line of item I8000 to record inpatient surgical information, we would provide a list of ICD-10-PCS codes that map to the surgical clinical categories. We believe this approach would allow for patients to be appropriately classified under the PDPM because it would provide sufficient information on the primary reason for SNF care and inpatient surgical procedures to assign a resident to the appropriate surgical or non-surgical clinical category. We invite comments on this proposal. In addition, we solicit comments on alternative methods for recording the type of inpatient surgical procedure to appropriately classify a patient into a clinical category. The clinical category into which the resident is classified would be used to classify the resident into a PT and OT category as discussed below, as well as an SLP category, as explained in section V.D.3.c. of this proposed rule.

As discussed above, we propose to categorize a resident into a PDPM clinical category for purposes of PT, OT, and SLP classification using the ICD-10-CM code in the first line of item I8000, and if applicable, the ICD-10 PCS code in the second line of item I8000. As an alternative to using item I8000 to classify a resident into a clinical category, we are considering

using a resident's primary diagnosis as reflected in MDS item I0020 as the basis for assigning the resident to a clinical category, and are evaluating the categories provided in item I0020 to determine if there is sufficient overlap between the categories used in item I0020 and the proposed PDPM clinical categories provided in Table 14 above that this item could serve as the basis for a resident's initial classification into a clinical category under PDPM. The MDS item I0020 would require facilities to select a primary diagnosis from a pre-populated list of primary diagnoses representing the most common types of beneficiaries treated in a SNF, while item I8000, if used to assign residents to clinical categories, would require facilities to code a specific ICD-10-CM code that corresponds to the primary reason for the resident's Part A SNF stay. As indicated above, we are also proposing that providers would code a specific ICD-10-PCS code in the second line of item I8000 when surgical information from the prior inpatient stay is necessary to assign a resident to a clinical category. If we were to use item I0020 to categorize residents under PDPM, we would not require providers to record additional information on inpatient surgical procedures as we expect the primary diagnosis information provided through item I0020 to be adequate to appropriately assign a resident to a clinical category. We invite comments on our proposal to categorize a resident into a PDPM clinical category using the ICD-10-CM code recorded in the first line of item I8000 on the MDS 3.0, and the ICD-10-PCS code recorded on the second line of item I8000 on the MDS 3.0. In addition, we solicit comments on the alternative of using item I0020 on the MDS 3.0, as discussed above, as the basis for resident classification into one of the ten clinical categories in Table 14.

Once we identified these clinical categories as being generally predictive of resource utilization in a SNF, we then undertook the necessary work to identify those categories predictive of PT and OT costs specifically. We conducted additional regression analyses to determine if any of these categories predicted similar levels of PT and OT as other categories,

which may provide a basis for combining categories. As a result of this analysis, for the RCS-I model presented in the ANPRM, we found that the ten inpatient clinical categories could be collapsed into five clinical categories, which predict varying degrees of PT and OT costs. However, we received comments on the ANPRM regarding the number of possible case-mix group combinations under RCS-I, so we sought to try and reduce this number of possible case-mix group combinations by further simplifying the model. As part of that effort, we observed similar PT and OT resource utilization patterns in the clinical categories of Non-Orthopedic Surgery and Acute Neurologic and, therefore, propose to collapse these categories for the purpose of PT and OT classification. Additionally, as reflected in the RCS-I model presented in the ANPRM, we propose that under PDPM, the remaining clinical categories would be collapsed as follows: Acute infections, cancer, pulmonary, cardiovascular and coagulations, and medical management would be collapsed into one clinical category entitled "Medical Management" because their residents had similar PT and OT costs. Similarly, we propose that orthopedic surgery (except major joint replacement or spinal surgery) and non-surgical orthopedic/musculoskeletal would be collapsed into a new "Other Orthopedic" category for equivalent reasons. Finally, the remaining category, Major Joint Replacement, showed a distinct PT and OT cost profile and, thus, we propose to retain it as an independent category. More information on this analysis can be found in section 3.4.2. of the SNF PMR technical report that accompanied the ANPRM and in section 3.4.2. of the SNF PDPM technical report, both available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. These proposed collapsed categories, which would be used to categorize a resident initially under the proposed PT and OT case-mix components, are presented in Table 15.

TABLE 15: Proposed Collapsed Clinical Categories for PT and OT Classification

PDPM Clinical Category	Collapsed PT and OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

As discussed previously in this section, regression analyses demonstrated that the resident's functional status is also predictive of PT and OT costs in addition to the resident's initial clinical categorization. In the RCS-I model discussed in the ANPRM, we presented a function score similar to the existing ADL score to measure functional abilities for the purposes of PT and OT payment. In response to the ANPRM, we received comments requesting that we consider replacing the functional items used to build the RCS-I function score with newer, IMPACT Act-compliant items from section GG. Therefore, we constructed, and are proposing as discussed below, a new function score for PT and OT payment based on section GG functional items.

Under the RUG-IV case-mix system, a resident's ADL or function score is calculated based on a combination of self-performance and support items coded by SNFs in section G of the MDS 3.0 for four ADL areas: transfers, eating, toileting, and bed mobility. These four areas are referred to as late-loss ADLs because they are typically the last functional abilities to be lost as a resident's function declines. Each ADL is assigned a score of up to four points, with a potential total score as high as 16 points. Under the proposed PDPM, we propose that section G items would be replaced with functional items from section GG of the MDS 3.0 (Functional Abilities and Goals) as the basis for calculating the function score for resident classification used under

PDPM. Section GG offers standardized and more comprehensive measures of functional status and therapy needs. Additionally, the use of section GG items better aligns the payment model with other quality initiatives. SNFs have been collecting section GG data since October 2016 as part of the requirements for the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Given the advantages of section GG and of using a more comprehensive measure of functional abilities, we received numerous comments in response to ANPRM requesting the incorporation of section GG items and of early ADLs items into the function score.

Multiple stakeholders commented that late-loss items do not adequately reflect functional abilities on their own. These commenters stated that early-loss ADL items also capture essential clinical information on functional status. Therefore, in building a new function score based on section GG items, we also investigated the incorporation of early-loss items. To explore the incorporation of section GG items, we evaluated each item's relationship with PT and OT costs. We ran individual regressions using each of the 12 section GG item assessed at admission to separately predict PT and OT costs per day. The regression results showed that early-loss items are indeed strong predictors of PT and OT costs, with the exception of two wheeling items. Both wheeling items were excluded from the functional measure due to their weak predictive relationship with PT and OT costs. We observed high predictive ability among the remaining items. In total, we selected ten items for inclusion in the functional measure for the PT and OT components based on the results of the analysis. Thus, under the proposed functional measure for the PT and OT components, a resident's function would be measured using four late-loss ADL activities (bed mobility, transfer, eating, and toileting) and two early-loss ADL activities (oral hygiene and walking). Specifically, the proposed measure includes: two bed mobility items, three transfer items, one eating item, one toileting item, one oral hygiene item, and two

walking items that were all found to be highly predictive of PT and OT costs per day. A list of proposed section GG items that would be included in the functional measure for the PT and OT components is shown in Table 18. Section 3.4.1. in the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on these analyses.

Similar to the RUG-IV ADL score, each of these ADL areas would be assigned a score of up to 4 points. However, in contrast to the RUG-IV ADL score, points are assigned to each response level to track functional independence rather than functional dependence. In other words, higher points are assigned to higher levels of independence. This approach is consistent with functional measures in other care settings, such as the IRF PPS. Further, under the RUG-IV model, if the SNF codes that the "activity did not occur" or "occurred only once," these items are assigned the same point value as "independent." However, we observed that residents who were unable to complete an activity had similar PT and OT costs as dependent residents. Therefore, when the activity cannot be completed, the equivalent section GG responses ("Resident refused," "Not applicable," "Not attempted due to medical condition or safety concerns") are grouped with "dependent" for the purpose of point assignment. For the two walking items, we propose an additional response level to reflect residents who skip the walking assessment due to their inability to walk. We believe this is appropriate because this allows us to assess the functional abilities of residents who cannot walk and assign them a function score. Without this modification, we could not calculate a function score for residents who cannot walk because they would not be assessed on the two walking items included in the function score. Residents who are coded as unable to walk receive the same score as dependent residents to match with clinical expectations. In Tables 16 and 17, we provide the proposed scoring algorithm for the PT and OT functional measure.

TABLE 16: Proposed PT and OT Function Score Construction (Except Walking Items)

Response		Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

TABLE 17: Proposed PT and OT Function Score Construction for Walking Items

Response		Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*	0

*Coded based on response to GG0170H1 (Does the resident walk?).

Unlike section G, section GG measures functional areas with more than one item. This results in substantial overlap between the two bed mobility items, the three transfer items, and the two walking items. Because of this overlap, a simple sum of all scores for each item may inappropriately overweight functional areas measured by multiple items. Therefore, to adjust for this overlap, we propose to calculate an average score for these related items. That is, we would average the scores for the two bed mobility items, the three transfer items, and the two walking items. The average bed mobility, transfer, and walking scores would then be summed with the scores for eating, oral hygiene, and toileting hygiene, resulting in equal weighting of the six activities. This proposed scoring algorithm produces a function score that ranges from 0 to 24. In section 3.4.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), we provide additional information on the analyses that led to the construction of this proposed function score.

TABLE 18: Proposed Section GG Items Included in PT and OT Functional Measure

Section GG Item	Score

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

Under the RCS-I case-mix model presented in the ANPRM, we used cognitive status to classify residents under the PT and OT components in addition to the primary reason for SNF care and functional ability. As will be explained in greater detail below, after publication of the ANPRM, we removed cognitive status as a determinant of resident classification for the PT and OT components. Still, although cognitive status was not ultimately selected as a determinant of PT and OT classification, it was considered as a possible element in developing the proposed resident groups for these components via the Classification and Regression Trees (CART) algorithm described in greater detail below. Because we included cognitive status as an independent variable in the CART analysis used to develop case-mix groups for PT and OT, we believe it is appropriate to discuss construction of the proposed new cognitive measure here even though it was not ultimately selected as a determinant of payment for PT and OT. Thus, we will discuss construction of the instrument used to measure cognitive status under the proposed PDPM here, rather than introducing it when discussing SLP classification, in which we propose cognitive status as a determinant of resident classification. Under the current SNF PPS, cognitive status is used to classify a small portion of residents that fall into the Behavioral Symptoms and Cognitive Performance RUG-IV category. For all other residents, cognitive status is not used in determining the appropriate payment for a resident's care. However, industry representatives and clinicians at multiple TEPs suggested that a resident's cognitive

status can have a significant impact on a resident's PT and OT costs. Based on this feedback, we explored a resident's cognitive status as a predictor of PT and OT costs.

Under the RUG-IV model, cognitive status is assessed using the Brief Interview for Mental Status (BIMS) on the MDS 3.0. The BIMS is based on three items: "repetition of three words," "temporal orientation," and "recall." These items are summed to produce the BIMS summary score. The BIMS score ranges from 0 to 15, with 0 assigned to residents with the worst cognitive performance and 15 assigned to residents with the highest performance. Residents with a BIMS score less than or equal to 9 classify for the Behavioral Symptoms and Cognitive Performance category. Residents with a summary score greater than 9 but not 99 (resident interview was not successful) are considered cognitively intact for the purpose of classification under RUG-IV.

In approximately 15 percent of 5-day MDS assessments, the BIMS is not completed: in 12 percent of cases the interview is not attempted, and for 3 percent of cases the interview is attempted but cannot be completed. The MDS directs assessors to skip the BIMS if the resident is rarely or never understood (this is scored as "skipped"). In these cases, the MDS requires assessors to complete the Staff Assessment for Mental Status (items C0700 through C1000). The Cognitive Performance Scale (CPS) is then used to assess cognitive function based on the Staff Assessment for Mental Status and other MDS items ("Comatose" (B0100), "Makes Self Understood" (B0700), and the self-performance items of the four late-loss ADLs). The Staff Assessment for Mental Status consists of four items: "Short-term Memory OK," "Long-term Memory OK," "Memory/Recall Ability," and "Cognitive Skills for Daily Decision Making." Only "Short-term Memory OK" and "Cognitive Skills for Daily Decision Making" are currently used for payment. In MDS 2.0, the CPS was used as the sole measure of cognitive status. A resident was assigned a CPS score from 0 to 6 based on the Staff Assessment for Mental Status

and other MDS items, with 0 indicating the resident was cognitively intact and 6 indicating the highest level of cognitive impairment. In addition to the items on the Staff Assessment for Mental Status, MDS items "Comatose" (B0100), "Makes Self Understood" (B0700), and the self-performance items of the four late-loss ADLs factored into the CPS score. Any score of 3 or above was considered cognitively impaired. The CPS on the current version of the MDS (3.0) functions very similarly. Instead of assigning a score to each resident, a resident is determined to be cognitively impaired if he or she meets the criteria to receive a score of 3 or above on the CPS, based on the MDS items mentioned above. In other words, whereas the MDS 2.0 assigned a CPS score to each resident, the MDS 3.0 only determines whether a resident's score is greater than or equal to 3 and does not assign a specific score to each resident for whom the CPS is used to assess cognitive status. Residents who are determined to be cognitively impaired based on the CPS are classified in the Behavioral Symptoms and Cognitive Performance category under RUG-IV, if they do not meet the criteria for a higher-paying category.

Given that the 15 percent of residents who are not assessed on the BIMS must be assessed using a different scale that relies on a different set of MDS items, there is currently no single measure of cognitive status that allows comparison across all residents. To address this issue, Thomas et al., in a 2015 paper, proposed use of a new cognitive measure, the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all residents (Thomas KS, Dosa D, Wysocki A, Mor V; The Minimum Data Set 3.0 Cognitive Function Scale. Med Care. https://www.ncbi.nlm.nih.gov/pubmed/?term=25763665). Following a suggestion from the June 2016 TEP, we explored using the CFS as a measure of cognition and found that there is a relationship between the different levels of the cognitive scale and resident costs. Specifically, we observed that as cognitive function declines, PT and OT costs per day decrease, while SLP

costs per day more than double. More information on this analysis can be found in section 3.4.1. of the SNF PMR technical report that accompanied the ANPRM available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. Based on these initial investigations, we used the CFS as a cognitive measure in the RCS-I payment model described in the ANPRM. As we noted above, the RUG-IV system incorporates both the BIMS and CPS score separately, but the CFS blends them together into one measure of cognitive status. Details on how the BIMS score and CPS score are determined using the MDS assessment are described above. The CFS uses these scores to place residents into one of four cognitive performance categories, as shown in Table 19. After publication of the ANPRM, we received stakeholder comments questioning this scoring methodology, specifically the classification of a CPS score of 0 as "mildly impaired." Based on a subsequent analysis showing that residents with a CPS score of 0 were similar to residents classified as "cognitively intact" under the CFS methodology, as well as clinical feedback, we determined that it was appropriate to reclassify residents with a CPS score of 0 as cognitively intact, consistent with ANPRM feedback. This analysis is described in more detail in section 3.4.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. The scoring methodology for the proposed PDPM cognitive measure is shown in Table 20. We would note once again that while we discuss this scoring methodology in this section because cognitive status was considered in developing the PT and OT classification, the cognitive score is not being proposed as a factor of classification for the PT and OT components under PDPM, as further discussed below.

TABLE 19: Cognitive Function Scale (CFS) Scoring Methodology

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	-
Mildly Impaired	8-12	0-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

TABLE 20: Proposed PDPM Cognitive Measure Classification Methodology

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

Once each of these variables—clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment—was identified, we then used a statistical regression technique called Classification and Regression Trees (CART) to explore the most appropriate splits in PT and OT case-mix groups using these three variables. In other words, CART was used to investigate how many PT and OT case-mix groups should exist under the proposed PDPM and what types of residents or score ranges should be combined to form each of those PT and OT case-mix groups. CART is a non-parametric decision tree learning technique that produces either classification or regression trees, depending on whether the dependent variable is categorical or numeric, respectively. Using the CART technique to create payment groups is advantageous because it is resistant to both outliers and irrelevant parameters. The CART algorithm has been used to create payment groups in other Medicare settings. For example, it was used to determine Case Mix Groups (CMGs) splits within rehabilitation impairment groups (RICs) when the inpatient rehabilitation facility (IRF) PPS was developed. This methodology is more thoroughly explained in section 3.4.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

We used CART to develop splits within the four collapsed clinical categories shown in Table 15. Splits within each of these four collapsed clinical categories were based on the two independent variables included in the algorithm: function score and cognitive status. The CART algorithm split residents into 18 groups for the PT component and 14 groups for the OT component. These splits are primarily based on differences in resident function. In the CART-generated groups, cognitive status plays a role in categorizing less than half of the PT groups and only two of the 14 OT groups. In addition, to create the proposed resident classification for the PT and OT components, we made certain administrative decisions that further refined the PT and OT case-mix classification groups beyond those produced through use of the CART algorithm. For example, while CART may have created slightly different breakpoints for the function score in different clinical categories, we believe that using a consistent split in scores across clinical categories improves the simplicity of the case-mix model without compromising its accuracy. Therefore, we used the splits created by the CART algorithm as the basis for the consistent splits selected for the case-mix groups, simplifying the CART output while retaining important features of the CART-generated splits. In our proposed classification for the PT and OT components, we retained function as the sole determinant of resident categorization within each of the four collapsed clinical categories. We created function score bins based on breakpoints that recurred in the CART splits, such as 5, 9, and 23. As noted above, we dropped cognitive status as a determinant of classification because of the reduced role it played in categorizing residents within the CART-generated groups. Finally, we used the same function score bins to categorize residents within each of the four collapsed clinical categories for both the PT and OT components. As shown in section 3.4.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), using the proposed case-mix groups for the PT and OT

components results in a reduction of 0.005 in the R-squared values for both PT and OT classification models. This shows that although the proposed case-mix groups improve simplicity by removing one predictor revealed to be less important in categorizing residents (cognitive status) and grouping residents similarly (using the same function score bins) across clinical categories, these decisions have only a minor negative impact on predictive accuracy. These analyses are described in further detail in section 3.4.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

Based on the CART results and the administrative decisions described above, we propose 16 case-mix groups to classify residents for PT and OT payment. We would note that this represents a marked reduction in the number of case-mix groups for PT and OT classification under the RCS-I model discussed in the ANPRM. As discussed throughout the sections above, after publication of the ANPRM, we received feedback from stakeholders that the RCS-I payment model was overly complex. In particular, commenters expressed concern about the relatively large number of possible combinations of case-mix groups. Based on this feedback, we sought to reduce the number of resident groups in the PT and OT components. First, because we observed similar PT and OT resource utilization patterns in the clinical categories of Non-Orthopedic Surgery and Acute Neurologic, we decided to collapse these categories for the purpose of PT and OT classification. In addition, as discussed in this section, we replaced the section G-based functional measure from RCS-I with a new functional measure based on section GG items. The inclusion of the section GG-based functional measure in the CART algorithm resulted in case-mix groups in which cognitive function played a less important role in classification. Based on these results, we determined that we could remove cognitive function as a determinant of PT and OT classification without a notable loss in the predictive ability of the

payment model, as discussed above. We also consulted with clinicians who advised CMS during development of PDPM, who confirmed the appropriateness of this decision. The decisions to collapse Non-Orthopedic Surgery and Acute Neurologic into one clinical category and remove cognitive status resulted in a large reduction in the number of PT and OT case-mix groups, from the 30 in RCS-I to the 16 in the proposed PDPM provided in Table 21. We provide the criteria for each of these groups along with its CMI for both the PT and OT components in Table 21. As shown in Table 21, two factors would be used to classify each resident for PT and OT payment: clinical category and function score. Each case-mix group corresponds to one clinical category and one function score range. We propose classifying each SNF resident into one of the 16 groups shown in Table 21 based on these two factors.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to its share of total costs of the component. CMIs for the PT and OT components are calculated based on two factors. One factor is the average per diem costs of a case-mix group relative to the population average. The other factor is the average variable per diem adjustment factor of the group relative to the population average. In this calculation, average per diem costs equal total PT or OT costs in the group divided by number of utilization days in the group. Similarly, the average variable per diem adjustment factor equals the sum of variable per diem adjustment factors corresponding to a given component (PT or OT) for all utilization days in the group divided by the number of utilization days in the group. We calculate CMIs such that they equal the ratio of relative average per diem costs for a group to the relative average variable per diem adjustment factor for the group. In this calculation, relative average per diem costs and the relative average variable per diem adjustment factor are weighted by length of stay to account for

the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). The relative average variable per diem adjustment factors for a given PT group and the corresponding OT group are the same because residents are classified into the same case-mix group under both components. However, relative average per diem costs are different across the two corresponding PT and OT groups, therefore the resulting CMIs calculated for each group are different, as shown in Table 21. After calculating CMIs as described above, we then apply adjustments to help ensure that the distribution of resources across payment components is aligned with the statutory base rates. The base rates implicitly allocate resources to case-mix components in proportion to the relative magnitude of the respective component base rates. For example, if the base rate for one component were twice as large as the base rate for another component, this would imply that the component with the larger base rate should receive double the resources of the other component. To ensure that the distribution of resources across payment components is aligned with the statutory base rates, we set CMIs such that the average product of the CMI and the variable per diem adjustment factor for a day of care equals 1.0 for each of the five case-mix-adjusted components in PDPM. If the average product of the CMI and the variable per diem adjustment factor for a day of care were different across case-mix components, this would result in allocating resources in a manner inconsistent with the distribution of resources implied by the statutory base rates.

After adjusting the CMIs to align the distribution of resources across payment components with the statutory base rates, a parity adjustment is then applied by multiplying the CMIs by the ratio of case-mix-related payments in RUG-IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. More information

on the variable per diem adjustment factors is discussed in section V.D.4. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

TABLE 21: Proposed PT and OT Case-mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

Under the proposed PDPM, all residents would be classified into one and only one of these 16 PT and OT case-mix groups for each of the two components. As opposed to the RUG-IV system that determines therapy payments based only on the amount of therapy provided, these groups classify residents based on the two resident characteristics shown to be most predictive of PT and OT utilization: clinical category and function score. Thus, we believe that the PT and OT case-mix groups better reflect relative resource use of clinically relevant resident subpopulations and therefore provide for more appropriate payment under the SNF PPS. We

invite comments on the approach we are proposing above to classify residents for PT and OT payment.

c. Proposed Speech-Language Pathology Case-Mix Classification

As discussed above, many of the resident characteristics that we found to be predictive of increased PT and OT costs were predictive of lower SLP costs. As a result of this inverse relationship, using the same set of predictors to case-mix adjust all three therapy components would obscure important differences in variables predicting variation in costs across therapy disciplines and make any model that attempts to predict total therapy costs inherently less accurate. Therefore, we believe it is appropriate to have a separately adjusted case-mix SLP component that is specifically designed to predict relative differences in SLP costs. As discussed in the prior section, costs derived from the charges on claims and CCRs on facility cost reports were used as the measure of resource use to develop an alternative payment model. Costs are reflective of therapy utilization as they are correlated to therapy minutes recorded for each therapy discipline.

Following the same methodology we used to identify predictors of PT and OT costs, our project team conducted cost regressions with a host of variables from the MDS assessment, prior inpatient claims, and SNF claims that were identified as likely to be predictive of relative increases in SLP costs. The variables were selected with the goal of being as inclusive of the measures recorded on the MDS assessment as possible and also included diagnostic information from the prior inpatient stay. The selection process also incorporated clinical input from TEP panelists, the contractor's clinical staff, and CMS clinical staff. These initial costs regressions were exploratory and meant to identify a broad set of resident characteristics that are predictive of SLP resource utilization. The results were used to inform which variables should be investigated further and ultimately included in the payment system. A table of all of the

variables considered in this analysis appears in the appendix of the SNF PMR technical report that accompanied the ANPRM (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

Based on these cost regressions, we identified a set of three categories of predictors relevant in predicting relative differences in SLP costs: clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically-altered diet, and the presence of an SLP-related comorbidity or cognitive impairment. A model using these predictors to predict SLP costs per day accounted for 14.5 percent of the variation in SLP costs per day, while a very extensive model using 1,016 resident characteristics only predicted 19.3 percent of the variation. This shows that these predictors alone explain a large share of the variation in SLP costs per day that can be explained with resident characteristics.

As with the proposed PT and OT components, we began with the set of clinical categories identified in Table 14 meant to capture general differences in resident resource utilization and ran cost regressions to determine which categories may be predictive of generally higher relative SLP costs. Through this analysis, we found that one clinical category, the Acute Neurologic group, was particularly predictive of increased SLP costs. More detail on this investigation can be found in section 3.5.2. of the SNF PMR technical report that accompanied the ANPRM, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. Therefore, to determine the initial resident classification into an SLP group under the proposed PDPM, residents would first be categorized into one of two groups using the clinical reasons for the resident's SNF stay recorded on the first line of Item I8000 on the MDS assessment: either the "Acute Neurologic" clinical category or a "Non-Neurologic" group that includes the remaining clinical categories in Table 14 (Major Joint Replacement or Spinal Surgery; Non-Surgical Orthopedic/Musculoskeletal; Orthopedic Surgery

(Except Major Joint Replacement or Spinal Surgery); Acute Infections; Cancer; Pulmonary; Non-Orthopedic Surgery; Cardiovascular and Coagulations; and Medical Management).

In addition to the clinical reason for the SNF stay, based on cost regressions and feedback from TEP panelists, we also identified the presence of a swallowing disorder or a mechanically-altered diet (which refers to food that has been altered to make it easier for the resident to chew and swallow to address a specific resident need) as a predictor of relative increases in SLP costs. First, residents who exhibited the signs and symptoms of a swallowing disorder, as identified using K0100Z on the MDS 3.0, demonstrated significantly higher SLP costs than those who did not exhibit such signs and symptoms. Therefore, we considered including the presence of a swallowing disorder as a component in predicting SLP costs. However, when this information was presented during the October 2016 TEP, stakeholders indicated that the signs and symptoms of a swallowing disorder may not be as readily observed when a resident is on a mechanically-altered diet and requested that we also consider evaluating the presence of a mechanically-altered diet, as determined by item K0510C2 on the MDS 3.0, as an additional predictor of increased SLP costs. Our project team conducted this analysis and found that there was an associated increase in SLP costs when a mechanically-altered diet was present. Moreover, this analysis revealed that while SLP costs may increase when either a swallowing disorder or mechanically-altered diet is present, resident SLP costs increased even more when both of these items were present. More detail on this investigation and these analyses can be found in section 3.5.3. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. As a result, we agree with the stakeholders that both swallowing disorder and mechanically-altered diet are important components of predicting relative increases in resident SLP costs, and thus, in addition to the clinical categorization, we propose classifying residents as having either a swallowing disorder, being on a mechanically

altered diet, both, or neither for the purpose of classifying the resident under the SLP component. We note that we do plan to monitor specifically for any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.

As a final aspect of the proposed SLP component case-mix adjustment, we explored how SLP costs vary according to cognitive status and the presence of an SLP-related comorbidity. We observed that SLP costs were notably higher for residents who had a mild to severe cognitive impairment (as defined by the PDPM cognitive measure methodology described in Table 20) or who had an SLP-related comorbidity present. For each condition or service included as an SLP-related comorbidity, the presence of the condition or service was associated with at least a 43 percent increase in average SLP costs per day. The presence of a mild to severe cognitive impairment was associated with at least a 100 percent increase in average SLP costs per day. Similar to the analysis conducted in relation to the PT and OT components, the project team ran cost regressions on a broad list of possible conditions. Based on that analysis, and in consultation with stakeholders during our TEPs and clinicians, we identified the conditions listed in Table 22 as SLP-related comorbidities which we believe best predict relative differences in SLP costs. We used diagnosis codes on the most recent inpatient claim and the first SNF claim as well as MDS items on the 5-day assessment for each SNF stay to identify these diagnoses and found that residents with these conditions had much higher SLP costs per day. Rather than accounting for each SLP-related comorbidity separately, all conditions were combined into a single flag. If the resident has at least one SLP-related comorbidity, the combined flag is turned on. We combined all SLP-related comorbidities into a single flag because we found that the predictive ability of including a combined SLP comorbidity flag is comparable to the predictive ability of including each SLP-related comorbidity as an individual predictor. Additionally, using

a combined SLP-related comorbidity flag greatly improves the simplicity of the payment model. More detail on these analyses can be found in section 3.5.1. of the SNF PMR technical report that accompanied the ANPRM (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

TABLE 22: Proposed SLP-related Comorbidities

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

Once each of these variables—clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically-altered diet, and the presence of an SLP-related comorbidity or cognitive impairment—found to be useful in predicting resident SLP costs was identified, we used the CART algorithm, as we discussed above in relation to the PT and OT components, to determine appropriate splits in SLP case-mix groups based on CART output breakpoints using these three variables. We then further refined the SLP case-mix classification groups beyond those produced by the CART algorithm. We used consistent criteria to group residents into 18 payment groups across the two clinical categories determined to be relevant to SLP utilization (Acute Neurologic and Non-Neurologic). These groups simplified the SLP case-mix classification by reducing the number of groups while maintaining the CART predictive power in terms of R-squared. This methodology and the results of our analysis are more thoroughly explained in sections 3.4.2. and 3.5.2. of the SNF PMR technical report that accompanied the ANPRM (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

Under the original RCS-I SLP component, a resident could be classified into one of 18 possible case-mix groups. Comments received in response to the ANPRM expressed concern

over the complexity of the payment model due to the high number of possible combinations of case-mix groups. To reduce the number of possible SLP case-mix groups, we simplified the consistent splits model selected for RCS-I. To accomplish this, we combined clinical category (Acute Neurologic or Non-Neurologic), cognitive impairment, and the presence of an SLP-related comorbidity into a single predictor due to the clinical relationship between acute neurologic conditions, cognition, and SLP comorbidities. These three predictors are highly interrelated as acute neurologic conditions may often result in cognitive impairment or SLP-related comorbidities such as speech and language deficits. Using this combined variable along with presence of a swallowing disorder or mechanically-altered diet results in 12 groups. We compared the predictive ability of the simplified model with more complex classification options, including the original RCS-I SLP model. Regression results showed that the reduction in case-mix groups by collapsing independent variables had little to no effect on payment accuracy. Specifically, the proposed PDPM SLP model has an R-squared value almost identical to that of the original RCS-I SLP model, while reducing the number of resident groups from 18 to 12. Therefore, we determined that 12 case-mix groups would be necessary to classify residents adequately in terms of their SLP costs in a manner that captures sufficient variation in SLP costs without creating unnecessarily granular separations. More information on this analysis can be found in section 3.5.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). We provide the criteria for each of these groups along with its CMI in Table 23.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to

its share of total costs of the component. CMIs for the SLP component are calculated based on the average per diem costs of a case-mix group relative to the population average. Relative average differences in costs are weighted by length of stay to account for the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). In this calculation, average per diem costs equal total SLP costs in the group divided by number of utilization days in the group. Because the SLP component does not have a variable per diem schedule (as further discussed in section 3.9.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), variable per diem adjustment factors are not involved in SLP CMI calculation. A parity adjustment is then applied by multiplying the CMI by the ratio of case-mix-related payments in RUG-IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. This method helps ensure that the share of payment for each case-mix group is equal to its share of total costs of the component and that PDPM is budget neutral relative to RUG-IV. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

TABLE 23: Proposed SLP Case-Mix Classification Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

As with the proposed PT and OT components, all residents would be classified into one and only one of these 12 SLP case-mix groups under the proposed PDPM. As opposed to the RUG-IV system that determines therapy payments based only on the amount of therapy provided, under the proposed PDPM, residents would be classified into SLP case-mix groups based on resident characteristics shown to be predictive of SLP utilization. Thus, we believe that the proposed SLP case-mix groups would provide a better measure of resource use and would provide for more appropriate payment under the SNF PPS. We invite comments on the approach we are proposing above to classify residents for SLP payment under the proposed PDPM.

d. Proposed Nursing Case-Mix Classification

The RUG-IV classification system first divides residents into "rehabilitation residents" and "non-rehabilitation residents" based on the amount of therapy a resident receives. Differences in nursing needs can be obscured for rehabilitation residents, where the primary driver of payment classification is the intensity of therapy services that a resident receives. For example, for two residents classified into the RUB RUG-IV category, which would occur on the basis of therapy intensity and ADL score alone, the nursing component for each of these residents would be multiplied by a CMI of 1.56. This reflects that residents in that group were found, during our previous Staff time measurement (STM) work, to have nursing costs 56 percent higher than residents with a 1.00 index. We would note that while this CMI also includes adjustments made in FY 2010 and FY 2012 for budget-neutrality purposes, what is clear is that two residents, who may have significantly different nursing needs, are nevertheless deemed to have the very same nursing costs, and SNFs would receive the same nursing payment

for each. Given the discussion above, which noted that approximately 60 percent of resident days are billed using one of three Ultra-High Rehabilitation RUGs (two of which have the same nursing index), the current case-mix model effectively classifies a significant portion of SNF therapy residents as having exactly the same degree of nursing needs and requiring exactly the same amount of nursing resources. As such, we believe that further refinement of the case-mix model would be appropriate to better differentiate among patients, particularly those who receive therapy services with different nursing needs.

An additional concern in the RUG-IV system is the use of therapy minutes to determine not only therapy payments but also nursing payments. For example, residents classified into the RUB RUG fall in the same ADL score range as residents classified into the RVB RUG. The only difference between those residents is the number of therapy minutes that they received. However, the difference in payment that results from this difference in therapy minutes impacts not only the RUG-IV therapy component but also the nursing component: Nursing payments for RUB residents are 40 percent higher than nursing payments for RVB residents. As a result of this feature of the RUG-IV system, the amount of therapy minutes provided to a resident is one of the main sources of variation in nursing payments, while other resident characteristics that may better reflect nursing needs play a more limited role in determining payment.

The more nuanced and resident-centered classifications in current RUG-IV non-rehabilitation categories are obscured under the current payment model, which utilizes only a single RUG-IV category for payment purposes and has over 90 percent of resident days billed using a rehabilitation RUG. The RUG-IV non-rehabilitation groups classify residents based on their ADL score, the use of extensive services, the presence of specific clinical conditions such as depression, pneumonia, or septicemia, and the use of restorative nursing services, among other characteristics. These characteristics are associated with nursing utilization, and the STRIVE

study accounted for relative differences in nursing staff time across groups. Therefore, we propose to use the existing RUG-IV methodology for classifying residents into non-rehabilitation RUGs to develop a proposed nursing classification that helps ensure nursing payment reflects expected nursing utilization rather than therapy utilization.

For example, consider two residents. The first patient classifies into the RUB rehabilitation RUG (on the basis of the resident's therapy minutes) and into the CC1 non-rehabilitation RUG (on the basis of having pneumonia), while the second classifies into the RUB rehabilitation RUG (on the basis of the resident's therapy minutes) and the HC1 non-rehabilitation RUG (on the basis of the resident having quadriplegia and a high ADL score). Under the current RUG-IV based payment model, the billing for both residents would utilize only the RUB rehabilitation RUG, despite clear differences in their associated nursing needs and resident characteristics. We propose an approach where, for the purpose of determining payment under the nursing component, the first resident would be classified into CC1, while the second would be classified into HC1 under the PDPM. We believe that classifying the residents in this manner for payment purposes would capture variation in nursing costs in a more accurate and granular way than relying on the rehabilitation RUG's nursing CMI.

While resident classification in the proposed PDPM nursing component is guided by RUG-IV methodology, we propose to make several modifications to the RUG-IV nursing RUGs and classification methodology under the proposed PDPM. First, the proposed PDPM would reduce the number of nursing RUGs by decreasing distinctions based on function. Under RUG-IV, residents with a serious medical condition/service such as septicemia or respiratory therapy are classified into one of eight nursing RUGs in the Special Care High category. The specific RUG into which a resident is placed depends on the resident's ADL score and whether the resident is depressed. RUG-IV groups ADL score into bins for simplicity (for example, 2-5 and

6-10). For example, under RUG-IV, a resident in the Special Care High category who has depression and an ADL score of 3 would fall into the 2-5 ADL score bin and therefore be classified into the HB2 RUG, which corresponds to Special Care High residents with depression and an ADL score between 2 and 5 (a mapping of clinical traits and ADL score to RUG-IV nursing groups is shown in the appendix of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). To explore options to reduce the number of nursing RUGs, we compared average nursing utilization across all 43 RUG-IV nursing RUGs. The dependent variable used in this investigation was the average wage-weighted staff time (WWST) for each nursing RUG from the STRIVE study. WWST is a measure of nursing resource utilization used in the STRIVE study. As discussed in more detail in section 3.2.1. of the PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), we were unable to construct a measure of nursing utilization based on current data because facilities do not report resident-specific nursing costs. We observed that nursing resource use as measured by WWST does not vary markedly between nursing case-mix groups defined by contiguous ADL score bins (for example, 11-14 and 15-16) but otherwise sharing the same clinical traits (for example, classified into Special Care High and depressed). This suggests that collapsing contiguous ADL score bins for RUGs that are otherwise defined by the same set of clinical traits is unlikely to notably affect payment accuracy. Section 3.6.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on this analysis.

In the Special Care High, Special Care Low, Clinically Complex, and Reduced Physical Function classification groups (RUGs beginning with H, L, C, or P), for nursing groups that were

otherwise defined with the same clinical traits (for example, extensive services, medical conditions, depression, restorative nursing services received), we propose to combine the following pairs of second characters due to their contiguous ADL score bins: (E, D) and (C, B). These characters correspond to ADL score bins (15 to 16, 11 to 14) and (6 to 10, 2 to 5), respectively. We observed that nursing utilization did not vary notably across these contiguous ADL score bins, therefore we believe it is appropriate to collapse pairs of RUGs in these classification groups that correspond to contiguous ADL score bins but are otherwise defined by the same clinical traits. For example, HE2 and HD2, which are both in the Special Care High group and both indicate the presence of depression, would be collapsed into a single nursing case-mix group. Similarly, PC1 and PB1 (Reduced Physical Function and 0 to 1 restorative nursing services) also would be combined into a single nursing case-mix group. Section 3.6.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on this analysis. In the Behavioral and Cognitive Performance classification group (RUGs beginning with B), for RUGs that are otherwise defined by the same number of restorative nursing services (0 to1 or 2 or more), we propose to combine RUGs with the second character B and A, which correspond to contiguous ADL score bins 2 to 5 and 0 to 1, respectively. We observed that nursing utilization did not vary notably across these contiguous ADL score bins, therefore we believe it is appropriate to collapse pairs of RUGs in this classification group that correspond to contiguous ADL score bins but are otherwise defined by the same clinical traits. In other words, BB2 and BA2 would be combined into a single nursing group, and BB1 and BA1 would also be combined into a single nursing group. Section 3.6.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on this analysis. The proposed

PDPM would maintain CA1, CA2, PA1, and PA2 as separate case-mix groups. We observed that these RUGs do not share similar levels of nursing resource use with RUGs in adjacent ADL score bins that are otherwise defined by the same clinical traits (for example, medical conditions, depression, restorative nursing services received). Rather, CA1, CA2, PA1, and PA2 are associated with distinctly lower nursing utilization compared to RUGs that otherwise have the same clinical traits (for example, medical conditions, depression, restorative nursing services received) but higher ADL score bins. Section 3.6.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on this analysis. ES3, ES2, and ES1 also would be maintained as separate case-mix groups under the nursing component of the proposed PDPM because, although they are defined by the same ADL score bin, they are defined by different clinical traits unlike the pairs of RUGs that were combined. Specifically, ES3, ES2, and ES1 are defined by different combinations of extensive services. We believe that collapsing case-mix groups based on ADL score for the RUGs specified above would reduce model complexity by decreasing the number of nursing case-mix groups from 43 to 25, which thereby decreases the total number of possible combinations of case-mix groups under the proposed PDPM. Table 26 shows the proposed 25 case-mix groups for nursing payment. Section 3.6.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides more detail on the analyses and data supporting these proposals.

The second modification to the RUG-IV nursing classification methodology would update the nursing ADL score to incorporate section GG items. Currently, the RUG-IV ADL score is based on four late-loss items from section G of MDS 3.0: eating, toileting, transfer, and bed mobility. Under the proposed PDPM, these section G items would be replaced with an

eating item, a toileting item, three transfer items, and two bed mobility items from the admission performance assessment of section GG. In contrast to the RUG-IV ADL score, the proposed PDPM score assigns higher points to higher levels of independence. Therefore, an ADL score of 0 (independent) corresponds to a section GG-based function score of 16, while an ADL score of 16 (dependent) corresponds to a section GG-based function score of 0. This scoring methodology is consistent with the proposed PDPM PT and OT function score as well as functional scores in other care settings, such as the IRF PPS. The proposed nursing scoring methodology also assigns 0 points when an activity cannot be completed ("Resident refused," "Not applicable," "Not attempted due to medical condition or safety concerns"). As described in section V.D.3.c. (PT and OT Case-Mix Classification) of this proposed rule, grouping these responses with "dependent" aligns with clinical expectations of resource utilization for residents who cannot complete an ADL activity. The proposed scoring methodology is shown in Table 24. As discussed in section V.D.3.c., section GG measures functional areas with more than one item, which results in substantial overlap between the two bed mobility items and the three transfer items. To address overlap, we propose to calculate an average score for each of these related items. That is, we would average the scores for the two bed mobility items and for the three transfer items. This averaging approach is also used in the proposed PT and OT function scores and is illustrated in Table 25. The final score sums the average bed mobility and transfer scores with eating and toileting scores, resulting in a nursing function score that ranges from 0 to 16.

TABLE 24: **Proposed Nursing Function Score Construction**

Response		ADL Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

TABLE 25: Section GG Items Included in Proposed Nursing Functional Measure

Section GG Item		ADL Score
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	

In addition to proposing to replace the nursing ADL score with a function score based on section GG items and to collapse certain nursing RUGs, we also propose to update the existing nursing CMIs using the STRIVE staff time measurement data that were originally used to create these indexes. Under the current payment system, non-rehabilitation nursing indexes were calculated to capture variation in nursing utilization by using only the staff time collected for the non-rehabilitation population. We believe that, to provide a more accurate reflection of the relative nursing resource needs of the SNF population, the nursing indexes should reflect nursing utilization for all residents. To accomplish this, we replicated the methodology described in the FY 2010 SNF PPS rule (74 FR 22236 through 22238) but classified the full STRIVE study population under non-rehabilitation RUGs using the RUG-IV classification rules. The methodology for updating resource use estimates for each nursing RUG proceeded according to the following steps:

(1) Calculate average wage-weighted staff time (WWST) for each STRIVE study resident using FY 2015 SNF wages.

(2) Assign the full STRIVE population to the appropriate non-rehabilitation RUG.

(3) Apply sample weights to WWST estimates to allow for unbiased population estimates. The reason for this weighting is that the STRIVE study was not a random sample of residents. Certain key subpopulations, such as residents with HIV/AIDS, were over-sampled to ensure that there were enough residents to draw conclusions on the subpopulations' resource use.

As a result, STRIVE researchers also developed sample weights, equal to the inverse of each resident's probability of selection, to permit calculation of unbiased population estimates. Applying the sample weights to a summary statistic results in an estimate that is representative of the actual population. The sample weight method is explained in Phase I of the STRIVE study. A link to the STRIVE study is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html.

(4) Smooth WWST estimates that do not match RUG hierarchy in the same manner as the STRIVE study. RUG-IV, from which the nursing RUGs are derived, is a hierarchical classification in which payment should track clinical acuity. It is intended that residents who are more clinically complex or who have other indicators of acuity, including a higher ADL score, depression, or restorative nursing services, would receive higher payment. When STRIVE researchers estimated WWST for each RUG, several inversions occurred because of imprecision in the means. These are defined as WWST estimates that are not in line with clinical expectations. The methodology used to smooth WWST estimates is explained in Phase II of the STRIVE study. A link to the STRIVE study is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html.

(5) Calculate nursing indexes, which reflect the average WWST for each of the 25 nursing case-mix groups divided by the average WWST for the study population used throughout our research. To impute WWST for each stay in the population, we assigned each resident the average WWST of the collapsed nursing RUG into which they are categorized. To derive the average WWST of each collapsed RUG, we first estimate the average WWST of the original 43 nursing RUGs based on steps 1 through 4 above, then calculate a weighted mean of the average WWST of the two RUGs that form the collapsed RUG. More details on this analysis can be found in section 3.6.3. of the SNF PDPM technical report (available at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

Through this refinement, we believe the nursing indexes under the proposed PDPM better reflect the varied nursing resource needs of the full SNF population. In Table 26, we provide the nursing indexes under the proposed PDPM.

To help ensure that payment reflects the average relative resource use at the per diem level, nursing CMIs would be set to reflect case-mix related relative differences in WWST across groups. Nursing CMIs would be calculated based on the average per diem nursing WWST of a case-mix group relative to the population average. In this calculation, average per diem WWST equals total WWST in the group divided by number of utilization days in the group. Because the nursing component does not have a variable per diem schedule (as further discussed in section 3.9.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), variable per diem adjustment factors are not involved in nursing CMI calculation. We then apply a parity adjustment by multiplying the CMI by the ratio of case-mix-related payments in RUG-IV over estimated case-mix-related payments in PDPM, as discussed further in section V.J. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

TABLE 26: Proposed Nursing Indexes under Proposed PDPM Classification Model

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	4.04
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	3.06
ES1	Infection	-	-	-	0-14	ES1	2.91
HE2/HD2	-	Serious medical	Yes	-	0-5	HDE2	2.39

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
		conditions e.g. comatose, septicemia, respiratory therapy					
HE1/HD1	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	1.99
HC2/HB2	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	2.23
HC1/HB1	-	Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	1.85
LE2/LD2	-	Serious medical conditions e.g. radiation therapy or dialysis	Yes	-	0-5	LDE2	2.07
LE1/LD1	-	Serious medical conditions e.g. radiation therapy or dialysis	No	-	0-5	LDE1	1.72
LC2/LB2	-	Serious medical conditions e.g. radiation therapy or dialysis	Yes	-	6-14	LBC2	1.71
LC1/LB1	-	Serious medical conditions e.g. radiation therapy or dialysis	No	-	6-14	LBC1	1.43
CE2/CD2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	1.86
CE1/CD1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	0-5	CDE1	1.62
CC2/CB2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	1.54
CA2	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	1.08
CC1/CB1	-	Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No	-	6-14	CBC1	1.34
CA1	-	Conditions requiring complex medical care	No	-	15-16	CA1	0.94

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	Nursing Case-Mix Index
		e.g. pneumonia, surgical wounds, burns					
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	1.04
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	0.99
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	1.57
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	1.47
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	1.21
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	0.70
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	1.13
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	0.66

As with the previously discussed components, all residents would be classified into one and only one of these 25 nursing case-mix groups under the proposed PDPM.

We also used the STRIVE data to quantify the effects of an HIV/AIDS diagnosis on nursing resource use. We controlled for case mix by including the proposed PDPM resident groups (in this case, the nursing RUGs) as independent variables. The results show that even after controlling for nursing RUG, HIV/AIDS status is associated with a positive and significant increase in nursing utilization. Based on the results of regression analyses, we found that wage-weighted nursing staff time is 18 percent higher for residents with HIV/AIDS. (The estimate of average wage-weighted nursing staff time for the SNF population is adjusted to account for the deliberate over-sampling of certain sub-populations in the STRIVE study. Specifically, we apply sample weights from the STRIVE dataset equal to the inverse of each resident's probability of

selection to permit calculation of an unbiased estimate.) Based on these findings, we concluded that the proposed PDPM nursing groups may not fully capture the additional nursing costs associated with HIV/AIDS residents. More information on this analysis can be found in section 3.8.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). Thus, as part of the case-mix adjustment of the nursing component, we are proposing an 18 percent increase in payment for the nursing component for residents with HIV/AIDS. This adjustment would be applied based on the presence of ICD-10-CM code B20 on the SNF claim. In cases where a resident is coded as having this diagnosis, the nursing component per diem rate for this resident would be multiplied by 1.18, to account for the 18 percent increase in nursing costs for residents with this diagnosis. We discuss this proposal, as well as its relation to the existing AIDS add-on payment under RUG-IV, in section V.I. of this proposed rule.

We invite comments on the approach we are proposing above to classify residents for nursing payment under the proposed PDPM.

e. Proposed Non-Therapy Ancillary Case-Mix Classification

Under the current SNF PPS, payments for NTA costs incurred by SNFs are incorporated into the nursing component. This means that the CMIs used to adjust the nursing component of the SNF PPS are intended to reflect not only differences in nursing resource use but also NTA costs. However, there have been concerns that the current nursing CMIs do not accurately reflect the basis for or the magnitude of relative differences in resident NTA costs. In its March 2016 Report to Congress, MedPAC wrote: "Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al.

2002)" (available at http://medpac.gov/docs/default-source/reports/chapter-7-skilled-nursing-facility-services-march-2016-report-.pdf). While the proposed PT, OT, and SLP components were designed to address the issue related to provision of therapy services raised by MedPAC above, the proposed NTA component discussed in this section was designed to address the issue related to accurately targeting payments for NTA services — specifically, that the current manner of using the RUG-IV case-mix system to determine NTA payment levels inadequately adjusts for relative differences in resident NTA costs.

As noted in the quotation from MedPAC above, MedPAC is not the only group to offer this critique of the SNF PPS. Just as the aforementioned criticisms that MedPAC cited have existed almost since the inception of the SNF PPS itself, ideas for addressing this concern have a similarly long history. In response to comments on the 1998 interim final rule which served to establish the SNF PPS, we published a final rule on July 30, 1999 (64 FR 41644). In this final rule, we acknowledged the commenters' concerns about the new system's ability to account accurately for NTA costs, such as the following:

> There were a number of comments expressing concern with the adequacy of the PPS rates to cover the costs of ancillary services other than occupational, physical, and speech therapy (non-therapy ancillaries), including such things as drugs, laboratory services, respiratory therapy, and medical supplies. Prescription drugs or medication therapy were frequently noted areas of concern due to their potentially high cost for particular residents. Some commenters suggested that the RUG–III case-mix classification methodology does not adequately provide for payments that account for the variation in, or the real costs of, these services provided to their residents. (64 FR 41647)

In response to those comments, we stated that "we are funding substantial research to examine the potential for refinements to the case-mix methodology, including an examination of medication therapy, medically complex patients, and other nontherapy ancillary services" (64 FR 41648). In this proposed rule, we are proposing a methodology that we believe would case-mix adjust SNF PPS payments more appropriately to reflect differences in NTA costs.

Following the same methodology we used for the proposed PT, OT, and SLP components, the project team ran cost regression models to determine which resident characteristics may be predictive of relative increases in NTA costs. The three categories of cost-related resident characteristics identified through this analysis were resident comorbidities, the use of extensive services (services provided to residents that are particularly expensive and/or invasive), and resident age. However, we removed age from further consideration as part of the NTA component based on concerns shared by TEP panelists during the June 2016 TEP. Particularly, some panelists expressed concern that including age as a determinant of NTA payment could create access issues for older populations. Additionally, the CART algorithm used to explore potential resident groups for the NTA component only selected age as a determinant of classification for 2 of the 7 groups created. We also tested a classification option that used age as a determinant of classification for every NTA group. This only led to a 5 percent increase in the R-squared value of the NTA classification. More information on these analyses can be found in section 3.7.1. of the SNF PMR technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

With regard to capturing comorbidities and extensive services associated with high NTA utilization, we used multiple years of data (FY 2014 to FY 2017) to estimate the impact of comorbidities and extensive services on NTA costs. This is in response to comments on the ANPRM that the design of the NTA component should be more robust and remain applicable in light of potential changes in the SNF population and care practices over time. Conditions and services were defined in three ways. First, clinicians identified MDS items that correspond to conditions/extensive services likely related to NTA utilization. However, since many conditions/extensive services related to NTA utilization are not included on the MDS

assessment, we then mapped ICD-10 diagnosis codes from the prior inpatient claim, the first SNF claim, and section I8000 of the 5-day MDS assessment to condition categories from the Part C risk adjustment model (CCs) and the Part D risk adjustment model (RxCCs). The CCs and RxCCs define conditions by aggregating related diagnosis codes into a single condition flag. We use the condition flags defined by the CCs and RxCCs to predict Part A and B expenditures or Part D expenditures, respectively for Medicare beneficiaries. The predicted relationship between the conditions defined in the respective models and Medicare expenditures is then used to risk-adjust capitated payments to Part C and Part D sponsors. Similarly, our comorbidities investigation aimed to use a comprehensive list of conditions and services to predict resource utilization for beneficiaries in Part A-covered SNF stays. Ultimately, the predicted relationship between these conditions/services and utilization of NTA services would be used to case-mix adjust payments to SNF providers, in a process similar to risk adjustment of capitated payments. Given these similarities, we decided to use the diagnosis-defined conditions from the Part C and Part D risk adjustment models to define conditions and services that were not defined on the MDS. Because the CCs were developed to predict utilization of Part A and B services, while the RxCCs were developed to predict Part D drug costs, the largest component of NTA costs, we believe that using both sources allows us to define the conditions and services potentially associated with NTA utilization more comprehensively. Lastly, we used ICD-10 diagnosis codes to define additional conditions that clinicians who advised CMS during PDPM development identified as being potentially associated with increased NTA service utilization but are not fully reflected in either the MDS or the CCs/RxCCs. The resulting list was meant to encompass as many diverse and expensive conditions and extensive services as possible from the MDS assessment, the CCs, the RxCCs, and diagnoses. Using cost regressions, we found that certain comorbidity conditions and extensive services were highly predictive of relative differences in

resident NTA costs. These conditions and services are identified in Table 27. More information on this analysis can be found in section 3.7.1. of the SNF PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. We would note that certain conditions that were associated with higher NTA utilization were nevertheless excluded from the list because of clinical concerns. Esophageal reflux was excluded because it is a very common condition in the SNF population and clinicians noted that coding can be discretionary. Migraine headache was also excluded due to clinicians' concerns about coding reliability. Additionally, clinicians stated that in many cases migraine headache is not treated by medication, the largest component of NTA costs.

Having identified the list of relevant conditions and services for adjusting NTA payments, we considered different options for how to capture the variation in NTA costs explained by these identified conditions and services. One such method would be merely to count the number of comorbidities and services a resident receives and assign a score to that resident based on this count. We found that this option accounts for the additive effect of having multiple comorbidities and extensive services but did not adequately reflect the relative differences in the impact of certain higher-cost conditions and services. We also considered a tier system similar to the one used in the IRF PPS, where SNF residents would be placed into payment tiers based on the costliest comorbidity or extensive service. However, we found that this option did not account for the additive effect noted above. To address both of these issues, we propose basing a resident's NTA score, which would be used to classify the resident into an NTA case-mix classification group, on a weighted-count methodology. Specifically, as shown in Table 27, each of the comorbidities and services that factor into a resident's NTA classification is assigned a certain number of points based on its relative impact on a resident's NTA costs.

Those conditions and services with a greater impact on NTA costs are assigned more points, while those with less of an impact are assigned fewer points. The relative impacts are estimated based the coefficients of an ordinary least squares (OLS) regression that used the selected conditions and extensive services to predict NTA costs per day. Points are assigned by grouping together conditions and extensive services with similar OLS regression estimates. More information on this methodology and analysis can be found in section 3.7.1. of the SNF PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. The effect of this methodology is that the NTA component would adequately reflect relative differences in the NTA costs for each condition or service as well as the additive effect of having multiple comorbidities.

A resident's total comorbidity score, which would be the sum of the points associated with all of a resident's comorbidities and services, would be used to classify the resident into an NTA case-mix group. For conditions and services where the source is indicated as MDS item I8000, section 3.7.1. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html) provides a crosswalk between the listed condition and the ICD-10-CM codes which may be coded to qualify that condition to serve as part of the resident's NTA classification. MDS item I8000 is an open-ended item in the MDS assessment where the assessment provider can fill in additional active diagnoses that are not explicitly on the MDS for the resident in the form of ICD-10 codes . In the case of Parenteral/IV Feeding, we observed that NTA costs per day increase as the amount of intake through parenteral or tube feeding increases. For this reason, we propose to separate this item into a high intensity item and a low intensity item, similar to how it is defined in the RUG-IV system. In order for a resident to qualify for the high intensity category, the percent of calories taken in by the resident by

parenteral or tube feeding, as reported in item K0710A2 on the MDS 3.0, must be greater than 50 percent. In order to qualify for the low intensity category, the percent of calories taken in by the resident by parenteral or tube feeding, as reported in item K0710A2 on the MDS 3.0, must be greater than 25 percent but less than or equal to 50 percent, and the resident must receive an average fluid intake by IV or tube feeding of at least 501cc per day, as reported in item K0710B2 of the MDS 3.0.

We also want to note that the source of the HIV/AIDS diagnosis is listed as the SNF claim. This is because 16 states have state laws that prevent the reporting of HIV/AIDS diagnosis information to CMS through the current assessment system and/or prevent CMS from seeing such diagnosis information within that system, should that information be mistakenly reported. The states are Alabama, Alaska, California, Colorado, Connecticut, Idaho, Illinois, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, South Carolina, Texas, Washington, and West Virginia. Given this restriction, it would not be possible to have SNFs utilize the MDS 3.0 as the vehicle to report HIV/AIDS diagnosis information for purposes of determining a resident's NTA classification. We note that the current SNF PPS uses a claims reporting mechanism as the basis for the temporary AIDS add-on payment which exists under RUG-IV. To address the issue discussed above with respect to reporting of HIV/AIDS diagnosis information under the proposed PDPM, we propose to utilize this existing claims reporting mechanism to determine a resident's HIV/AIDS status for the purpose of NTA classification. More specifically, HIV/AIDS diagnosis information reported on the MDS would be ignored by the GROUPER software used to classify a resident into an NTA case-mix group. Instead, providers would be instructed to locate the HIPPS code provided to the SNF on the validation report associated with that assessment and report it to CMS on the associated SNF claim. Following current protocol, the provider would then enter ICD-10-CM code B20 on the

associated SNF claim as if it were being coded to receive payment through the current AIDS add-on payment. The PRICER software, which we use to determine the appropriate per diem payment for a provider based on their wage index and other factors, would make the adjustment to the resident's NTA case-mix group based on the presence of the B20 code on the claim as well as adjust the associated per diem payment based on the adjusted resident HIPPS code. Again, we note that this methodology follows the same logic that the SNF PPS currently uses to pay the temporary AIDS add-on adjustment but merely changes the target and type of adjustment from the SNF PPS per diem to the NTA component of the proposed PDPM. The difference is that while under the current system, the presence of the B20 code would lead to a 128 percent increase in the per diem rate, under the proposed PDPM, the presence of the B20 code would mean the addition of 8 points (as determined by the OLS regression described above) to the resident's NTA score, the categorization of the resident into the appropriate NTA group, and an adjustment to the nursing component, as described in section V.D.3.d. of this proposed rule. Section 1888(e)(12) of the Social Security Act enacted a temporary 128 percent increase in the PPS per diem payment for SNF residents with HIV/AIDS and stipulated that the temporary adjustment was to be applied only until the Secretary certifies that there is an appropriate case-mix adjustment to compensate for the increased costs associated with this population. Based on this language, we conducted an analysis similar to that used to determine the HIV/AIDS add-on for the nursing component to examine the adequacy of payment for ancillary services (all non-nursing services: PT, OT, SLP, and NTA) for residents with HIV/AIDS under the proposed PDPM. This analysis determined that after accounting for the 8 points assigned for HIV/AIDS in the NTA component and controlling for case-mix classification across the three therapy components and NTA component, HIV/AIDS was not associated with an increase in ancillary costs. Nursing costs were not included in this regression because we separately investigated the

increased nursing utilization associated with HIV/AIDS, as described in section V.D.3.d. of this proposed rule. Based on the results of this investigation, we concluded that the four ancillary case-mix components (PT, OT, SLP, and NTA) adequately reimburse costs associated with residents with HIV/AIDS. Therefore, we do not believe an HIV/AIDS add-on is warranted for the ancillary cost components. More information on this analysis can be found in section 3.8.2. of the PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Table 27 provides the proposed list of conditions and extensive services that would be used for NTA classification, the source of that information, and the associated number of points for that condition.

TABLE 27: Proposed Conditions and Extensive Services Used for NTA Classification

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1

Condition/Extensive Service	Source	Points
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300X1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I8000	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

Given the NTA scoring methodology described above and following the same methodology used for the PT, OT, and SLP components, we used the CART algorithm to determine the most appropriate splits in resident NTA case-mix groups. This methodology is more thoroughly explained in sections 3.4.2. and 3.7.2. of the SNF PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. Based on the breakpoints generated by the CART algorithm, we determined that 6 case-mix groups would be necessary to classify residents adequately in terms of their NTA costs in a manner that captures sufficient variation in NTA costs without creating unnecessarily granular separations. We made certain administrative decisions that further refined the NTA case-mix classification groups beyond those produced through use of the CART algorithm but maintained the CART output predictive accuracy. The proposed NTA case-mix classification departs from the CART comorbidity score bins in

grouping residents with a comorbidity score of 1 with residents with scores of 2 instead of with residents with scores of 0. This is to maintain the distinction between residents with no comorbidities and the rest of the population. In addition, we grouped residents with score of 5 together with residents with scores of 3 to 4 based on their similarity in average NTA costs per day. More information on this analysis can be found in section 3.7.2. of the SNF PDPM technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. We provide the criteria for each of these groups along with its CMI in Table 28.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to its share of total costs of the component. CMIs for the NTA component are calculated based on two factors. One factor is the average per diem costs of a case-mix group relative to the population average. The other factor is the average variable per diem adjustment factor of the group relative to the population average. In this calculation, average per diem costs equal total NTA costs in the group divided by number of utilization days in the group. Similarly, the average variable per diem adjustment factor equals the sum of NTA variable per diem adjustment factors for all utilization days in the group divided by the number of utilization days in the group. We calculate CMIs such that they equal the ratio of relative average per diem costs for a group to the relative average variable per diem adjustment factor for the group. In this calculation, relative average per diem costs and the relative average variable per diem adjustment factor are weighted by length of stay to account for the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-

Payment/SNFPPS/therapyresearch.html). After calculating CMIs as described above, we then apply adjustments to ensure that the distribution of resources across payment components is aligned with the statutory base rates as discussed in section V.D.3.b. of this proposed rule. We also apply a parity adjustment by multiplying the CMIs by the ratio of case-mix-related payments in RUG-IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. More information on the variable per diem adjustment factor is discussed in section V.D.4. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).

TABLE 28: Proposed NTA Case-Mix Classification Groups

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

As with the previously discussed components, all residents would be classified into one and only one of these 6 NTA case-mix groups under the proposed PDPM. The proposed PDPM would create a separate payment component for NTA services, as opposed to combining NTA and nursing into one component as in the RUG-IV system. This separation would allow payment for NTA services to be based on resident characteristics that predict NTA resource utilization rather than nursing staff time. Thus, we believe that the proposed NTA case-mix groups would provide a better measure of resource utilization and lead to more accurate payments under the SNF PPS.

We invite comments on the approach proposed above to classify residents for NTA

payment under the proposed PDPM.

f. Payment Classifications under Proposed PDPM

RUG-IV classifies each resident into a single RUG, with a single payment for all services. By contrast, the proposed PDPM would classify each resident into five components (PT, OT, SLP, NTA, and nursing) and provide a single payment based on the sum of these individual classifications. The payment for each component would be calculated by multiplying the CMI for the resident's group first by the component federal base payment rate, then by the specific day in the variable per diem adjustment schedule (as discussed in section V.D.4 of this proposed rule). Additionally, for residents with HIV/AIDS indicated on their claim, the nursing portion of payment would be multiplied by 1.18 (as discussed in section V.D.3.d. of this proposed rule). These payments would then be added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate under the proposed PDPM. This section describes how two hypothetical residents would be classified into payment groups under the current RUG-IV model and proposed PDPM. To begin, consider two residents, Resident A and Resident B, with the resident characteristics identified in Table 29.

TABLE 29: Hypothetical Resident Characteristics

Resident Characteristics	Resident A	Resident B
Rehabilitation Received?	Yes	Yes
Therapy Minutes	730	730
Extensive Services	No	No
ADL Score	9	9
Clinical Category	Acute Neurologic	Major Joint Replacement
PT and OT Function Score	10	10
Nursing Function Score	7	7
Cognitive Impairment	Moderate	Intact
Swallowing Disorder?	No	No
Mechanically Altered Diet?	Yes	No
SLP Comorbidity?	No	No
Comorbidity Score	7 (IV Medication and DM)	1 (Chronic Pancreatitis)
Other Conditions	Dialysis	Septicemia
Depression?	No	Yes

Currently under the SNF PPS, Resident A and Resident B would be classified into the

same RUG-IV group. They both received rehabilitation, did not receive extensive services, received 730 minutes of therapy, and have an ADL score of 9. This places the two residents into the "RUB" RUG-IV group and SNFs would be paid at the same rate, despite the many differences between these two residents in terms of their characteristics, expected care needs, and predicted costs of care.

Under the proposed PDPM, however, these two residents would be classified very differently. With regard to the PT and OT components, Resident A would fall into group TO, as a result of his categorization in the Acute Neurologic group and a function score within the 10 to 23 range. Resident B, however, would fall into group TC for the PT and OT components, as a result of his categorization in the Major Joint Replacement group and a function score within the 10 to 23 range. For the SLP component, Resident A would be classified into group SH, based on his categorization in the Acute Neurologic group, the presence of moderate cognitive impairment, and the presence of Mechanically-Altered Diet, while Resident B would be classified into group SA, based on his categorization in the Non-Neurologic group, the absence of cognitive impairment or any SLP-related comorbidity, and the lack of any swallowing disorder or mechanically-altered diet. For the Nursing component, following the existing nursing case-mix methodology, Resident A would fall into group LBC1, based on his use of dialysis services and a nursing function score of 7, while Resident B would fall into group HBC2, due to the diagnosis of septicemia, presence of depression, and a nursing function score of 7. Finally, with regard to NTA classification, Resident A would be classified in group NC, with an NTA score of 7, while Resident B would be classified in group NE, with an NTA score of 1. This demonstrates that, under the proposed PDPM, more aspects of a resident's unique characteristics and needs factor into determining the resident's payment classification, which makes for a more resident-centered case-mix model while also eliminating, or greatly reducing,

the number of service-based factors which are used to determine the resident's payment classification. Because this system is based on specific resident characteristics predictive of resource utilization for each component, we expect that payments will be better aligned with resident need.

4. Proposed Variable Per Diem Adjustment Factors and Payment Schedule

Section 1888(e)(4)(G)(i) of the Act provides that payments must be adjusted for case mix, based on a resident classification system which accounts for the relative resource utilization of different types of residents. Additionally, section 1888(e)(1)(B) of the Act specifies that payments to SNFs through the SNF PPS must be made on a per-diem basis. Currently under the SNF PPS, each RUG is paid at a constant per diem rate, regardless of how many days a resident is classified in that particular RUG. However, during the course of the SNF PMR project, analyses on cost over the stay for each of the case-mix adjusted components revealed different trends in resource utilization over the course of the SNF stay. These analyses utilized costs derived from claim charges as a measure of resource utilization. Costs were derived by multiplying charges from claims by the CCRs on facility-level costs reports. As described in section V.B.3.b. of this proposed rule, costs better reflect differences in the relative resource use of residents as opposed to charges, which partly reflect decisions made by providers about how much to charge payers for certain services. In examining costs over a stay, we found that for certain categories of SNF services, notably PT, OT and NTA services, costs declined over the course of a stay. Based on the claim submission schedule and variation in the point during the month when a stay began, we were able to estimate resource use for a specific day in a stay. Facilities are required to submit monthly claims. Each claim covers the period from the first day during the month a resident is in the facility to the end of the month. If a resident was admitted on the first day of the month, remains in the facility, and continues to have Part A SNF coverage

until the end of the month, the claim for that month will include all days in the month. However, if a resident is admitted after the first day of the month, the first claim associated with the resident's stay will be shorter than a month. To estimate resource utilization for each day in the stay, we used the marginal estimated cost from claims of varying length based on random variation in the day of a month when a stay began. Using this methodology, we observed a decline in the marginal estimated cost of each additional day of SNF care over the course of the stay. To supplement this analysis, we also looked at changes in the number of therapy minutes reported in different assessments throughout the stay. Because therapy minutes are recorded on the MDS, the presence of multiple assessments throughout the stay provided information on changes in resource use. For example, it was clear whether the number of therapy minutes a resident received changed from the 5-day assessment to the 14-day assessment. The results from this analysis were consistent with the cost from claims analysis and showed that, on average, the number of therapy minutes is lower for assessments conducted later in the stay. This finding is consistent across different lengths of stay. More information on these analyses can be found in section 3.9. of the SNF PDPM technical report and section 3.9. of the SNF PMR technical report that accompanied the ANPRM, both available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Analyses of the SLP component revealed that the per diem costs remain relatively constant over time, while the PT, OT, and NTA component cost analyses indicate that the per diem cost for these three components decline over the course of the stay. In the case of the PT and OT components, costs start higher at the beginning of the stay and decline slowly over the course of the stay. The NTA component cost analyses indicate significantly increased NTA costs at the beginning of a stay that then drop to a much lower level that holds relatively constant over the remainder of the SNF stay. This is consistent with how most SNF drug costs are

typically incurred at the outset of a SNF stay. These results indicate that resource utilization for PT, OT, and NTA services changes over the course of the stay. More information on these analyses can be found in section 3.9.1. of the SNF PMR technical report that accompanied the ANPRM available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. We were unable to assess potential changes in the level of nursing costs over a resident's stay, in particular because nursing charges are not separately identifiable in SNF claims, and nursing minutes are not reported on the MDS assessments. However, stakeholders (industry representatives and clinicians) at multiple TEPs indicated that nursing costs tend to remain relatively constant over the course of a resident's stay.

Constant per diem rates, by definition, do not track variations in resource use throughout a SNF stay. We believe this may lead to too few resources being allocated for SNF providers at the beginning of a stay. Given the trends in resource utilization over the course of a SNF stay discussed above, and that section 1888(e)(4)(G)(i) of the Act requires the case-mix classification system to account for relative resource use, we are proposing adjustments to the PT, OT, and NTA components in the proposed PDPM to account for changes in resource utilization over a stay. These adjustments are referred to as the variable per diem adjustments. We are not proposing such adjustments to the SLP and nursing components based on findings and stakeholder feedback, as discussed above, that resource use tends to remain relatively constant over the course of a SNF stay.

As noted above and discussed more thoroughly in section 3.9. of the SNF PMR technical report that accompanied the ANPRM (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), PT and OT costs decline at a slower rate than the decline in NTA costs. Therefore, in addition to proposing a variable per diem adjustment, we further are proposing separate adjustment schedules and indexes for the PT and

OT components and the NTA component to more closely reflect the rate of decline in resource utilization for each component. Table 30 provides the adjustment factors and schedule we are proposing for the PT and OT components, while Table 31 provides the adjustment factors and schedule we are proposing for the NTA component.

In Table 30, the adjustment factor for the PT and OT components is 1.00 for days 1 to 20. This is because the analyses described above indicated that PT and OT costs remain relatively high for the first 20 days and then decline. The estimated daily rates of decline for PT and OT costs relative to the initial 20 days are both 0.3 percent. A convenient and appropriate way to reflect this is to bin days in the PT and OT variable per diem adjustment schedules such that payment declines at less frequent intervals, while still reflecting a 0.3 percent daily rate of decline in PT and OT costs. Therefore, we propose to set the adjustment factors such that payment would decline 2 percent every 7 days after day 20 (0.3 * 7 = 2.1). The 0.3 percent rate of decline is derived from a regression model that estimates the level of resource use for each day in the stay relative to the beginning of the stay. The regression methodology and results are presented in section 3.9. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

As described previously in this section, NTA resource utilization exhibits a somewhat different pattern. The analyses described above indicate that NTA costs are very high at the beginning of the stay, drop rapidly after the first three days, and remain relatively stable from the fourth day of the stay. Starting on day 4 of a stay, the per diem costs drop to roughly one-third of the per diem costs in the initial 3 days. This suggests that many NTA services are provided in the first few days of a SNF stay. Therefore, we propose setting the NTA adjustment factor to 3.00 for days 1 to 3 to reflect the extremely high initial costs, then setting it at 1.00 (two-thirds

lower than the initial level) for subsequent days. The value of the adjustment factor was set at 3.00 for the first 3 days and 1.00 after (rather than, for example, 1.00 and 0.33, respectively) for simplicity. The results are presented in section 3.9. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Case-mix adjusted federal per diem payment for a given component and a given day would be equal to the base rate for the relevant component (either urban or rural), multiplied by the CMI for that resident, multiplied by the variable per diem adjustment factor for that specific day, as applicable. Additionally, as described in further detail in section V.D.3.d. of this proposed rule, an additional 18 percent would be added to the nursing per-diem payment to account for the additional nursing costs associated with residents who have HIV/AIDS. These payments would then be added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate under the proposed PDPM.

We invite comments on the proposed variable per diem adjustment factors and payment schedules discussed in this section.

TABLE 30: Proposed Variable Per-diem Adjustment Factors and Schedule – PT and OT

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

TABLE 31: Proposed Variable Per-diem Adjustment Factors and Schedule – NTA

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

E. Use of the Resident Assessment Instrument—Minimum Data Set, Version 3

1. Proposed Revisions to Minimum Data Set (MDS) Completion Schedule

Consistent with section 1888(e)(6)(B) of the Act, to classify residents under the SNF PPS, we use the MDS 3.0 Resident Assessment Instrument. Within the SNF PPS, there are two categories of assessments, scheduled and unscheduled. In terms of scheduled assessments, SNFs are currently required to complete assessments on or around days 5, 14, 30, 60, and 90 of a resident's Part A SNF stay, including certain grace days. Payments based on these assessments depend upon standard Medicare payment windows associated with each scheduled assessment. More specifically, each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The ARD is the last day of the observation (or "look-back") period that the assessment covers for the resident. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. The clinical data collected from the look-back period is used to determine the payment associated with each assessment. For example, the ARD for the 5-day PPS Assessment is any day between days 1 to 8 (including Grace Days). The clinical data collected during the look-back period for that assessment is used to determine the SNF payment for days 1 to 14. Unscheduled assessments, such as the Start of Therapy (SOT) Other Medicare Required Assessment (OMRA), the End of Therapy OMRA (EOT OMRA), the Change of Therapy (COT) OMRA, and the Significant Change in Status Assessment (SCSA or Significant Change), may be required during the resident's Part A SNF stay when triggered by certain defined events.

For example, if a resident is being discharged from therapy services, but remaining within the facility to continue the Part A stay, then the facility may be required to complete an EOT OMRA. Each of the unscheduled assessments affects payment in different and defined manners. A description of the SNF PPS scheduled and unscheduled assessments, including the criteria for using each assessment, the assessment schedule, payment days covered by each assessment, and other related policies, are set forth in the MDS 3.0 RAI manual on the CMS Web site (available at https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf).

Table 32 outlines when each SNF PPS assessment is required to be completed and its effect on SNF PPS payment.

TABLE 32: Current PPS Assessment Schedule

Scheduled PPS assessments			
Medicare MDS assessment schedule type	**Assessment reference date**	**Assessment reference date grace days**	**Applicable standard Medicare payment days**
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled PPS assessments			
Start of Therapy OMRA	5-7 days after the start of therapy		Date of the first day of therapy through the end of the standard payment period.
End of Therapy OMRA	1-3 days after all therapy has ended		First non-therapy day through the end of the standard payment period.
Change of Therapy OMRA	Day 7 (last day) of the COT observation period		The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment.
Significant Change in Status Assessment	No later than 14 days after significant change identified		ARD of Assessment through the end of the standard payment period.

An issue which has been raised in the past with regard to the existing SNF PPS assessment schedule is that the sheer number of assessments, as well as the complex interplay of the assessment rules, significantly increases the administrative burden associated with the SNF PPS. Case-mix classification under the proposed SNF PDPM that we are proposing relies to a

much lesser extent on characteristics that may change very frequently over the course of a resident's stay (for example, therapy minutes may change due to resident refusal or unexpected changes in resident status), but instead relies on more stable predictors of resource utilization by tying case-mix classification, to a much greater extent, to resident characteristics such as diagnosis information. In view of the greater reliance of the proposed SNF PDPM (as compared to the RUG-IV model) on resident characteristics that are relatively stable over a stay and our general focus on reducing administrative burden for providers across the Medicare program, we are making an effort to reduce the administrative burden on providers by concurrently proposing to revise the assessments that would be required under the proposed SNF PDPM. Specifically, we are proposing to use the 5-day SNF PPS scheduled assessment to classify a resident under the proposed SNF PDPM for the entirety of his or her Part A SNF stay effective beginning FY 2020 in conjunction with the implementation of the proposed PDPM, except as described below. If we were to finalize this proposal, we would propose revisions to the regulations at §413.343(b) during the FY 2020 rulemaking cycle so that such regulations would no longer reflect the RUG-IV SNF PPS assessment schedule as of the proposed conversion to the PDPM on October 1, 2019.

We also understand that Medicare beneficiaries are each unique and can experience clinical changes which may require a SNF to reassess the resident to capture changes in the resident's condition. Therefore, to allow SNFs to capture these types of changes, effective October 1, 2019 in conjunction with the proposed implementation of the PDPM, we propose to require providers to reclassify residents as appropriate from the initial 5-day classification using a new assessment called an Interim Payment Assessment (IPA), which would be comprised of the 5-day SNF PPS MDS Item Set (Item Set NP). Providers would be required to complete an IPA in cases where the following two criteria are met:

(1) There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the proposed PDPM (which are those clinical or nursing payment criteria identified in the first column in Tables 21, 23, 26, and 27), such that the resident would be classified into a classification group for that component that differs from that provided by the 5-day scheduled PPS assessment, and the change in classification group results in a change in payment either in one particular payment component or in the overall payment for the resident; and

(2) The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

In addition, we propose that the Assessment Reference Date (ARD) for the IPA would be no later than 14 days after a change in a resident's first tier classification criteria is identified. The IPA is meant to capture substantial changes to a resident's clinical condition and not every day, frequent changes. We believe 14 days gives the facility an adequate amount of time to determine whether the changes identified are in fact routine or substantial. To clarify, the change in classification group described above refers to not only a change in one of the first tier classification criteria in any of the proposed payment components, but also to one that would be sufficient to change payment in either one component or in the overall payment for the resident. For example, given the collapsed categories under the PT and OT components, this would mean that a change from the medical management group to the cancer group would not necessitate an IPA, as they are both collapsed under the medical management group for purposes of the PT and OT components. However, a change from the major joint replacement group to the medical management group would necessitate an IPA, as this would change the resident's clinical category group for purposes of categorization under the PT and OT components and would result in a change in payment.

We believe that the proposed requirement to complete an IPA balances the need to ensure accurate payment and monitor for changes in the resident's condition with the importance of ensuring a more streamlined assessment approach under the proposed PDPM.

In cases where the IPA is required and a facility fails to complete one, we propose that the facility would follow the guidelines for late and missed unscheduled MDS assessments which are explained in Chapters 2.13 and 6.8 of the MDS RAI Manual (https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf). Specifically, if the SNF fails to set the ARD within the defined ARD window for an IPA, and the resident is still in a Part A stay, the SNF would be required to complete a late assessment. The ARD can be no earlier than the day the error was identified. If the ARD on the late assessment is set for a date that is prior to the end of the time period during which the assessment would have controlled the payment, had the ARD been set timely, the SNF would bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). For example, a SNF Part A resident who is in the major joint replacement payment category for the PT and OT components develops a skin ulcer that is of such a quality that, in terms of developing a care and treatment plan for this resident, the skin ulcer takes precedence as the resident's primary diagnosis. As a result, the resident's primary diagnosis, as coded in item I8000, is for this skin ulcer, which would cause him to be classified into the medical management category for these components. The facility notes this clinical change on November 10, 2018. However, they do not complete the IPA until November 26, 2018 which is 16 days after the change in criteria was identified and two days after the ARD window. The facility would bill the default rate for the two days that it was out of compliance. If the SNF fails to set the ARD for an IPA within the defined ARD window for that assessment, and the resident has

been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. Taking the example above, if the facility recognized the IPA needed to be completed after the resident has left the building, the facility would be liable for all days from November 10, 2018 until the date of the resident's Part A Discharge. We invite comments on these proposals.

In addition to requiring the completion of the IPA as described above, we have also considered the implications of a SNF completing an IPA on the variable per diem adjustment schedule described in section V.D.4. this proposed rule. More specifically, we have considered whether an SNF completing an IPA should cause a reset in the variable per diem adjustment schedule for the associated resident. In examining costs over a stay, we found that for certain categories of SNF services, notably PT, OT and NTA services, costs declined over the course of a stay. Our analyses showed that, on average, the number of therapy minutes is lower for assessments conducted later in the stay. Additionally, we are concerned that by providing for the variable per diem adjustment schedule to be reset after an IPA is completed, providers may be incentivized to conduct multiple IPAs during the course of a resident's stay to reset the variable per diem adjustment schedule each time the adjustment is reduced. Therefore, in cases where an IPA is completed, we are proposing that this assessment would reclassify the resident for payment purposes as outlined in Table 33, but the resident's variable per diem adjustment schedule would continue rather than being reset on the basis of completing the IPA.

Finally, we believe that, regardless of the payment system or case-mix classification model used, residents should continue to receive therapy that is appropriate to their care needs, and this includes both the intensity and modes of therapy utilized. However, we recognize that because the initial 5-day PPS assessment would classify a resident for the entirety of his or her

Part A SNF stay (except in cases where a IPA is completed) as outlined above, there is no mechanism by which SNFs are required to report the amount of therapy provided to a resident over the course of the stay or by which we may monitor that they are in compliance with the proposed 25 percent group and concurrent therapy limit as described in section V.F. of this proposed rule. Therefore, for these reasons, under the proposed PDPM, we propose to require that SNFs continue to complete the PPS Discharge Assessment, as appropriate (including the proposed therapy items discussed in section V.E.3. of this proposed rule), for each SNF Part A resident at the time of Part A or facility discharge (see section V.E. of this proposed rule for a discussion of our proposed revisions to this assessment to include therapy items). Under the current instructions in the MDS 3.0 RAI manual, the Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (MDS 3.0 RAI Manual Chapter 2.7). However, we are proposing to require this assessment to be completed at the time of facility discharge for Part A residents as well. Thus, we would continue to collect data on therapy provision as proposed in section V.F. of this proposed rule, to assure that residents are receiving therapy that is reasonable, necessary, and specifically tailored to meet their unique needs. We believe that the combination of the 5-day Scheduled PPS Assessment, the IPA Assessment, and PPS Discharge Assessment would provide flexibility for providers to capture and report accurately the resident's condition, as well as accurately reflect resource utilization associated with that resident, while minimizing the administrative burden on providers under the proposed SNF PDPM.

In addition to the proposed changes above, we also examined the current use of grace days in the MDS assessment schedule. Grace days have been a longstanding part of the SNF PPS. They were created in order to allow clinical flexibility when setting ARD dates of scheduled PPS assessments. In the FY 2012 final rule (76 FR 48519), we discussed that in

practice, there is no difference between regular ARD windows and grace days and we encouraged the use of grace days if their use would allow a facility more clinical flexibility or would more accurately capture therapy and other treatments:

> Thus, we do not intend to penalize any facility that chooses to use the grace days for assessment scheduling or to audit facilities based solely on their regular use of grace days. We may explore the option of incorporating the grace days into the regular ARD window in the future; nevertheless, we will retain them as part of the assessment schedule at the present time consistent with the current policy and the new assessment schedule proposed in the proposed rule.

We propose, effective beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM, to incorporate the grace days into the existing assessment window. This proposal would eliminate grace days from the SNF PPS assessment calendar and provide for only a standard assessment window. As discussed, there is no practical difference between the regular assessment window and grace days and there is no penalty for using grace days. As such, we believe it would be appropriate to eliminate the use of grace days in PPS assessments.

Table 33 sets forth the proposed SNF PPS assessment schedule, incorporating our proposed revisions above, which would be effective October 1, 2019 concurrently with the proposed PDPM.

TABLE 33: Proposed PPS Assessment Schedule under PDPM

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

We would note that, as in previous years, we intend to continue to work with providers and software developers to assist them in understanding changes we are proposing to the MDS.

Further, we would note that none of the proposals related to changes to the MDS assessment schedule should be understood to change any assessment requirements which derive from the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which establishes assessment requirements for all nursing home residents, regardless of payer. We invite comments on our proposals to revise the SNF PPS assessment schedule and related policies as discussed above. We also solicit comment on the extent to which implementing these proposals would reduce provider burden.

2. Proposed Item Additions to the Swing Bed PPS Assessment

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section III.B.4. of this proposed rule.

For purposes of the proposed PDPM, we propose to add three items to the Swing Bed PPS Assessment. Until now, these additional items have not been part of the Swing Bed PPS Assessment form because they have not been used for payment. However, the presence of each of these items would be used to classify swing bed residents under the proposed SNF PDPM as explained in section V.D. of this proposed rule. Thus, we believe it is necessary and appropriate to include these items in the Swing Bed PPS Assessment beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM. The items we propose to add to the Swing Bed PPS assessment are provided in Table 34. We invite comments on this proposal.

TABLE 34: Proposed Items to Add to Swing Bed PPS Assessment

MDS Item Number	Item Name	Related PDPM

		Payment component
K0100	Swallowing Disorder	SLP
I4300	Active Diagnoses: Aphasia	SLP
O0100D2	Special Treatments, Procedures and Programs: Suctioning, While a Resident	NTA

3. Proposed Items to be Added to the PPS Discharge Assessment

As noted above, under the MDS 3.0, the Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (MDS 3.0 RAI Manual Chapter 2.7). The PPS Discharge Assessment uses the Item Set NPE and does not currently contain section O of the MDS 3.0. The therapy items in section O of the MDS allow CMS to collect data from providers on the volume, type (physical therapy, occupational therapy and speech-language pathology), and mode (individual, concurrent, or group therapy) of the therapy provided to SNF residents. As noted in comments received on the ANPRM in relation to therapy provision, this data would be particularly important to monitor. Specifically, a significant number of commenters expressed concerns that the amount of therapy provided to SNF residents, were RCS-I to have been implemented, would drop considerably as compared to the amount currently delivered under RUG-IV. Commenters noted that this is because the incentive to provide a high volume of therapy services to SNF residents to achieve the highest resident therapy group classification, would no longer exist under RCS-I, leading providers to potentially significantly reduce the amount of therapy provided to SNF residents.

Given that the RCS-I model and PDPM both present the potential for providers to significantly reduce the amount of therapy provided to SNF residents, as compared to RUG-IV, we believe that the same potential result may occur under the proposed PDPM as commenters identified with RCS-I. To better track therapy utilization under PDPM, and to better ensure that residents continue to receive an appropriate amount of therapy commensurate with their needs, given the reduction in the frequency of resident assessments required under the proposed PDPM,

we propose to add therapy collection items to PPS Discharge assessment and to require providers to complete these items beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM.

Specifically, we propose to add the items listed in Table 35 to the PPS Discharge Assessment.

TABLE 35: Proposed Items to Add to SNF PPS Discharge Assessment

MDS Item Number	Item Name
O0400A5	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy Start Date
O0400A6	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy End Date
O0400A7	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Individual Minutes
O0400A8	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Concurrent Minutes
O0400A9	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Group Minutes
O0400A10	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Days
O0400B5	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy Start Date
O0400B6	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy End Date
O0400B7	Special Treatments, Procedures and Programs: Occupational Therapy: Total Individual Minutes
O0400B8	Special Treatments, Procedures and Programs: Occupational Therapy: Total Concurrent Minutes
O0400B9	Special Treatments, Procedures and Programs: Occupational Therapy: Total Group Minutes
O0400B10	Special Treatments, Procedures and Programs: Occupational Therapy: Total Days
O0400C5	Special Treatments, Procedures and Programs: Physical Therapy: Therapy Start Date
O0400C6	Special Treatments, Procedures and Programs: Physical Therapy: Therapy End Date
O0400C7	Special Treatments, Procedures and Programs: Physical Therapy: Total Individual Minutes
O0400C8	Special Treatments, Procedures and Programs: Physical Therapy: Total Concurrent Minutes
O0400C9	Special Treatments, Procedures and Programs: Physical Therapy: Total Group Minutes
O0400C10	Special Treatments, Procedures and Programs: Physical Therapy: Total Days

For the proposed items which refer to the total number of minutes for each therapy discipline and each therapy mode, this would allow CMS to both conduct reviews of changes in the volume and intensity of therapy services provided to SNF residents under the proposed PDPM, compared to that provided under RUG-IV, as well as to assess compliance with the proposed group and concurrent therapy limit discussed in section V.F of this proposed rule. The proposed "total days" items for each discipline and mode of therapy would further support our

monitoring efforts for therapy, as requested by commenters on the ANPRM, by allowing us to monitor not just the total minutes of therapy provided to SNF residents under the proposed PDPM, but also assess the daily intensity of therapy provided to SNF residents under the proposed PDPM, as compared to that provided under RUG-IV. Ultimately, these proposed items would allow facilities to easily report therapy minutes provided to SNF residents and allow us to monitor the volume and intensity of therapy services provided to SNF residents under the proposed PDPM, as suggested by commenters on the ANPRM. If we discover that the amount of therapy provided to SNF residents does change significantly under the proposed PDPM, if implemented, then we will assess the need for additional policies to ensure that SNF residents continue to receive sufficient and appropriate therapy services consistent with their unique needs and goals. We invite comments on our proposals above to add items to the SNF PPS Assessment.

F. Proposed Revisions to Therapy Provision Policies Under the SNF PPS

Currently, almost 90 percent of residents in a Medicare Part A SNF stay receive therapy services. Under the current RUG–IV model, therapy services are case mix-adjusted primarily based on the therapy minutes reported on the MDS. When the original SNF PPS model was developed, most therapy services were furnished on an individual basis, and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. Over the years, we have monitored provider behavior and have made policy changes as it became apparent that, absent safeguards like quality measurement to ensure that the amount of therapy provided did not exceed the resident's actual needs, there were certain inherent incentives for providers to furnish as much therapy as possible. Thus, for example, in the SNF PPS FY 2010 final rule (74 FR 40315 through 40319), we decided to allocate concurrent therapy minutes for purposes of establishing the RUG-IV group to which the patient belongs, and to limit

concurrent therapy to two patients at a time who were performing different activities.

Following the decision to allocate concurrent therapy, using STRIVE data as a baseline, we found two significant provider behavior changes with regard to therapy provision under the RUG-IV payment system. First, there was a significant decrease in the amount of concurrent therapy that was provided in SNFs. Simultaneously, we observed a significant increase in the provision of group therapy, which was not subject to allocation at that time. We concluded that the manner in which group therapy minutes were counted in determining a patient's RUG-IV group created a payment incentive to provide group therapy rather than individual therapy or concurrent therapy, even in cases where individual therapy (or concurrent therapy) was more appropriate for the resident. Thus, we made two policy changes regarding group therapy in the FY 2012 SNF PPS final rule (76 FR 48511 through 48517). We defined group therapy as exactly four residents who are performing the same or similar therapy activities. Additionally, we allocated group therapy among the four patients participating in group therapy--meaning that the total amount of time that a therapist spent with a group would be divided by 4 (the number of patients that comprise a group) to establish the RUG-IV group to which the patient belongs.

Since we began allocating group therapy and concurrent therapy, these modes of therapy (group and concurrent) represent less than one percent of total therapy provided to SNF residents. Table 36, which appeared in the FY 2014 SNF PPS Proposed Rule (78 FR 26464) and sets forth our findings with respect to the effect of policies finalized in the FY 2012 SNF PPS Final Rule, demonstrates the change in therapy provision between the STRIVE study and the implementation of the therapy policy changes in FY 2012. We would note that the distribution of therapy modes presented in Table 36 reflecting therapy provision in FY 2012 is also an accurate reflection of current therapy provision based on resident data collected in the QIES Database and continued monitoring of therapy utilization.

TABLE 36: Mode of Therapy Provision

	STRIVE	FY 2011	FY 2012
Individual	74%	91.8%	99.5%
Concurrent	25%	0.8%	0.4%
Group	<1%	7.4%	0.1%

Based on our prior experience with the provision of concurrent and group therapy in SNFs, we again are concerned that if we were to implement the proposed SNF PDPM, providers may base decisions regarding the particular mode of therapy to use for a given resident on financial considerations rather than on the clinical needs of SNF residents. Because the proposed SNF PDPM would not use the minutes of therapy provided to a resident to classify the resident for payment purposes, we are concerned that SNFs may once again become incentivized to emphasize group and concurrent therapy, over the kind of individualized therapy which is tailored to address each beneficiary's specific care needs which we believe is generally the most appropriate mode of therapy for SNF residents. As we stated in the FY 2012 proposed rule (76 CFR 26387):

> While…group therapy can play an important role in SNF patient care, we note that group therapy is not appropriate for either all patients or for all conditions, and is primarily effective as a supplement to individual therapy, which we maintain should be considered the primary therapy mode and standard of care in therapy services provided to SNF residents. As evidenced by the application of a cap on the amount of group therapy services that may be provided to SNF residents, we do not believe that a SNF providing the preponderance of therapy in the form of group therapy would be demonstrating the intensity of therapy appropriate to this most frail and vulnerable nursing home population.

Since the inception of the SNF PPS, we have limited the amount of group therapy provided to each SNF Part A resident to 25 percent of the therapy provided to them by discipline. As stated in the FY 2000 final rule (64 FR 41662):

> Although we recognize that receiving PT, OT, or ST as part of a group has clinical merit in select situations, we do not believe that services received within a group setting should account for more than 25 percent of the Medicare resident's therapy regimen during the SNF stay. For this reason, no more than 25 percent of the minutes reported in the MDS

> may be provided within a group setting. This limit is to be applied for each therapy discipline; that is, only 25 percent of the PT minutes reported in the MDS may be minutes received in a group setting and, similarly, only 25 percent of the OT, or the ST minutes reported may be minutes received in a group setting.

Although we recognize that group and concurrent therapy may have clinical merit in specific situations, we also continue to believe that individual therapy is generally the best way of providing therapy to a resident because it is most tailored to that specific resident's care needs.

As such, individual therapy should represent the majority of the therapy services received by SNF residents both from a clinical and payment perspective. As stated in the FY 2012 proposed rule (76 CFR 26372):

> Moreover, even under the previous RUG–53 model, it is clear that the predominant mode of therapy that the payment rates were designed to address was individual therapy rather than concurrent or group therapy.

To help ensure that SNF residents would receive the majority of therapy services on an individual basis, if we were to implement the proposed PDPM, we believe concurrent and group therapy combined should be limited to no more than 25 percent of a SNF resident's therapy minutes by discipline. In combination, this limit would ensure that at least 75 percent of a resident's therapy minutes are provided on an individual basis. Because the change in how therapy services would be used to classify residents under the proposed PDPM gives rise to the concern that providers may begin to utilize more group and concurrent therapy due to financial considerations, we are proposing to set a combined 25 percent limit on concurrent therapy and group therapy for each discipline of therapy provided. For example, if a resident received 800 minutes of physical therapy, no more than 200 minutes of this therapy could be provided on a concurrent or group basis. Finally, we note that under RUG-IV, we currently allocate minutes of therapy because we pay for therapy based on therapy minutes and not resident characteristics. Given that therapy minutes would no longer be a factor in determining payment classifications

for residents under the proposed PDPM, we would utilize the total, unallocated number of minutes by therapy mode reported on the MDS, to determine compliance with the proposed limit. Utilizing unallocated therapy minutes also serves to underscore the patient-driven nature of the PDPM, as it focuses the proposed limit on concurrent and group therapy on the way in which the therapy is received by the beneficiary, rather than furnished by the therapist, and would better ensure that individual therapy represents at least a vast majority of the therapy services received by a resident.

We considered other possible limits, and even no limit, on group and concurrent therapy. For example, we considered placing no limit on group or concurrent therapy, in order to afford providers the greatest degree of flexibility in designing a therapy program for each SNF resident. However, even in response to this option to have no limit on concurrent and group therapy, many commenters on the ANPRM expressed concerns regarding the lack of appropriate safeguards for ensuring that SNF residents continue to receive an appropriate level of therapy under the revised case-mix model. We agree with these commenters and believe that there should be some limit on the amount of group and concurrent therapy that is provided to residents in order to ensure that residents receive an appropriate amount of individual therapy that is tailored to their specific needs. Also, in the ANPRM, we discussed the possibility of proposing a 25 percent limit on each of concurrent and group therapy, allowing for up to 50 percent of therapy services provided in the SNF to be provided in a non-individual modality. This option sought to balance the flexibility afforded to therapists in designing an appropriate therapy plan that meets the needs and goals of the specific resident with the importance of ensuring that SNF residents receive an appropriate level of individual therapy. However, we are concerned that a separate 25 percent limit for group and concurrent therapy would not provide sufficient assurance that at least a majority of a resident's therapy would be provided on an individual basis. Therefore, we believe

that the separate 25 percent limits on concurrent and group therapy discussed in the ANPRM, or any option which would impose a higher limit on group and concurrent therapy, would not provide the necessary protection for SNF residents. By contrast, we believe that a combined 25 percent limit on group and concurrent therapy would provide sufficient assurance that at least a majority of each resident's therapy would be provided on an individual basis, consistent with our position that individual therapy is generally the best way of providing therapy to SNF residents because it is most tailored to their care needs. We would also note that, assuming that existing therapy delivery patterns (as set forth in Table 36) are accurate and they reflect the individually-tailored needs of SNF residents currently being treated under the SNF benefit, the number of group and concurrent minutes that have been reported by SNFs thus far are significantly lower than the limit described in this proposal. In other words, based on the data presented in Table 36, the proposed limit on group and concurrent therapy affords a significantly greater degree of flexibility on therapy modality than appears to be required to meet the needs of SNF residents, given that less than one percent of therapy currently being delivered is either group or concurrent therapy. Therefore, a combined limit of 25 percent for group and concurrent therapy should provide SNFs with more than enough flexibility with respect to therapy mode to meet the care needs of their residents.

We believe that individual therapy is usually the best mode of therapy provision as it permits the greatest degree of interaction between the resident and therapist, and should therefore represent, at a minimum, the majority of therapy provided to an SNF resident. However, we recognize that, in very specific clinical situations, group or concurrent therapy may be the more appropriate mode of therapy provision, and therefore, we would want to allow providers the flexibility to be able to utilize these modes. We continue to stress that group and concurrent therapy should not be utilized to satisfy therapist or resident schedules, and that all group and

concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition. We invite comments on the proposal discussed above. In addition, we solicit comments on other ways in which therapy limits may be applied to appropriately meet the care needs of SNF residents.

Currently the RUG-IV grouper calculates the percentage of group therapy each resident receives in the SNF based on the algorithms described in section 6.6 of the MDS RAI Manual (found at https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf). When a resident is found to have exceeded the 25 percent group therapy limit, the minutes of therapy received in excess are not counted towards the calculation of the RUG-IV therapy classification. Because the proposed PDPM would not use the minutes of therapy provided to a resident to classify the resident for payment purposes, we would need to determine a way under the proposed PDPM to address situations in which facilities exceed the combined 25 percent group and concurrent therapy limit.

Therefore, we are proposing that at a component level (PT, OT, SLP), when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, that providers would receive a non-fatal warning edit on the validation report that the provider receives when submitting an assessment which would alert the provider to the fact that the therapy provided to that resident exceeded the threshold. To explain, a fatal error in the QIES ASAP system occurs when one or more items in the submitted record fail to pass the requirements identified in the MDS data submission specifications. A warning error occurs when an item or combination of items in the submitted record trigger a non-fatal edit in the QIES ASAP system. The non-fatal warning would serve as a reminder to the facility that they are out of compliance with the proposed limit for group and concurrent therapy. As part of our regular

monitoring efforts on SNF Part A services, we would monitor group and concurrent therapy utilization under the proposed PDPM and consider making future proposals to address abuses of this proposed policy or flag providers for additional review should an individual provider be found to consistently exceed the proposed threshold after the implementation of the proposed PDPM. We would note that as the proportion of group and/or concurrent therapy (which are, by definition, non-individual modes of therapy provision) increases, the chances that the provider is still meeting the individualized needs of each resident would diminish. Given that meeting the individualized needs of the resident is a component of meeting the coverage requirements for SNF Part A services, as described in section 1814(a)(2)(B) of the Act and further described in Section 30 of Chapter 8 of the Medicare Benefit Policy Manual (accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf) where it states that services furnished to SNF residents may be considered reasonable and necessary insomuch as the services are consistent with "the individual's particular medical needs", excessive levels of group and/or concurrent therapy could constitute a reason to deny SNF coverage for such stays. We invite comments on this proposed compliance mechanism.

G. Proposed Interrupted Stay Policy

Under section 1812(a)(2)(A) of the Act, Medicare Part A covers a maximum of 100 days of SNF services per spell of illness, or "benefit period". A benefit period starts on the day the beneficiary begins receiving inpatient hospital or SNF benefits under Medicare Part A. (See section 1861(a) of the Act; §409.60). SNF coverage also requires a prior qualifying, inpatient hospital stay of at least 3 consecutive days' duration (counting the day of inpatient admission but not the day of discharge). (See section 1861(i) of the Act; §409.30(a)(1)). Once the 100 available days of SNF benefits are used, the current benefit period must end before a beneficiary can renew SNF benefits under a new benefit period. For the current benefit period to end so a

new benefit period can begin, a period of 60 consecutive days must elapse throughout which the beneficiary is neither an inpatient of a hospital nor receiving skilled care in a SNF. (See section 1861(a) of the Act; §409.60). Once a benefit period ends, the beneficiary must have another qualifying 3-day inpatient hospital stay and meet the other applicable requirements before Medicare Part A coverage of SNF care can resume. (See section 1861(i); §409.30)

While the majority of SNF benefit periods, approximately 77 percent, involve a single SNF stay, it is possible for a beneficiary to be readmitted multiple times to a SNF within a single benefit period, and such cases represent the remaining 23 percent of SNF benefit periods. For instance, a resident can be readmitted to a SNF within 30 days after a SNF discharge without requiring a new qualifying 3-day inpatient hospital stay or beginning a new benefit period. SNF admissions that occur between 31 and 60 days after a SNF discharge require a new qualifying 3-day inpatient hospital stay, but fall within the same benefit period. (See sections 1861(a) and (i) of the Act; §§409.30, 409.60)

Other Medicare post-acute care (PAC) benefits have "interrupted stay" policies that provide for a payment adjustment when the beneficiary temporarily goes to another setting, such as an acute care hospital, and then returns within a specific timeframe. In the inpatient rehabilitation facility (IRF) and inpatient psychiatric facility (IPF) settings, for instance, an interrupted stay occurs when a patient returns to the same facility (or in the case of an IPF, the same or another IPF) within 3 days of discharge. The interrupted stay policy for long-term care hospitals (LTCHs) is more complex, consisting of several policies depending on the length of the interruption and, at times, the discharge destination: an interruption of 3 or fewer days is always treated as an interrupted stay, which is similar to the IRF PPS and IPF PPS policies; if there is an interruption of more than 3 days, the length of the gap required to trigger a new stay varies depending on the discharge setting. In these three settings, when a beneficiary is discharged and

returns to the facility within the interrupted stay window, Medicare treats the two segments as a single stay.

While other Medicare PAC benefit categories have interrupted stay policies, the SNF benefit under the RUG-IV case-mix model has had no need for such a policy because given a resident's case-mix group, payment does not change over the course of a stay. In other words, assuming no change in a patient's condition or treatment, the payment rate is the same on Day 1 of a covered SNF stay as it is at Day 7. Accordingly, a beneficiary's readmission to the SNF—even if only a few days may have elapsed since a previous discharge—could essentially be treated as a new and different stay without affecting the payment rates.

However, as described in section V.D. of this proposed rule, the proposed PDPM would adjust the per diem rate across the length of a stay (the variable per diem adjustment) to better reflect how and when costs are incurred and resources used over the course of the stay, such that earlier days in a given stay receive higher payments, with payments trending lower as the stay continues. In other words, the adjusted payment rate on Day 1 and Day 7 of a SNF stay may not be the same. Although we believe this variable per diem adjustment schedule more accurately reflects the increased resource utilization in the early portion of a stay for single-stay benefit periods (which represent the majority of cases), we considered whether and how such an adjustment should be applied to payment rates for cases involving multiple stays per benefit period. In other words, we considered instances in which a resident has a Part A stay in a SNF, leaves the facility for some reason, and then is readmitted to the same SNF or a different SNF; and how this readmission should be viewed in terms of both resident classification and the variable per diem adjustment schedule under the proposed PDPM. Application of the variable per diem adjustment is of particular concern because providers may consider discharging a resident and then readmitting the resident shortly thereafter to reset the resident's variable per

diem adjustment schedule and maximize the payment rates for that resident.

Given the potential harm which may be caused to the resident if discharged inappropriately, and other concerns outlined previously in this section, we discussed in the ANPRM the possibility of adopting an interrupted stay policy under the SNF PPS in conjunction with the implementation of the RCS-I case-mix model. Several commenters expressed support for this interrupted stay policy in responding to the ANPRM, saying that the interrupted stay policy is in alignment with similar policies in other post-acute settings, and that a similar policy would likely be implemented under any cross-setting PAC payment system.

Thus, we are proposing to implement an interrupted stay policy as part of the SNF PPS, effective beginning FY 2020 in conjunction with the proposed implementation of the SNF PDPM. Specifically, in cases where a resident is discharged from a SNF and returns to the same SNF by 12:00am at the end of the third day of the interruption window (as defined below), we propose treating the resident's stay as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule. In cases where the resident's absence from the SNF exceeds this 3-day interruption window (as defined below), or in any case where the resident is readmitted to a different SNF, we propose treating the readmission as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1. Consistent with the existing interrupted stay policies for the IRF and IPF settings, we would define the interruption window as the 3-day period starting with the calendar day of discharge and additionally including the 2 immediately following calendar days. For the purposes of the interrupted stay policy, the source of the readmission would not be relevant. That is, the beneficiary may be readmitted from the community, from an intervening hospital stay, or from a different kind of facility, and the interrupted stay policy would operate in the same manner. The

only relevant factors in determining if the interrupted stay policy would apply are the number of days between the resident's discharge from a SNF and subsequent readmission to a SNF, and whether the resident is readmitted to the same or a different SNF.

Consider the following examples, which we believe aid in clarifying how this policy would be implemented:

Example A: A beneficiary is discharged from a SNF on Day 3 of the stay. Four days after the date of discharge, the beneficiary is then readmitted (as explained above, this readmission would be in the same benefit period) to the same SNF. The SNF would conduct a new 5-day assessment at the start of the second admission and reclassify the beneficiary accordingly. In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to Day 1 payment rates for the beneficiary's new case-mix classification.

Example B: A beneficiary is discharged from a SNF stay on Day 7 and is readmitted to the same SNF within the 3-day interruption window. For the purposes of classification and payment, this would be considered a continuation of the previous stay (an interrupted stay). The SNF would not conduct a new 5-day assessment to reclassify the patient and for purposes of the variable per diem adjustment schedule, the payment schedule would continue where it left off; in this case, the first day of the second stay would be paid at the Day 8 per diem rates under that schedule.

Example C: A beneficiary is discharged from a SNF stay on Day 7 and is readmitted to a different SNF within the 3-day interruption window. The SNF would conduct a new 5-day assessment at the start of the second admission and classify the beneficiary accordingly. In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to Day 1 payment rates for the beneficiary's new case-mix

classification.

We also considered alternative ways of structuring the interrupted stay policy. For example, we considered possible ranges for the interrupted stay window other than the three calendar day window proposed in this rule. For example, we considered windows of fewer than 3 days (for example, 1 or 2 day windows for readmission) as well as windows of more than 3 days (for example, 4 or 5 day windows for readmission). However, we believe that 3 days represents a reasonable window after which it is more likely that a resident's condition and resource needs will have changed. We also believe that consistency with other payment systems, like that of IRF and IPF, is helpful in providing clarity and consistency to providers in understanding Medicare payment systems, as well as making progress toward standardization among PAC payment systems.

In addition, to determine how best to operationalize an interrupted stay policy within the SNF setting, we considered three broad categories of benefit periods consisting of multiple stays. The first type of scenario, SNF-to-SNF transfers, is one in which a resident is transferred directly from one SNF to a different SNF. The second case we considered, and the most common of all three multiple-stay benefit period scenarios, is a benefit period that includes a readmission following a new hospitalization between the two stays—for instance, a resident who was discharged from a SNF back to the community, re-hospitalized at a later date, and readmitted to a SNF (the same SNF or a different SNF) following the new hospital stay. The last case we considered was a readmission to the same SNF or a different SNF following a discharge to the community, with no intervening re-hospitalization.

To simplify the analysis, we primarily examined benefit periods with two stays. Benefit periods with exactly two stays account for a large majority (70 percent) of all benefit periods with multiple stays, and benefit periods with more than two stays represent a very small portion

(less than 7 percent) of all benefit periods overall. We therefore assume the data for cases where there are exactly two stays in a benefit period are representative of all benefit periods with multiple stays. Of cases where there are exactly two stays in a benefit period, over three quarters (76.4 percent) consist of re-hospitalization and readmission (to the same SNF or a different SNF). Discharge to the community and readmission without re-hospitalization cases represent approximately 14 percent of cases, while direct SNF-to-SNF transfers represent approximately 10 percent.

For each of these case types, in which a resident was readmitted to a SNF after discharge, we examined whether (1) the variable per diem adjustment schedule should be "reset" back to the Day 1 rates at the outset of the second stay versus "continuing" the variable per diem adjustment schedule at the point at which the previous stay ended, and (2) a new 5-day assessment and resident classification should be required at the start of the subsequent SNF stay.

With regard to the first question above, specifically whether or not a readmission to a SNF within the proposed 3-day interruption window would reset the resident's variable per diem adjustment schedule, in each of the cases described above, we were concerned generally that an interrupted stay policy that "restarts" the variable per diem adjustment schedule to Day 1 after readmissions could incentivize unnecessary discharges with quick readmissions. This concern is particularly notable in the second and third cases described above, as the beneficiary may return to the same facility. To investigate this question, we conducted linear regression analyses to examine changes in costs in terms of both PT/OT and NTA costs per day from the first to second admission for the three scenarios described above (SNF-to-SNF direct transfers, readmissions following re-hospitalization, and readmissions following community discharge). As discussed in section V.D.4. of this proposed rule, investigations revealed that utilization of PT, OT, and NTA services changes over the course of a stay. Based on both empirical analysis and feedback from

multiple technical expert panels, we determined that SLP and nursing utilization remained fairly constant over a stay. Therefore, we are proposing variable per diem adjustment schedules for the PT, OT, and NTA components but not for the SLP or nursing components. Because the analysis of changes in costs across two stays in a single benefit period is relevant to determining how the variable per diem payment adjustments should apply to benefit periods with multiple stays, we restricted our analysis to the three payment components for which we are proposing variable per diem adjustments (PT, OT, and NTA). For this analysis, both the re-hospitalization and community discharge cases were separated into two sub-cases: when the resident returns to the same SNF, and when the resident is admitted to a different SNF. By definition, SNF-to-SNF transfer cases always have different providers for the first and second stays. The regression results showed that PT/OT costs from the first to second admission were very similar for SNF-to-SNF transfers and for readmissions to a different provider following re-hospitalization or discharge to community, suggesting that the second admission is comparable to a new stay. NTA costs from the first to second admission also were very similar for SNF-to-SNF transfers. For readmissions following re-hospitalization or discharge to community, NTA costs for readmissions to the same provider were notably less than NTA costs for readmissions to a different provider. Overall, these results suggest that a readmission to a <u>different</u> SNF, regardless of whether it was a direct SNF-to-SNF transfer, or whether the beneficiary was re-hospitalized or discharged to the community before the second admission, are more comparable to a new stay than an interrupted stay. Thus, we are proposing to always reset the variable per diem adjustment schedule to Day 1 whenever residents are discharged and readmitted to a different SNF. We acknowledge that this could lead to patterns of inappropriate discharges and readmissions that could be inconsistent with the intent of this policy; for example, we would be concerned about patients in SNF A consistently being admitted to SNF B to the exclusion of

other SNFs in the area. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking. However, based on the results of our regression analyses, and because of the concern that a SNF provider could discharge and promptly readmit a resident to reset the variable per diem adjustment schedule to Day 1, in cases where a resident returns to the *same* provider we are proposing to allow the payment schedule to reset only when the resident has been out of the facility for at least 3 days. As previously mentioned, we believe that 3 days represents a reasonable window after which it is more likely that a resident's condition and resource needs will have changed, and this 3-day requirement is also consistent with the interrupted stay policies of similar Medicare PAC benefits. Moreover, while we found that PT and OT costs for cases where the gap is longer than 3 days are similar to PT and OT costs for cases where the gap is shorter than 3 days, NTA costs are notably higher for cases where the gap is longer than 3 days. This provides further support for resetting the variable per diem schedule for cases where the gap is longer than 3 days (as costs tend to be higher, similar to a new stay). More information on these analyses can be found in section 3.10.3. of the SNF PMR technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

With regard to the question of whether or not SNFs would be required to complete a new 5-day assessment and reclassify the resident after returning to the SNF within the proposed 3-day interruption window, we investigated changes in resident characteristics from the first to the second stay within a benefit period. First, we looked at changes in clinical categories from the first to second stay for residents with an intervening re-hospitalization. This analysis could only be conducted for residents with a re-hospitalization because, as described in section 3.10.2. of the SNF PMR technical report, for research purposes, classification into clinical categories was

based on the diagnosis from the prior inpatient stay. For those residents who had a re-hospitalization and were readmitted to a SNF (either the same or a different SNF), and therefore could be reclassified into a new clinical category (because of new diagnostic information as a result of the intervening re-hospitalization), we found that a majority had the same clinical category for both the first and second admission. Because we could not conduct this investigation for SNF-to-SNF transfers or community discharge cases (as they lack a new hospitalization), we separately investigated changes in function from the first to second stay for SNF-to-SNF transfers and for readmissions following community discharge. We found that in a large majority of cases, there was no change in function from the first to second stay, regardless of whether the second provider was the same or different as the first provider. Thus, we believe it would be appropriate to maintain the classification from the first stay for those residents returning to the same SNF no more than 3 calendar days after discharge from the same facility. However, because we are proposing to exclude from the interrupted stay policy readmissions to a different SNF (regardless of the number of days between admissions) and readmissions to the same SNF when the gap between admissions is longer than 3 days, and to treat these readmissions as new stays for purpose of the variable per diem adjustment schedule, we believe it would be appropriate and consistent to treat these cases as new stays for purposes of clinical classification and to require a new 5-day PPS assessment. More information on these analyses can be found in section 3.10.2. of the SNF PMR technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html. Additionally, we note that under the approach discussed in section V.E.1. of this proposed rule, providers would be afforded the flexibility to use the IPA, which would allow for resident reclassification under certain circumstances.

We invite comments on the proposals outlined above. We would also note that we

believe that frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. Given this belief, we plan to monitor the use of this policy closely to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the three-day window used as part of the proposed interrupted stay policy. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.

H. Proposed Relationship of the PDPM to Existing Skilled Nursing Facility Level of Care Criteria

As discussed previously in section IV.A. of this proposed rule, the establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix adjustment aspect of the SNF PPS has been based, in part, on the beneficiary's need for skilled nursing care and therapy, we have coordinated claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG-IV system to assist in making certain SNF level of care determinations.

As further discussed below, we propose to adopt a similar approach under the PDPM effective October 1, 2019, by retaining an administrative presumption mechanism that would utilize the initial assignment of one of the case-mix classifiers that we designate for this purpose to assist in making certain SNF level of care determinations. This designation would reflect an administrative presumption under the PDPM that beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare required assessment.

As under the existing RUG-IV administrative presumption, a beneficiary who is not assigned one of the designated classifiers would not automatically be classified as either meeting or not meeting the level of care definition, but instead would receive an individual level of care determination using the existing administrative criteria. The use of the administrative presumption reflects the strong likelihood that those beneficiaries who are assigned one of the designated classifiers during the immediate post-hospital period require a covered level of care, which would be less likely for other beneficiaries.

In the ANPRM (82 FR 21007), we discussed some potential adaptations of the RUG-IV model's administrative presumption to accommodate specific features of the RCS-I model, including the possible designation of the following case-mix classifiers for purposes of the administrative presumption:

- Continued designation of the same nursing (non-rehabilitation) groups that currently comprise the Extensive Services, Special Care High, Special Care Low, and Clinically Complex categories under RUG-IV, as those groups would crosswalk directly from RUG-IV to the RCS-I model we were considering;

- In addition, designation of the most intensive functional score (14 to 18) under the RCS-I model's combined PT/OT component, as well as the uppermost comorbidity score (11+) under its NTA component.

In response, a number of comments expressed concern that the possible adaptations of the presumption could adversely affect access to care for some beneficiaries. Others asked whether using the PT/OT component's highest functional score bin (14 to 18) as a trigger for the presumption would be appropriate, inasmuch as the residents that typically require the most therapy are those with only moderate functional impairments. In addition, commenters questioned the discussion's inclusion of the RCS-I model's NTA component as a possible

classifier under the presumption, as well as its omission of RCS-I's SLP component.

Regarding the commenters' concerns about access to care, we note that we have indicated in the ANPRM and in previous rulemaking that the actual purpose of the level of care presumption has always been to afford a streamlined and simplified administrative procedure for readily identifying those beneficiaries with the greatest likelihood of meeting the level of care criteria; however, we have also emphasized that in focusing on such beneficiaries, this approach in no way serves to disadvantage other beneficiaries who may also meet the level of care criteria. As we noted in the ANPRM,

> . . . an individual beneficiary's inability to qualify for the administrative presumption would not in itself serve to disqualify that resident from receiving SNF coverage . . . while such residents are not automatically presumed to require a skilled level of care, neither are they automatically classified as requiring nonskilled care. Rather, any resident who does not qualify for the presumption would instead receive an individual level of care determination using the existing administrative criteria (82 FR 21007).

As we further explained in the FY 2016 SNF PPS final rule, structuring the presumption in this manner serves ". . . specifically to ensure that the presumption does not disadvantage such residents, by providing them with an individualized level of care determination that fully considers all pertinent factors" (80 FR 46406, August 4, 2015).

As for concerns about the appropriateness of certain classifiers, including the possible use of the PT/OT component's highest functional score bin (14 to 18) for this purpose under RCS-I, we note that the case-mix classification model for PT and OT that we are now proposing in connection with the PDPM would essentially reconfigure the PT/OT component from the RCS-I model. As discussed in section V.D.3.b. of this proposed rule, the proposed PDPM would divide the RCS-I model's combined PT/OT component into two separate case-mix adjusted components, under which each resident would be assigned separate case-mix groups for PT and OT payment. Those groups would classify residents based on clinical category and function

score, the two resident characteristics shown to be most predictive of PT and OT utilization.

Further, as we noted in section III.B.4. of the ANPRM ("Variable Per Diem Adjustment Factors and Payment Schedule") and section V.D.4. of this proposed rule, our initial analyses revealed that in contrast to the SLP component--where per diem costs remain relatively constant over time--costs for the PT, OT, and NTA components typically are highest at the outset and then decline over the course of the stay. Our research to date continues to show a strong correlation between the dependent variables used for the proposed separate PT and OT components and a similarity in predictors, in that the associated costs for both therapy disciplines remain highest in the initial (and typically most intensive) portion of the SNF stay. This heightened resource intensity during the initial part of the SNF stay under the PT, OT, and NTA components, in turn, more closely reflects the distinctive utilization patterns that served as the original foundation for the level of care presumption itself--that is, the tendency as noted in the FY 2000 SNF PPS final rule for ". . . SNF stays to be at their most intensive and unstable immediately following admission as justifying a presumption of coverage at the very outset of the SNF stay" (64 FR 41667, July 30, 1999). We believe this would make the most intensive classifiers within each of these three proposed components well-suited to serve as clinical proxies for identifying those beneficiaries with the most intensive care needs and greatest likelihood of requiring an SNF level of care.

Accordingly, for purposes of the administrative presumption under the proposed PDPM, we propose to continue utilizing the same designated nursing (non-rehabilitation) categories under the PDPM as have been used to date under RUG-IV. We note that the most direct crosswalk between the existing RUG-IV model and the proposed PDPM would involve nursing services, for which, under the proposed PDPM, each resident would continue to be classified into one of the groups that fall within the existing non-rehabilitation RUG-IV categories. (As

explained in section V.D.3.d. of this proposed rule, while the total number of nursing case-mix groups would be streamlined from the current 43 under RUG-IV down to 25 under PDPM through the consolidation of similar groups within individual categories, the overall number and structure of the nursing categories themselves would remain the same.) Under our proposal, effective in conjunction with the proposed implementation of the PDPM (that is, as of October 1, 2019), the administrative presumption would apply to those groups encompassed by the same nursing categories as are currently designated for this purpose under the existing RUG-IV model:

- Extensive Services;
- Special Care High;
- Special Care Low; and,
- Clinically Complex.

In addition, along with the continued use of the RUG-IV nursing categories above, we also propose to apply the administrative presumption using those other classifiers under the proposed PDPM that we believe would relate the most directly to identifying a patient's need for skilled care at the outset of the SNF stay. As explained below, we would designate such classifiers for this purpose based on their ability to fulfill the administrative presumption's role as described in the FY 2000 SNF PPS final rule--that is, to identify those ". . . situations that involve a high probability of the need for skilled care . . . when taken in combination with the characteristic tendency . . . for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay" (64 FR 41668 through 41669, July 30, 1999).

Specifically, we additionally propose to designate for this purpose proposed PT and OT case-mix groups TB, TC, TD, TF, and TG, the groups displayed in Table 21 that collectively account for the five highest case-mix indexes for PT as well as for OT and, thus, would consistently be associated with the most resource-intensive care across both of these therapy

disciplines. We also propose to designate the uppermost comorbidity group (11+) under the NTA component, as we believe this particular classifier would serve to identify those cases that are the most likely to involve the kind of complex medication regimen (for example, a highly intensive drug requiring specialized expertise to administer, or an exceptionally large and diverse assortment of medications posing an increased risk of adverse drug interactions) that would require skilled oversight to manage safely and effectively.

Under this proposed approach, those residents not classifying into a case-mix group in one of the designated nursing RUG categories under the proposed PDPM on the initial, 5-day Medicare-required assessment could nonetheless still qualify for the administrative presumption on that assessment by being placed in one of the designated case-mix groups for either the PT or OT components, or by receiving the uppermost comorbidity score (11+) under the NTA component. We believe that these particular clinical indicators would appropriately serve to fulfill the administrative presumption's role of identifying those cases with the highest probability of requiring an SNF level of care throughout the initial portion of the SNF stay. We note that in order to help improve the accuracy of these newly-designated groups in serving this function, we would continue to review the new designations going forward and may make further adjustments to the proposed designations over time as we gain actual operating experience under the new classification model. As discussed above, this administrative presumption mechanism would take effect October 1, 2019 in conjunction with the proposed PDPM. We invite comments on our proposed administrative presumption mechanism under the proposed PDPM.

I. Effect of Proposed PDPM on Temporary AIDS Add-on Payment

As discussed in section III.C. of this proposed rule and also in section III.E. of the ANPRM, section 511(a) of the MMA amended section 1888(e)(12) of the Act to provide for a

temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS was intended to be of limited duration, as the MMA legislation specified that it was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents.

The temporary add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.gov/transmittals/downloads/r160cp.pdf. In the SNF PPS final rule for FY 2010 (74 FR 40288, August 11, 2009), we did not address this certification in that final rule's implementation of the case-mix refinements for RUG-IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect for the time being.

In the House Ways and Means Committee Report that accompanied the MMA, the explanation of the MMA's temporary AIDS adjustment notes the following under Reason for Change: "According to prior work by the Urban Institute, AIDS patients have much higher costs than other patients in the same resource utilization groups in skilled nursing facilities. The adjustment is based on that data analysis" (H. Rep. No. 108-178, Part 2 at 221). The data analysis from that February 2001 Urban Institute study (entitled "Medicare Payments for Patients with HIV/AIDS in Skilled Nursing Facilities"), in turn, had been conducted under a Report to Congress mandated under a predecessor provision, section 105 of the BBRA. This earlier BBRA provision, which ultimately was superseded by the temporary AIDS add-on provision required by the MMA, had amended section 1888(e)(12) of the Act to provide for special consideration for facilities serving specialized patient populations (that is, those who are "immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the

Secretary").

As we noted in the ANPRM, at this point over a decade and a half has elapsed since the Urban Institute conducted its study on AIDS patients in SNFs, a period that has seen major advances in the state of medical practice in treating this condition. These advances have notably included the introduction of powerful new drugs and innovative prescription regimens that have dramatically improved the ability to manage the viral load (the amount of human immunodeficiency virus (HIV) in the blood). The decrease in viral load secondary to medications has contributed to a shift from intensive nursing services for AIDS-related illnesses to an increase in antiretroviral therapy. This phenomenon, in turn, is reflected in our recent analysis of differences in SNF resource utilization, which indicates that while the overall historical disparity in costs between AIDS and non-AIDS patients has not entirely disappeared, that disparity is now far greater with regard to drugs than it is for nursing. Specifically, NTA costs per day for residents with AIDS were 151 percent higher than those for other residents while the difference in wage-weighted nursing staff time between the two groups was only 19 percent, as discussed in section 3.8.3. of the SNF PRM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), which the ANPRM referenced for further information on the underlying data analysis (82 FR 21007 through 21008). In the ANPRM, we also described how the RCS-I model would account for those NTA costs, including drugs, which specifically relate to residents with AIDS (82 FR 20997 through 20999). We additionally discussed the possibility of making a specific 19 percent AIDS adjustment as part of the case-mix adjustment of the nursing component (82 FR 20995 through 20997). We further expressed our belief that,

> . . . when taken collectively, these adjustments . . . would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA . . . which would

> permit the MMA's existing, temporary AIDS add-on to be replaced by a permanent adjustment in the case mix . . . that appropriately compensates for the increased costs associated with these residents (82 FR 21008).

In response, we received comments expressing concerns that a projected 40 percent drop in overall payments for SNF residents with AIDS under the RCS-I model could adversely affect access to care for this patient population. Regarding those concerns, we note that the special add-on for SNF residents with AIDS itself was never meant to be permanent, and does not serve as a specific benchmark for use in establishing either the appropriate methodology or level of payment for this patient population. Rather, as discussed in the ANPRM, it was designed to be only a temporary measure, representing a general approximation that reflected the current state of research and clinical practice at the time (82 FR 21007 through 21008). As such, the special add-on would not account for the significant changes in the care and treatment of this condition that have occurred over the intervening years. Moreover, as a simple across-the-board multiplier, the MMA adjustment by its very nature is not accurately targeted at those particular rate components that actually account for the disparity in cost between AIDS patients and others.

As discussed previously in section V.D.3.e. of this proposed rule, based on our updated investigations into the adequacy of payments under the proposed PDPM for residents with HIV/AIDS, we believe that the four proposed ancillary payment components (PT, OT, SLP, and NTA) adequately reimburse ancillary costs associated with HIV/AIDS residents (see section 3.8.2. of the SNF PDPM technical report, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). Therefore, we believe it would be appropriate to issue the prescribed certification under section 511(a) of the MMA on the basis of the proposed PDPM's ancillary case-mix adjustment alone, as effectively providing the required appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. However, to further ensure that the proposed PDPM would account as fully as

possible for any remaining disparity with regard to nursing costs, as discussed in section V.D.3 d., we are additionally proposing to include a specific AIDS adjustment as part of the case-mix adjustment of the nursing component. As discussed in section V.D.3.d. of this proposed rule, we used the STRIVE data to quantify the effects of HIV/AIDS diagnosis on nursing resource use. Regression analyses found that wage-weighted nursing staff time is 18 percent higher for residents with HIV/AIDS, controlling for the non-rehabilitation RUG of the resident. We note that this figure is slightly lower than the 19 percent increase in wage-weighted nursing staff time reported in the ANPRM and the SNF PRM technical report because the updated investigation uses a FY 2017 study population and is based on the PDPM case-mix groups, while the earlier analysis was based on a FY 2014 study population and the RCS-I case-mix groups. More information on this analysis can be found in section 3.8.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). Thus, we are proposing an 18 percent increase in payment for the nursing component for residents with HIV/AIDS under the proposed PDPM to account for the increased nursing costs for such residents. Similar to the NTA adjustment for residents with HIV/AIDS discussed in section V.D.3.e. of this proposed rule, this adjustment would be identified by ICD-10-CM code B20 on the SNF claim and would be processed through the PRICER software used by CMS to set the appropriate payment rate for a resident's SNF stay. The 18 percent adjustment would be applied to the unadjusted base rate for the nursing component, and then this amount would be further case-mix adjusted per the resident's PDPM classification.

We believe that when taken collectively, these adjustments under the proposed PDPM would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA effective with the proposed conversion to the PDPM on October 1, 2019, thus

permitting the MMA's existing, temporary AIDS add-on to be replaced by a permanent adjustment in the case mix (as proposed under the PDPM) that appropriately compensates for the increased costs associated with these residents. We invite comments on this proposal.

At the same time, we acknowledge that even with an accurately targeted model that compensates for the increased costs of SNF residents with AIDS, an abrupt conversion to an altogether different payment methodology might nevertheless be potentially disruptive for facilities, particularly those that serve a significant number of patients with AIDS and may have become accustomed to operating under the existing payment methodology for those patients. Accordingly, we specifically invite comments on possible ways to help mitigate any potential disruption stemming from the proposed replacement of the special add-on payment with the permanent case-mix adjustments for SNF residents with AIDS under the proposed PDPM.

J. Potential Impacts of Implementing the Proposed PDPM and Proposed Parity Adjustment

This section outlines the projected impacts of implementing the proposed PDPM effective October 1, 2019 under the SNF PPS and the related policy proposals in sections V.A. through V.I of this proposed rule that would be effective in conjunction with the proposed PDPM.

This impact analysis makes a series of assumptions, as described below. First, the impacts presented here assume consistent provider behavior in terms of how care is provided under RUG-IV and how care might be provided under the proposed PDPM, as we do not make any attempt to anticipate or predict provider reactions to the implementation of the proposed PDPM. That being said, we acknowledge the possibility that implementing the proposed PDPM could substantially affect resident care and coding behaviors. Most notably, based on the concerns raised during a number of TEPs, we acknowledge the possibility that, as therapy payments under the proposed PDPM would not have the same connection to service provision as

they do under RUG-IV, it is possible that some providers may choose to reduce their provision of therapy services to increase margins under the proposed PDPM. However, we do not have any basis on which to assume the approximate nature or magnitude of these behavioral responses, nor have we received any sufficiently specific guidance on the likely nature or magnitude of behavioral responses from ANPRM commenters, TEP panelists, or other sources of feedback. As a result, lacking an appropriate basis to forecast behavioral responses, we do not adjust our analyses of resident and provider impacts discussed in this section for projected changes in provider behavior. However, we do intend to monitor behavior which may occur in response to the implementation of PDPM, if finalized, and may consider proposing policies to address such behaviors to the extent determined appropriate. Additionally, we acknowledge that a number of states utilize some form of the RUG-IV case-mix classification system as part of their Medicaid programs and that any change in Medicare policy can have an impact on state programs. Again, we do not have any basis on which to assume the approximate nature or magnitude of these responses, for the same reasons cited above. Additionally, we do not expect impacts on state Medicaid programs resulting from PDPM implementation to have a notable impact on payments for Medicare-covered SNF stays, which are the basis for the impact analyses discussed in this section. Therefore, we do not consider possible changes to state Medicaid programs when conducting these analyses. We invite comments on our assumptions that behavior would remain unchanged under the proposed PDPM and that changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays. We also invite comment on the impact of these policy proposals on state Medicaid programs.

As with prior system transitions, we propose to implement the proposed PDPM case-mix system, along with the other policy changes discussed in section V of this proposed rule, in a

budget neutral manner through application of a parity adjustment to the case-mix weights under the proposed PDPM, as further discussed below. We are proposing to implement the PDPM in a budget neutral manner because, as with prior system transitions, in proposing changes to the case-mix methodology, we do not intend to change the aggregate amount of Medicare payments to SNFs. Rather, we aim to utilize a case-mix methodology to classify residents in such a manner as to best ensure that payments made for specific residents are an accurate reflection of resource utilization without introducing potential incentives which could encourage inappropriate care delivery, as we believe may exist under the current case-mix methodology. Therefore, the impact analysis presented here assumes implementation of these proposed changes in a budget neutral manner. We invite comments on the proposal, as further discussed below, to implement the PDPM in a budget neutral manner. In addition, we solicit comment on whether it would be appropriate to implement the proposed PDPM in a manner that is not budget neutral.

As discussed above, the impact analysis presented here assumes implementation of these changes in a budget neutral manner without a behavioral change. The prior sections describe how case-mix weights are set to reflect relative resource use for each case-mix group. The proposed PDPM payment before application of a parity adjustment would be calculated using the unadjusted CMI for each component, the variable per diem payment adjustment schedule, the unadjusted urban and rural federal per diem rates shown in Tables 12 and 13, the labor-related share, and the geographic wage indexes. In applying a parity adjustment to the case-mix weights, we would maintain the relative value of each CMI but would multiply every CMI by a ratio to achieve parity in overall SNF PPS payments under the proposed PDPM and under the RUG-IV case-mix model. The parity adjustment multiplier is calculated through the following steps. First, we calculate RUG-IV total payment. Total RUG-IV payments are calculated by

adding total allowed amounts across all FY 2017 SNF claims. The total allowed amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the sum of Medicare claim payment amount, National Claim History (NCH) primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Second, we calculate what total payment would have been under the proposed PDPM in FY 2017 before application of the parity adjustment. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays. This represents the total allowed amount if PDPM had been in place in FY 2017. Total estimated FY 2017 payments under the proposed PDPM are calculated using resident information from FY 2017 SNF claims, the MDS assessment, and other Medicare claims, as well as the unadjusted CMI for each component, the variable per diem payment adjustment schedule, the unadjusted urban and rural federal per diem rates shown in Tables 12 and 13, the labor-related share, and the geographic wage indexes. After calculating total actual RUG-IV payments and total estimated case-mix-related PDPM payments, we subtract non-case-mix component payments from total RUG-IV payments, as this component does not change across systems. This subtraction does not include the temporary add-on for residents with HIV/AIDS in the RUG-IV system, which PDPM replaces with additional payments for residents with HIV/AIDS through the NTA and nursing components (as discussed in sections V.I. of this proposed rule). By retaining the portion of non-case-mix component payments associated with the temporary HIV/AIDS add-on in total RUG-IV payments, all payments associated with the add-on under RUG-IV are re-allocated to the case-mix-adjusted components in PDPM. This is appropriate because, as discussed, under the proposed PDPM, additional payments for residents with HIV/AIDS are made exclusively through the case-mix-

adjusted components (that is, the nursing and NTA components). Lastly, in calculating budget neutrality, we must set total estimated case-mix-related payment under PDPM such that it equals total allowable Medicare payments under RUG-IV. To do this, we divide the remaining total RUG-IV payments over the remaining total estimated PDPM payments prior to the parity adjustment. This division yields a ratio (parity adjustment) of 1.46 by which the proposed PDPM CMIs are multiplied so that total estimated payments under the proposed PDPM would be equal to total actual payments under RUG-IV, assuming no changes in the population, provider behavior, and coding. If this parity adjustment had not been applied, total estimated payments under the proposed PDPM would be 46 percent lower than total actual payments under RUG-IV, therefore the implementation of the proposed PDPM would not be budget neutral. We invite comments on our proposal discussed above to apply a parity adjustment to the CMIs under the proposed PDPM and to implement the proposed PDPM in a budget neutral manner. More details regarding this calculation and analysis are described in section 3.11.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). The impact analysis presented in this section focuses on how payments under the proposed PDPM would be re-allocated across different resident groups and among different facility types, assuming implementation in a budget neutral manner.

The projected resident-level impacts are presented in Table 37. The first column identifies different resident subpopulations and the second column shows what percent of SNF stays in FY 2017 are represented by the given subpopulation. The third column shows the projected change in total payments for residents in a given subpopulation, represented as a percentage change in actual FY 2017 payments made for that subpopulation under RUG-IV versus estimated payments which would have been made to that subpopulation in FY 2017 had the proposed PDPM been in place. Total RUG-IV payments are calculated by adding total

allowed amounts across all FY 2017 SNF claims associated with a resident subpopulation. The total allowed amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the summation of Medicare claim payment amount, NCH primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Payments corresponding to the non-case-mix component are subtracted from the RUG-IV total payments, not including the portion of non-case-mix payments corresponding to the temporary add-on for residents with HIV/AIDS. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays associated with a resident subpopulation. Positive changes in this column represent a projected positive shift in payments for that subpopulation under the proposed PDPM, while negative changes in this column represent projected negative shifts in payment for that subpopulation. More information on the construction of current payments under RUG-IV and payments under the proposed PDPM for purposes of this impact analysis can be found in section 3.12. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). Based on the data presented in Table 37, we observe that the most significant shift in payments created by implementation of the proposed PDPM would be to redirect payments away from residents who are receiving very high amounts of therapy under the current SNF PPS, which strongly incentivizes the provision of therapy, to residents with more complex clinical needs. For example, we project that for residents whose most common therapy level is RU (ultra-high therapy)--the highest therapy level, there would be a reduction in associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent. Other resident types for which

there may be higher relative payments under the proposed PDPM are: residents who have high NTA costs, receive extensive services, are dually enrolled in Medicare and Medicaid, use IV medication, have ESRD, diabetes, or a wound infection, receive amputation/prosthesis care, and/or have longer prior inpatient stays.

In response to comments received on the ANPRM, we investigated a few additional subpopulations that commenters believed were not adequately accounted for under the RCS-I model, including residents with addictions, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care. Table 37 shows that the proposed PDPM is projected to increase the proportion of total payment associated with each of those subpopulations.

TABLE 37: Proposed PDPM Impact Analysis, Resident-Level

Resident Characteristics	% of Stays	Percent Change
All Stays	100.0%	0.0%
Sex		
Female	60.3%	-0.8%
Male	39.7%	1.2%
Age		
Below 65 years	10.3%	7.2%
65-74 years	24.1%	3.1%
75-84 years	32.5%	-0.4%
85-89 years	17.6%	-3.1%
Over 90 years	15.6%	-4.3%
Race/Ethnicity		
White	83.8%	-0.2%
Black	11.2%	0.8%
Hispanic	1.7%	0.9%
Asian	1.3%	-0.6%
Native American	0.5%	7.1%
Other or Unknown	1.5%	0.8%
Medicare/Medicaid Dual Status		
Dually Enrolled	34.7%	3.3%
Not Dually Enrolled	65.3%	-2.1%
Original Reason for Medicare Enrollment		
Aged	74.6%	-1.7%
Disabled	24.5%	4.8%
ESRD	0.9%	10.5%
Utilization Days		
1-15 days	35.4%	13.7%
16-30 days	33.8%	0.0%
31+ days	30.9%	-2.5%
Utilization Days = 100		

Resident Characteristics	% of Stays	Percent Change
No	98.4%	0.1%
Yes	1.6%	-1.9%
Length of Prior Inpatient Stay		
0-2 days	2.2%	1.3%
3 days	22.5%	-3.3%
4-30 days	73.6%	0.7%
31+ days	1.7%	6.7%
Most Common Therapy Level		
RU	58.4%	-8.4%
RV	22.4%	11.4%
RH	6.8%	27.4%
RM	3.3%	41.1%
RL	0.1%	67.5%
Non-Rehab	9.1%	50.5%
Number of Therapy Disciplines Used		
0	2.3%	63.1%
1	2.4%	44.2%
2	51.6%	1.6%
3	43.7%	-3.1%
Physical Therapy Utilization		
No	3.7%	50.9%
Yes	96.3%	-0.7%
Occupational Therapy Utilization		
No	4.5%	47.7%
Yes	95.5%	-0.8%
Speech Language Pathology Utilization		
No	55.0%	2.8%
Yes	45.0%	-2.5%
Therapy Utilization		
PT+OT+SLP	43.7%	-3.1%
PT+OT Only	50.8%	1.3%
PT+SLP Only	0.4%	27.3%
OT+SLP Only	0.4%	30.1%
PT Only	1.3%	41.3%
OT Only	0.6%	47.9%
SLP Only	0.5%	46.8%
Non-Therapy	2.3%	63.1%
NTA Costs ($)		
0-10	13.7%	-3.5%
10-50	44.5%	-3.2%
50-150	32.2%	4.2%
150+	9.6%	18.7%
NTA Comorbidity Score		
0	23.5%	-10.4%
1-2	30.5%	-4.7%
3-5	31.0%	4.0%
6-8	9.9%	15.0%
9-11	3.6%	24.4%
12+	1.4%	27.2%
Extensive Services Level		
Tracheostomy and Ventilator/Respirator	0.3%	22.2%
Tracheostomy or Ventilator/Respirator	0.6%	7.3%

Resident Characteristics	% of Stays	Percent Change
Infection Isolation	1.1%	9.1%
Neither	98.0%	-0.3%
CFS Level		
Cognitively Intact	58.5%	-0.3%
Mildly Impaired	20.7%	-0.2%
Moderately Impaired	16.8%	-0.7%
Severely Impaired	3.9%	8.8%
Clinical Category		
Acute Infections	6.5%	3.4%
Acute Neurologic	6.4%	-3.7%
Cancer	4.6%	-3.2%
Cardiovascular and Coagulations	9.8%	0.5%
Major Joint Replacement or Spinal Surgery	8.6%	-2.1%
Medical Management	30.4%	0.0%
Non-Orthopedic Surgery	10.8%	5.7%
Non-Surgical Orthopedic/Musculoskeletal	5.9%	-6.1%
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	8.9%	-2.4%
Pulmonary	8.1%	5.4%
Level of Complications in MS-DRG of Prior Inpatient Stay		
No Complication	35.8%	-3.1%
CC/MCC	64.2%	1.7%
Stroke		
No	90.9%	0.0%
Yes	9.1%	0.3%
HIV/AIDS		
No	99.7%	0.3%
Yes	0.3%	-40.5%
IV Medication		
No	91.7%	-2.1%
Yes	8.3%	23.5%
Diabetes		
No	64.0%	-3.0%
Yes	36.0%	5.4%
Wound Infection		
No	98.9%	-0.3%
Yes	1.1%	22.2%
Amputation/Prosthesis Care		
No	100.0%	0.0%
Yes	0.0%	6.4%
Presence of Dementia		
No	70.9%	0.5%
Yes	29.1%	-1.2%
MDS Alzheimer's		
No	95.2%	0.0%
Yes	4.8%	-0.3%
Unknown	0.0%	5.0%
Presence of Addictions		
No	94.6%	-0.1%
Yes	5.4%	1.8%
Presence of Bleeding Disorders		
No	90.9%	-0.1%

Resident Characteristics	% of Stays	Percent Change
Yes	9.1%	1.5%
Presence of Behavioral Issues		
No	53.1%	-0.9%
Yes	46.9%	1.0%
Presence of Chronic Neurological Conditions		
No	74.4%	-0.2%
Yes	25.6%	0.6%
Presence of Bariatric Care		
No	91.3%	-0.6%
Yes	8.7%	6.5%

The projected provider-level impacts are presented in Table 38. The first column identifies different facility subpopulations and the second column shows what percentage of SNFs in FY 2017 are represented by the given subpopulation. The third column shows the projected change in total payments for facilities in a given subpopulation, represented as a percentage change in actual FY 2017 payments made for that subpopulation under RUG-IV versus estimated payments which would have been made to that subpopulation in FY 2017 had the proposed PDPM been in place. Total RUG-IV payments are calculated by adding total allowed amounts across all FY 2017 SNF claims associated with a facility subpopulation. The total allowed amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the summation of Medicare claim payment amount, NCH primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Payments corresponding to the non-case-mix component are subtracted from the RUG-IV total payments, not including the portion of non-case-mix payments corresponding to the temporary add-on for residents with HIV/AIDS. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays associated with a facility subpopulation. Positive changes in this column represent a projected positive shift in payments for that subpopulation under the

proposed PDPM, while negative changes in this column represent projected negative shifts in payment for that subpopulation. More information on the construction of current payments under RUG-IV and payments under the proposed PDPM for purposes of this impact analysis can be found in section 3.12. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html). Based on the data presented in Table 38, we observe that the most significant shift in Medicare payments created by implementation of the proposed PDPM would be from facilities with a high proportion of rehabilitation residents (particularly facilities with high proportions of Ultra-High Rehabilitation residents) to facilities with high proportions of non-rehabilitation residents. We project that payments to facilities that bill 0 to 10 percent of utilization days as RU (ultra-high rehabilitation) would increase an estimated 27.6 percent under the proposed PDPM while facilities that bill 90 to 100 percent of utilization days as RU would see an estimated decrease in payments of 9.8 percent. Other facility types that may see higher relative payments under the proposed PDPM are small facilities, non-profit facilities, government-owned facilities, and hospital-based and swing-bed facilities.

TABLE 38: Proposed PDPM Impact Analysis, Facility-level

Provider Characteristics	% of Providers	Percent Change
All Stays	100.0%	0.0%
Ownership		
For profit	72.0%	-0.7%
Non-profit	22.6%	1.9%
Government	5.4%	4.2%
Number of Certified SNF Beds		
0-49	10.0%	3.5%
50-99	38.2%	0.6%
100-149	34.7%	-0.2%
150-199	11.1%	-0.3%
200+	5.9%	-1.8%
Location		
Urban	72.7%	-0.7%
Rural	27.3%	3.8%
Facility Type		

Freestanding	96.2%	-0.3%
Hospital-Based/Swing Bed	3.8%	16.7%
Location by Facility Type		
Urban | Freestanding	70.6%	-1.0%
Urban | Hospital-Based/Swing Bed	2.2%	15.3%
Rural | Freestanding	25.6%	3.2%
Rural | Hospital-Based/Swing Bed	1.6%	21.1%
Census Division		
New England	5.9%	2.0%
Middle Atlantic	10.8%	-2.6%
East North Central	20.6%	0.7%
West North Central	12.5%	6.7%
South Atlantic	15.7%	-0.4%
East South Central	6.6%	1.0%
West South Central	13.1%	-1.0%
Mountain	4.7%	1.1%
Pacific	10.1%	-0.8%
Location by Region		
Urban | New England	5.1%	1.8%
Urban | Middle Atlantic	9.5%	-2.9%
Urban | East North Central	14.4%	-0.1%
Urban | West North Central	6.0%	4.6%
Urban | South Atlantic	12.6%	-1.1%
Urban | East South Central	3.6%	0.3%
Urban | West South Central	8.7%	-1.2%
Urban | Mountain	3.4%	0.1%
Urban | Pacific	9.5%	-0.9%
Rural | New England	0.8%	4.0%
Rural | Middle Atlantic	1.3%	2.7%
Rural | East North Central	6.2%	3.6%
Rural | West North Central	6.5%	10.5%
Rural | South Atlantic	3.1%	4.2%
Rural | East South Central	3.0%	2.1%
Rural | West South Central	4.4%	-0.1%
Rural | Mountain	1.3%	6.2%
Rural | Pacific	0.6%	2.2%
% Stays with Maximum Utilization Days = 100		
0-10%	94.4%	0.1%
10-25%	5.1%	-2.8%
25-100%	0.4%	-3.6%
% Medicare/Medicaid Dual Enrollment		
0-10%	8.6%	-1.3%
10-25%	17.5%	-1.3%
25-50%	36.0%	0.3%
50-75%	26.5%	1.3%
75-90%	8.2%	0.4%
90-100%	3.1%	1.6%
% Utilization Days Billed as RU		
0-10%	8.9%	27.6%
10-25%	8.0%	15.5%
25-50%	24.1%	7.0%
50-75%	39.2%	-0.4%
75-90%	17.2%	-6.0%
90-100%	2.6%	-9.8%
% Utilization Days Billed as Non-Rehab		

0-10%	79.8%	-1.5%
10-25%	16.6%	8.6%
25-50%	2.7%	23.1%
50-75%	0.4%	35.8%
75-90%	0.2%	41.8%
90-100%	0.4%	33.6%

In addition to the impacts discussed throughout this section, we also note that we expect a significant reduction in regulatory burden under the SNF PPS, due to the changes we are proposing in the MDS assessment schedule, as discussed above in section V.E.1. of this proposed rule. Based on the calculations outlined in section VII.B.1. of this proposed rule, we anticipate that the proposed assessment schedule changes discussed in this rule would reduce administrative costs for each provider by approximately $12,000 and reduce the time for administrative issues by approximately 183 hours for each provider. We anticipate that this proposed reduction in administrative burden would permit providers greater flexibility in interacting with their patients and focusing on their patient's individual care needs.

With regard to the proposed changes to the SNF PPS discussed in section V of this proposed rule, we provide an accounting of our reasons for each of the proposed policies throughout the subsections in section V and invite comments on any of those proposed changes. In this section, we discuss alternatives considered which relate generally to implementation of the proposed changes discussed in section V, most notably the implementation of the proposed PDPM.

We are proposing to implement the PDPM effective beginning in FY 2020 (that is, October 1, 2019). This proposed effective date incorporates a one year period to allow time for provider education and training, internal system transitions, and to allow states to make any Medicaid program changes which may be necessary based on the proposed changes related to PDPM.

When making major system changes, CMS often considers possible transition options for

providers and other stakeholders between the former system and the new system. For example, when we updated OMB delineations used to establish a provider's wage index under the SNF PPS in FY 2015, we utilized a blended rate in the first year of implementation, whereby 50 percent of the provider's payment was derived from their former OMB delineation and 50 percent from their new OMB delineation (79 FR 45644 – 45646).

However, due to the fundamental nature of the change from the current RUG-IV case-mix model to the proposed PDPM, which includes differences in resident assessment, payment algorithms, and other policies, we believe that proposing a blended rate for the whole system (that would require two full case-mix systems (RUG-IV and the proposed PDPM) to run concurrently) is not advisable as part of any transition strategy for implementing the proposed PDPM, due to the significant administrative and logistical issues that would be associated with such a transition strategy. Specifically, CMS and providers would be required to manage both the RUG-IV payment model and proposed PDPM simultaneously, creating significant burden and undue complexity for all involved parties. Furthermore, providers would be required to follow both sets of MDS assessment rules, each of which carries with it its own level of complexity. CMS would also be required to process assessments and claims under each system, which would entail a significant amount of resources and burden for CMS, MACs, and providers. Finally, a blended rate option would also mitigate some of the burden reduction associated with implementing PDPM, estimated to save SNFs close to $200 million per year as compared to estimated burden under RUG-IV, given that the current assessment schedule would need to continue until full implementation of PDPM was achieved. We believe these issues also would be implicated in any alternative transition strategy which would require both case-mix systems to exist concurrently, such as giving providers a choice in the first year of implementation of operating under either the RUG-IV or PDPM. Therefore, we did not pursue

any alternatives which required concurrent operation of both the RUG-IV and PDPM.

We then considered alternative effective dates for implementing the proposed PDPM, and other policy changes proposed in section V of this rule. We considered implementing the new case-mix model effective beginning in FY 2019, but we believe that this would not permit sufficient time for providers and other stakeholders, including CMS, to make the necessary preparations for this magnitude of a change in the SNF PPS. We also believe that such a quick transition would not be in keeping with how similar types of SNF PPS changes have been implemented in the past. We also considered implementing PDPM more than one year after being finalized, such as implementing the proposed PDPM effective beginning October 1, 2020 (FY 2021). However, we believe that setting the effective date of PDPM this far out is not necessary, based on our prior experience with similar SNF PPS changes. As is customary, we plan to continue to provide free software to providers which can be used to group residents under the proposed PDPM, as well as providing data specifications for this grouper software as soon as is practicable, should the proposed PDPM be finalized, thereby mitigating potential concerns around software vendors having sufficient time to develop products for PDPM. Moreover, given the issues identified throughout this proposed rule with the current RUG-IV model, notably the issues surrounding the burdensome and complex PPS assessment schedule under the SNF PPS currently and concerns around the incentives for therapy provision under the RUG-IV system, we believe it appropriate to implement the proposed PDPM as soon as is practicable. Therefore, we propose to implement the PDPM, as well as the other proposed changes discussed in section V of this proposed rule, effective beginning October 1, 2019.

Finally, we considered alternatives related to the proposal discussed in section V.I., specifically the proposed certification that we have met the requirements set forth in section 511(a) of the MMA, which would permit us to use the PDPM's proposed permanent case-mix

adjustments for SNF residents with AIDS to replace the temporary special add-on in the PPS per diem payment for such residents. As noted in section V.I. above, this special add-on for SNF residents with AIDS was intended to be of limited duration, as the MMA legislation specified that it was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. We considered maintaining this adjustment under the proposed PDPM. However, given the adjustment incorporated into the NTA and nursing components under the proposed PDPM to account for the increased costs of treating residents with AIDS, this would result in a substantial increase in payment for such residents beyond even the current add-on payment. Moreover, as discussed in section V.I., we believe that the proposed PDPM provides a tailored case-mix adjustment that more accurately accounts for the additional costs and resource use of residents with AIDS, as compared to an undifferentiated add-on which simply applies an across-the-board multiplier to the full SNF PPS per diem. Finally, as stated in section 3.8.2. of the SNF PDPM technical report (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html), HIV/AIDS was associated with a negative and statistically significant decrease in PT, OT and SLP costs per day. This means inherently that, to the extent that the existing add-on is applied against the full SNF PPS per diem payment, the magnitude of the add-on payment increases with increases in therapy payment, which conflicts with the data described above regarding the relationship between therapy costs and the presence of an AIDS diagnosis. As a result, maintaining the current add-on would create an inconsistency between how SNF payments would be made and the data regarding AIDS diagnoses and resident therapy costs. Therefore, we are proposing to replace this add-on payment with appropriate case-mix adjustments for the increased costs of care for this population of residents through the proposed NTA and nursing components of the proposed PDPM.

We invite comments on the projected impacts and on the proposals and alternatives discussed throughout this section.

VI. Other Issues

A. Other Proposed Revisions to the Regulation Text

Along with our proposals to revise the regulations as discussed elsewhere in this proposed rule, we are also proposing to make two other revisions in the regulation text. The first involves §411.15(p)(3)(iv), which specifies that whenever a beneficiary is formally discharged (or otherwise departs) from the SNF, this event serves to end that beneficiary's status as a "resident" of the SNF for purposes of consolidated billing (the SNF "bundling" requirement), unless he or she is readmitted (or returns) to that or another SNF "by midnight of the day of departure." In initially establishing this so-called "midnight rule," the FY 2001 SNF PPS final rule (65 FR 46770, July 31, 2000) noted in this particular context that:

> As we explained in the proposed rule, a patient "day" begins at 12:01 a.m. and ends the following midnight, so that the phrase "midnight of the day of departure" refers to the midnight that immediately follows the actual moment of departure, rather than to the midnight that immediately precedes it (65 FR 46792).

However, the Medicare program's standard practice for counting inpatient days is actually one in which an inpatient day would begin at midnight (see, for example, §20.1 in the Medicare Benefit Policy Manual, Chapter 3, which specifies that in counting inpatient days, ". . . a day begins at midnight and ends 24 hours later" (emphasis added)). Accordingly, in order to ensure consistency with that approach, we now propose to revise §411.15(p)(3)(iv) to specify that for consolidated billing purposes, a beneficiary's "resident" status ends whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF "before the following midnight." We note that this revision would not alter the underlying principle that a beneficiary's SNF "resident" status in this context ends upon departure from the SNF unless he or she returns to that or another SNF later on that same day; rather, it would simply serve to conform the actual wording of the applicable regulations

text with the Medicare manual's standard definition of the starting point of a patient "day."

We are also proposing a technical correction to §424.20(a)(1)(i), which describes the required content of the SNF level of care certification, in order to conform it more closely to that of the corresponding statutory requirements at section 1814(a)(2)(B) of the Act. This statutory provision defines the SNF level of care in terms of skilled services furnished on a daily basis which, as a practical matter, can only be provided on an inpatient basis in a SNF. In addition, it provides that the SNF-level care must be for either:

- An ongoing condition that was one of the conditions that the beneficiary had during the qualifying hospital stay; or
- A new condition that arose while the beneficiary was in the SNF for treatment of that ongoing condition.

In setting forth the SNF level of care definition itself, the implementing regulations at §409.31 reflect both of the above two points (at paragraphs (b)(2)(i) and (b)(2)(ii), respectively); however, the regulations describing the content of the initial level of care certification at §424.20(a)(1)(i) have inadvertently omitted the second point. Accordingly, we now propose to revise §424.20(a)(1)(i) to rectify this omission, so that it more accurately tracks the language in the corresponding statutory authority at section 1814(a)(2)(B) of the Act.

We invite comments on our proposed revisions to §411.15(p)(3)(iv) and §424.20(a)(1)(i).

B. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

1. Background

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Act and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Under the SNF QRP, the Secretary reduces by 2 percentage points the annual market basket percentage update described in section 1888(e)(5)(B)(i) of the Act applicable to a SNF for a fiscal year, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018), in the case of a SNF that does not submit data in accordance with sections 1888(e)(6)(B)(i) of the Act for that fiscal year. For more information on the requirements we have adopted for the SNF QRP, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429), FY 2017 SNF PPS final rule (81 FR 52009 through 52010) and FY 2018 SNF PPS final rule (82 FR 36566).

Although we have historically used the preamble to the SNF PPS proposed and final rules each year to remind stakeholders of all previously finalized program requirements, we have concluded that repeating the same discussion each year is not necessary for every requirement, especially if we have codified it in our regulations. Accordingly, the following discussion is limited as much as possible to a discussion of our proposals for future years of the SNF QRP, and it represents the approach we intend to use in our rulemakings for this program going forward.

2. General Considerations Used for the Selection of Measures for the SNF QRP

a. Background

For a detailed discussion of the considerations we historically used for the selection of SNF QRP quality, resource use, and other measures, we refer readers to the FY 2016 SNF PPS

final rule (80 FR 46429 through 46431).

b. Accounting for Social Risk Factors in the SNF QRP

In the FY 2018 SNF PPS final rule (82 FR 36567 through 36568), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex residents, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[4] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex residents as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[5] As we noted in the FY 2018 SNF PPS final rule (82 FR 36567 through 36568), ASPE's report to Congress, which was required by the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that

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4 See, for example United States Department of Health and Human Services. "Healthy People 2020: Disparities. 2014." Available at http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities; or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

5 Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." December 2016. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 SNF PPS final rule (82 FR 36357), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.6 The trial period ended in April 2017 and a final report is available at http://www.qualityforum.org/SES_Trial_Period.aspx. The trial concluded that "measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship" between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[7] allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging us to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in resident backgrounds that might affect outcomes; to explore risk adjustment

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6 Available at http://www.qualityforum.org/SES_Trial_Period.aspx.
7 Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.

approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by resident dual eligibility. In general, commenters noted that stratified measures could serve as tools for SNFs to identify gaps in outcomes for different groups of residents, improve the quality of health care for all residents, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting (IQR) Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

3. Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures

As a part of our Meaningful Measures Initiative discussed in section I.D. of this proposed rule, we strive to put patients first, ensuring that they, along with their clinicians, are empowered to make decisions about their own healthcare using data-driven information that is increasingly aligned with a parsimonious set of meaningful quality measures. We began reviewing the SNF QRP's measures in accordance with the Meaningful Measures Initiative, and we 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, we believe 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.

We also evaluated the appropriateness and completeness of the SNF QRP's current measure removal factors. We have previously finalized that we would use notice and comment rulemaking to remove measures from the SNF QRP based on the following factors (80 FR 46431 through 46432):8

- Factor 1. Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

- Factor 2. Performance or improvement on a measure does not result in better resident outcomes.

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8 We refer readers to the FY 2016 SNF PPS final rule (80 FR 46431 through 46432) for more information on the factors we consider for removing measures.

- Factor 3. A measure does not align with current clinical guidelines or practice.
- Factor 4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5. A measure that is more proximal in time to desired resident outcomes for the particular topic is available.
- Factor 6. A measure that is more strongly associated with desired resident outcomes for the particular topic is available.
- Factor 7. Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

We continue to believe that these measure removal factors are appropriate for use in the SNF QRP. However, even if one or more of the measure removal factors applies, we may nonetheless choose to retain the measure for certain specified reasons. Examples of such instances could include when a particular measure addresses a gap in quality that is so significant that removing the measure could in turn result in poor quality, or in the event that a given measure is statutorily required. We note further that, consistent with other quality reporting programs, we apply these factors on a case-by-case basis.

We are proposing to adopt an additional factor to consider when evaluating potential measures for removal from the SNF QRP measure set:

- Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program.

As we discussed in section I.D. of this proposed rule, with respect to our new Meaningful Measures Initiative, we are engaging in efforts to ensure that the SNF QRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multifaceted and include not only

the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have identified several different types of costs, including, but not limited to: (1) the provider and clinician information collection burden and burden associated with the submission/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and (5) the provider and clinician cost associated with compliance with other federal and/or state regulations (if applicable).

For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice). It may also be costly for health care providers to track the confidential feedback, preview reports, and publicly reported information on a measure where we use the measure in more than one program. CMS may also have to expend unnecessary resources to maintain the specifications for the measure, as well as the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs.

When these costs outweigh the evidence supporting the continued use of a measure in the SNF QRP, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the SNF QRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making data public related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by

beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the SNF QRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

We also are proposing to add a new § 413.360(b)(3) to our regulations that would codify the removal factors we have previously finalized for the SNF QRP as well as the new measure removal factor that we are proposing to adopt in this proposed rule.

We are inviting public comment on these proposals.

4. Quality Measures Currently Adopted for the FY 2020 SNF QRP

The SNF QRP currently has 12 measures for the FY 2020 program year, which are outlined in Table 39.

TABLE 39: Quality Measures Currently Adopted for the FY 2020 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set	
Pressure Ulcer	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment /Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

* The measure will be replaced with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure, effective October 1, 2018.

5. IMPACT Act Implementation Update

In the FY 2018 SNF PPS final rule (82 FR 36596 through 36597), we stated that we intended to specify two measures that would satisfy the domain of accurately communicating the existence and provision of the transfer of health information and care preferences under section 1899B(c)(1)(E) of the Act no later than October 1, 2018, and intended to propose to adopt them for the FY 2021 SNF QRP, with data collection beginning on or about October 1, 2019.

As a result of the input provided during a public comment period initiated by our contractor between November 10, 2016 and December 11, 2016, input provided by a technical expert panel (TEP) convened by our contractor, and pilot measure testing conducted in 2017, we are engaging in continued development work on these two measures, including supplementary measure testing and providing the public with an opportunity for comment in 2018. Further we

expect to reconvene a TEP for these measures in mid-2018. We now intend to specify the measures under section 1899B(c)(1)(E) of the Act no later than October 1, 2019, and intend to propose to adopt the measures for the FY 2022 SNF QRP, with data collection beginning with residents admitted as well as discharged on or after October 1, 2020. For more information on the pilot testing, we refer readers to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

6. Form, Manner, and Timing of Data Submission Under the SNF QRP

Under our current policy, SNFs report data on SNF QRP assessment-based measures and standardized resident assessment data by reporting the designated data elements for each applicable resident on the Minimum Data Set (MDS) resident assessment instrument and then submitting completed instruments to CMS using the using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system. We refer readers to the FY 2018 SNF PPS final rule (82 FR 36601 through 36603) for the data collection and submission time frames for assessment-based measures and standardized resident assessment data that we finalized for the SNF QRP.

7. Proposed Changes to the SNF QRP Reconsideration Requirements

Section 413.360(d)(1) of our regulations states, in part, that SNFs that do not meet the SNF QRP requirements for a program year will receive a letter of non-compliance through the QIES ASAP system, as well as through the United States Postal Service.

We are proposing to revise § 413.360(d)(1) to expand the methods by which we would notify a SNF of non-compliance with the SNF QRP requirements for a program year. Revised §413.360(d)(1) would state that we would notify SNFs of non-compliance with the SNF QRP requirements via a letter sent through at least one of the following notification methods: the

QIES ASAP system; the United States Postal Service; or via an e-mail from the Medicare Administrative Contractor (MAC). We believe that this change will address feedback from providers requesting additional methods for notification.

In addition, § 413.360(d)(4) currently states that we will make a decision on the request for reconsideration and provide notice of the decision to the SNF through the QIES ASAP system and via letter sent through the United States Postal Service.

We are proposing to revise § 413.360(d)(4) to state that we will notify SNFs, in writing, of our final decision regarding any reconsideration request via a letter sent through at least one of the following notification methods: the QIES ASAP system, the United States Postal Service, or via an e-mail from the Medicare Administrative Contractor (MAC).

We are inviting public comments on these proposals.

8. Proposed Policies Regarding Public Display for the SNF QRP

Section 1899B(g) of the Act requires the Secretary to establish procedures for the public reporting of SNFs' performance on measures under sections 1899B(c)(1) and 1899B(d)(1) of the Act. Measure data will be displayed on the Nursing Home Compare website, an interactive web tool that assists individuals by providing information on SNF quality of care to those who need to select a SNF.

In the FY 2018 SNF PPS final rule (82 FR 36606 through 36607), we finalized that we would publicly display the Medicare Spending Per Beneficiary-PAC SNF QRP and Discharge to Community-PAC SNF QRP measures in calendar year 2018 based on discharges from October 1, 2016 through September 30, 2017. In this proposed rule, we are proposing to increase the number of years of data used to calculate the Medicare Spending Per Beneficiary-PAC SNF QRP and Discharge to Community-PAC SNF QRP measures for purposes of display from 1 year to 2 years. Under this proposal, data on these measures would be publicly reported in CY 2019, or as

soon thereafter as operationally feasible, based on discharges from October 1, 2016 through September 30, 2018.

Increasing the measure calculation and public display periods from 1 to 2 years of data increases the number of SNFs with enough data adequate for public reporting for the Medicare Spending Per Beneficiary-PAC SNF QRP measure from 86 percent (based on 2016 Medicare FFS claims data) to 95 percent (based on 2015 through 2016 Medicare FFS claims data), and for the Discharge to Community-PAC SNF QRP measure from 83 percent (based on 2016 Medicare FFS claims data) to 94 percent (based on 2015 through 2016 Medicare FFS claims data). Increasing measure public display periods to 2 years also aligns with the public display periods of these measures in the IRF and LTCH QRPs.

We also propose to begin publicly displaying data in CY 2020, or as soon thereafter as is operationally feasible, on the following four assessment-based measures: (1) Change in Self-Care Score (NQF #2633); (2) Change in Mobility Score (NQF #2634); (3) Discharge Self-Care Score (NQF #2635); and (4) Discharge Mobility Score (NQF #2636). SNFs are required to submit data on these four assessment-based measures with respect to admissions as well as discharges occurring on or after October 1, 2018. We are proposing to display data for these assessment-based measures based on 4 rolling quarters of data, initially using 4 quarters of discharges from January 1, 2019 through December 31, 2019. To ensure the statistical reliability of the measure rates for these four assessment-based measures, we are also proposing that if a SNF has fewer than 20 eligible cases during any 4 consecutive rolling quarters of data that we are displaying for any of these measures, then we would note in our public display of that measure that with respect to that SNF, the number of cases/resident stays is too small to publicly report.

We are inviting public comment on these proposals.

C. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

1. Background

Section 215(b) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93) authorized the SNF VBP Program (the "Program") by adding section 1888 (h) to the Act. As a prerequisite to implementing the SNF VBP Program, in the FY 2016 SNF PPS final rule (80 FR 46409 through 46426), we adopted an all-cause, all-condition hospital readmission measure, as required by section 1888(g)(1) of the Act. In the FY 2017 SNF PPS final rule (81 FR 51986 through 52009), we adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs, as required by section 1888(g)(2) of the Act. In the FY 2018 SNF PPS final rule (82 FR 36608 through 36623), we adopted additional policies for the Program, including an exchange function methodology for disbursing value-based incentive payments.

Section 1888(h)(1)(B) of the Act requires that the SNF VBP Program apply to payments for services furnished on or after October 1, 2018. The SNF VBP Program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. We believe the implementation of the SNF VBP Program is an important step towards transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely rewarding volume.

For additional background information on the SNF VBP Program, including an overview of the SNF VBP Report to Congress and a summary of the Program's statutory requirements, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46409 through 46410). We also refer readers to the FY 2017 SNF PPS final rule (81 FR 51986 through 52009) for discussion of the policies that we adopted related to the potentially preventable hospital readmission measure, scoring, and other topics. Finally, we refer readers to the FY 2018 SNF PPS final rule (82 FR

36608 through 36623) for discussions of the policies that we adopted related to value-based incentive payments, the exchange function, and other topics.

In this proposed rule, we are proposing additional requirements for the FY 2021 SNF VBP Program, as well as other program policies.

2. Measures

For background on the measures we have adopted for the SNF VBP Program, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46419), where we finalized the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) that we are currently using for the SNF VBP Program. We also refer readers to the FY 2017 SNF PPS final rule (81 FR 51987 through 51995), where we finalized the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) that we will use for the SNF VBP Program instead of the SNFRM as soon as practicable, as required by statute.

We are not proposing any changes to the Program's measures at this time.

a. Accounting for Social Risk Factors in the SNF VBP Program

In the FY 2018 SNF PPS final rule (82 FR 36611 through 36613), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health

outcomes and how some of this disparity is related to the quality of health care.[9] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients, as well as those with social risk factors, receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[10] As we noted in the FY 2018 SNF PPS final rule (82 FR 36611), ASPE's report to Congress found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. In addition, as noted in the FY 2018 SNF PPS final rule, the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[11] The trial period ended in April 2017 and a final report is available at http://www.qualityforum.org/SES_Trial_Period.aspx. The trial concluded that "measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship" between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk

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[9] See, for example United States Department of Health and Human Services. "Healthy People 2020: Disparities. 2014." Available at http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities; or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[10] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." December 2016. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

[11] Available at http://www.qualityforum.org/SES_Trial_Period.aspx.

factors. NQF has extended the socioeconomic status (SES) trial,[12] allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in patient backgrounds that might affect outcomes; to explore risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the

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[12] Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.

provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences

3. Proposed Performance Standards

a. Proposed FY 2021 Performance Standards

We refer readers to the FY 2017 SNF PPS final rule (81 FR 51995 through 51998) for a summary of the statutory provisions governing performance standards under the SNF VBP Program and our finalized performance standards policy, as well as the numerical values for the achievement threshold and benchmark for the FY 2019 program year. We also responded to public comments on these policies in that final rule.

We published the final numerical values for the FY 2020 performance standards in the FY 2018 SNF PPS final rule (82 FR 36613), and for reference, we are displaying those values again here.

TABLE 40: Final FY 2020 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.80218	0.83721

We will continue to adopt the achievement threshold and benchmark as previously finalized in our rules. However, due to timing constraints associated with the compilation of the FY 2017 MedPAR file to include 3 months of data following the last discharge date, we are unable to provide estimated numerical values for the FY 2021 Program year's performance standards at this time. As discussed further below, we are proposing to adopt FY 2017 as the baseline period for the FY 2021 program year. While we do not expect either the achievement threshold or benchmark to change significantly from what was finalized for the FY 2020 Program year, we intend to publish the final numerical values for the performance standards based on the FY 2017 baseline period in the FY 2019 SNF PPS final rule.

We welcome public comment on this approach.

b. Proposal to Correct Performance Standard Numerical Values in Cases of Errors

As we described above, section 1888(h)(3)(C) of the Act requires that we establish and announce the performance standards for a fiscal year not later than 60 days prior to the performance period for the fiscal year involved. However, we currently do not have a policy that would address the situation where, subsequent to publishing the numerical values for the finalized performance standards for a program year, we discover an error that affects those numerical values. Examples of the types of errors that we could subsequently discover are inaccurate variables on Medicare claims, programming errors, excluding data should have been included in the performance standards calculations, and other technical errors that resulted in inaccurate achievement threshold and benchmark calculations. While we do not have reason to believe that the SNF VBP Program has previously published inaccurate numerical values for

performance standards, we are concerned about the possibility that we would discover an error in the future and have no ability to correct the numerical values.

We are aware that SNFs rely on the performance standards that we publicly display in order to target quality improvement efforts, and we do not believe that it would be fair to SNFs to repeatedly update our finalized performance standards if we were to identify multiple errors. In order to balance the need of SNFs to know what performance standards they will be held accountable to for a SNF VBP program year with our obligation to provide SNFs with the most accurate performance standards that we can based on the data available at the time, we are proposing that if we discover an error in the calculations subsequent to having published the numerical values for the performance standards for a program year, we would update the numerical values to correct the error. We are also proposing that we would only update the numerical values one time, even if we subsequently identified a second error, because we believe that a one-time correction would allow us to incorporate new information into the calcuations without subjecting SNFs to multiple updates. Any update we would make to the numerical values based on a calculation error would be announced via the CMS website, listservs, and other available channels to ensure that SNFs are made fully aware of the update.

We welcome public comments on this proposal.

4. Proposed FY 2021 Performance Period and Baseline Period and for Subsequent Years

a. Background

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46422) for a discussion of our considerations for determining performance periods under the SNF VBP Program. Based on those considerations, as well as public comment, we adopted CY 2017 as the performance period for the FY 2019 SNF VBP Program, with a corresponding baseline period of CY 2015.

Additionally, in the FY 2018 SNF PPS final rule (82 FR 36613 through 36614), we

adopted FY 2018 as the performance period for the FY 2020 SNF VBP Program, with a corresponding baseline period of FY 2016. We refer readers to that rule for a discussion of the need to shift the Program's measurement periods from the calendar year to the fiscal year.

b. FY 2021 Proposals

As we discussed with respect to the FY 2019 and FY 2020 SNF VBP Program years, we continue to believe that a 12-month duration for the performance and baseline period is most appropriate for the SNF VBP Program. Therefore, we propose to adopt FY 2019 (October 1, 2018 through September 30, 2019) as the performance period for the FY 2021 SNF VBP Program year. We also propose to adopt FY 2017 (October 1, 2016 through September 30, 2017) hospital discharges as the baseline period for the FY 2021 SNF VBP Program year.

We welcome public comment on these proposals.

c. Proposed Performance Periods and Baseline Periods for Subsequent Program Years

As we have described in previous rules (see, for example, the FY 2016 SNF PPS final rule, 80 FR 46422), we strive to link performance furnished by SNFs as closely as possible to the program year to ensure clear connections between quality measurement and value-based payment. We also strive to measure performance using a sufficiently reliable population of patients that broadly represent the total care provided by SNFs.

Therefore, we propose that beginning with the FY 2022 program year and for subsequent program years, we would adopt for each program year, a performance period that is the 1 year period following the performance period for the previous program year. We also propose that beginning with the FY 2022 program year and for subsequent program years, we would adopt for each program year a baseline period that is the 1 year period following the baseline period for the previous year. Under this policy, the performance period for the FY 2022 program year would be FY 2020 (the 1 year period following the proposed FY 2021 performance period of FY 2019),

and the baseline period for the FY 2022 program year would be FY 2018 (the 1 year period following the proposed FY 2021 baseline period of FY 2017). We believe adopting this policy will provide SNFs with certainty about the performance and basline periods during which their performance will be assessed for future program years.

We welcome public comments on this proposal.

5. SNF VBP Performance Scoring

a. Background

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52000 through 52005) for a detailed discussion of the scoring methodology that we have finalized for the Program, along with responses to public comments on our policies and examples of scoring calculations. We also refer readers to the FY 2018 SNF PPS final rule (82 FR 36614 through 36616) for discussion of the rounding policy we adopted, our request for comments on SNFs with zero readmissions, and our request for comments on a potential extraordinary circumstances exception policy.

b. Proposed Scoring Policy for SNFs without Sufficient Baseline Period Data

In some cases, a SNF will not have sufficient baseline period data available for scoring for a Program year, whether due to the SNF not being open during the baseline period, only being open for a small portion of the baseline period, or other reasons (such as receiving an extraordinary circumstance exception, if that proposal described below is finalized). The availability of baseline data for each SNF is an integral component of our scoring methodology, and we are concerned that the absence of sufficient baseline data for a SNF will preclude us from being able to score that SNF on improvement for a program year. As discussed further below, with respect to the proposed scoring adjustment for a SNF without sufficient data in the performance period to create a reliable SNF performance score, we are concerned that measuring

SNFs with fewer than 25 eligible stays (or index SNF stays that would be included in the calculation of the SNF readmission measure) during the baseline period may result in unreliable improvement scores, and as a result, unreliable SNF performance scores. We considered policy options to address this issue.

We continue to believe it is important to compare SNF performance during the same periods to control for factors that may not be attributable to the SNF, such as increased patient case-mix acuity during colder weather periods when influenza, pneumonia, and other seasonal conditions and illnesses are historically more prevalent in the beneficiary population. Using a 12-month performance and baseline period for all SNFs ensures that, to the greatest extent possible, differences in performance can be attributed to the SNF's care quality rather than to exogenous factors.

Additionally, because we have proposed that for FY 2021 and future Program years, the start of the performance period for a Program year would begin exactly 12 months after the end of the baseline period for that Program year and there would not be sufficient time to compute risk-standardized readmission rates from another 12-month baseline period before the performance period if a SNF had insufficient data during the baseline period. For the FY 2021 Program, for example, the proposed baseline period would conclude at the end of FY 2017 (September 30, 2017) and the proposed performance period would begin on the first day of FY 2019 (October 1, 2018). We also do not believe it would be equitable to score SNFs without sufficient baseline period data using data from a different period. Doing so would, in our view, impede our ability to compare SNFs' performance on the Program's quality measure fairly, as additional factors that may affect SNFs' care could arise when comparing performance during different time periods. Therefore, we have concluded that it is not operationally feasible or equitable to use different baseline periods for purposes of awarding improvement scores to SNFs

for a Program year.

We believe that SNFs without sufficient data from a single baseline period, which we would define for this purpose as SNFs with fewer than 25 eligible stays during the baseline period for a fiscal year based on an analysis of Pearson correlation coefficients at various denominator counts, should not be measured on improvement for that Program year. Accordingly, we are proposing to score these SNFs based only on their achievement during the performance period for any Program year for which they do not have sufficient baseline period data. The analysis of Pearson correlation coefficients at various denominator counts used in developing this proposal is available on our website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNFRM-Reliability-Testing-Memo.docx.

We are proposing to codify this proposal by adding §413.338(d)(1)(iv) to our regulations. We welcome public comment on this proposal.

c. Proposed SNF VBP Scoring Adjustment for Low-Volume SNFs

In previous rules, we have discussed and sought comment on policies related to SNFs with zero readmissions during the performance period. For example, in the FY 2018 SNF PPS rule (82 FR 36615 through 36616), we sought comment on policies we should consider for SNFs with zero readmissions during the performance period because under the risk adjustment and the statistical approach used to calculate the SNFRM, outlier values are shifted towards the mean, especially for smaller SNFs. As a result, SNFs with observed readmission rates of zero may receive risk-standardized readmission rates that are greater than zero. We continue to be concerned about the effects of the SNFRM's risk adjustment and statistical approach on the scores that we award to SNFs under the Program. We are specifically concerned that as a result of this approach, the SNFRM is not sufficiently reliable to generate accurate performance scores

for SNFs with a low number of eligible stays during the performance period. We would like to ensure that the Program's scoring methodology results in fair and reliable SNF performance scores because those scores are linked to a SNF's ranking and payment.

Therefore, we considered whether we should make changes to our methodology for assessing the total performance of SNFs for a Program year that better accounts for SNFs with zero or low numbers of eligible stays during the performance period. Because the number of eligible SNF stays makes up the denominator of the SNFRM, we have concluded that the reliability of a SNF's measure rate and resulting performance score is adversely impacted if the SNF has less than 25 eligible stays during the performance period, as the Pearson correlation coefficient is lower at denominator counts of 5, 10, 15, and 20 eligible stays in comparison to 25 eligible stays. The analysis of Pearson correlation coefficients at various denominator counts used in developing this proposal is available on our website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNFRM-Reliability-Testing-Memo.docx.

We believe that the most appropriate way to ensure that low-volume SNFs (which we define for purposes of the SNF VBP Program as SNFs with fewer than 25 eligible stays during the performance period) receive sufficiently reliable SNF performance scores is to adopt an adjustment to the scoring methodology we use for the SNF VBP Program. We are proposing that if a SNF has less than 25 eligible stays during a performance period for a Program year, we would assign a performance score to the SNF for that Program year. That assigned performance score would, when used to calculate the value-based incentive payment amount for the SNF, result in a value-based incentive payment amount that is equal to the adjusted Federal per diem rate that the SNF would have received for the fiscal year in the absence of the Program. The actual performance score that we would assign to an individual low-volume SNF for a Program

year would be identified based on the distribution of all SNFs' performance scores for that Program year after calculating the exchange function. We would then assign that score to an individual low-volume SNF, and we would notify the low-volume SNF that it would be receiving an assigned performance score for the Program year in the SNF Performance Score Report that we provide not later than 60 days prior to the fiscal year involved.

We believe this scoring adjustment policy would appropriately ensure that our SNF performance score methodology is fair and reliable for SNFs with fewer than 25 eligible stays during the performance period for a Program year.

In section X.A.6. of this proposed rule, we estimate that $527.4 million will be withheld from SNFs' payments for the FY 2019 Program year based on the most recently available data. Additionally, the 60 percent payback percentage will result in an estimated $316.4 million being paid to SNFs in the form of value-based incentive payments with respect to FY 2019 services. Of the $316.4 amount, we estimate that $8.6 million will be paid to low-volume SNFs. However, if our proposal to adopt a scoring adjustment for low-volume SNFs is finalized, we estimate that we would redistribute an additional $6.7 million in value-based incentive payments to low-volume SNFs with respect to FY 2019 services, for a total of $15.3 million of the estimated $527.4 million available for value-based incentive payments for that Program year. The additional $6.7 million in value-based incentive payments that would result from finalizing this proposal would increase the 60 percent payback percentage for FY 2019 by approximately 1.28 percent, which would result in a payback percentage 61.28 percent of withheld funds. The payback percentage would similarly increase for all other Program years, however the actual amount of the increase for a particular Program year would vary based on the number of low-volume SNFs that we identify for that Program year and the distribution of all SNFs' performance scores for that Program year.

As an alternative, we also considered assigning a performance score to SNFs with fewer than 25 eligible stays during the performance period that would result in a value-based incentive payment percentage of 1.2 percent, or 60 percent of the 2 percent withhold. This amount would match low-volume SNFs' incentive payment percentages with the finalized SNF VBP Program payback percentage of 60 percent, and would represent a smaller adjustment to low-volume SNFs' incentive payment percentages than the proposed policy described above. We estimate that this alternative would redistribute an additional $1 million with respect to FY 2019 services to low-volume SNFs. We also estimate that this alternative would increase the 60 percent payback percentage for FY 2019 by approximately 0.18 percent of the approximately $527.4 million of the total withheld from SNFs' payments, which would result in a payback percentage of 60.18 percent of the estimated $527.4 million in withheld funds for that Program year. However, as with the proposal above, the specific amount by which the payback percentage would increase for each Program year would vary based on the number of low-volume SNFs that we identify for each Program year and the distribution of all SNFs' performance scores for that Program year.

We welcome public comments on this proposal and on the alternative that we considered. We are also proposing to codify the definition of low-volume SNF at §413.338(a)(16) of our regulations, and the definition of eligible stay at §413.338(a)(17) of our regulations. We are proposing to codify the low-volume scoring adjustment proposal at §413.338(d)(3) of our regulations. We are also proposing a conforming edit to the payback percentage policy at §413.338(c)(2)(i).

d. Proposed Extraordinary Circumstances Exception Policy for the SNF VBP Program

In the FY 2018 SNF PPS final rule (82 FR 36616), we summarized public comments that we received on the topic of a possible extraordinary circumstances exception policy for the SNF

VBP Program. As we stated in that rule, in other value-based purchasing and quality reporting programs, we have adopted Extraordinary Circumstances Exceptions (ECE) policies intended to allow facilities to receive relief from program requirements due to natural disasters or other circumstances beyond the facility's control that may affect the facility's ability to provide high-quality health care.

In other programs, we have defined a "disaster" as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation or otherwise affect the facility's ability to continue normal operations. Natural disasters could include events such as hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis. Man-made disasters could include such events as terrorist attacks, bombings, flood caused by man-made actions, civil disorders, and explosions. A disaster may be widespread and impact multiple structures or be isolated and affect a single site only. As a result of either a natural or man-made disaster, we are concerned that SNFs' care quality and subsequent impact on measure performance in the SNF VBP Program may suffer, and as a result, SNFs might be penalized under the Program's quality measurement and scoring methodology. However, we do not wish to penalize SNFs in these circumstances. For example, we recognize that SNFs might receive patients involuntarily discharged from hospitals facing mandatory evacuation due to probable flooding, and these patients might be readmitted to inpatient acute care hospitals and result in poorer readmission measure performance in the SNF VBP Program. We are therefore proposing to adopt an ECE policy for the SNF VBP Program to provide relief to SNFs affected by natural disasters or other circumstances beyond the facility's control that affect the care provided to the facility's patients. We propose that if a SNF can demonstrate that an extraordinary circumstance affected the care that it provided to its patients and subsequent measure performance, we would

exclude from the calculation of the measure rate for the applicable baseline and performance periods the calendar months during which the SNF was affected by the extraordinary circumstance. Under this proposal, a SNF requesting an ECE would indicate the dates and duration of the extraordinary circumstance in its request, along with any available evidence of the extraordinary circumstance, and if approved, we would exclude the corresponding calendar months from that SNF's measure rate for the applicable measurement period and by extension, its SNF performance score.

We further propose that SNFs must submit this ECE request to CMS by filling out the ECE request form that we will place on the QualityNet Website to the SNFVBPinquiries@cms.hhs.gov mailbox within 90 days following the extraordinary circumstance.

To accompany an ECE request, SNFs must provide any available evidence showing the effects of the extraordinary circumstance on the care they provided to their patients, including, but not limited to, photographs, newspaper and other media articles, and any other materials that would aid CMS in making its decision. We will review exception requests, and at our discretion based on our evaluation of the impact of the extraordinary circumstances on the SNF's care, provide a response to the SNF as quickly as feasible.

We intend for this policy to offer relief to SNFs whose care provided to patients suffered as a result of the disaster or other extraordinary circumstance, and we believe that excluding calendar months affected by extraordinary circumstances from SNFs' measure performance under the Program appropriately ensures that such circumstances do not unduly affect SNFs' performance rates or performance scores. We developed this process to align with the ECE process adopted by the SNF Quality Reporting Program to the greatest extent possible and to minimize burden on SNFs. This proposal is not intended to preclude us from granting

exceptions to SNFs that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. If we make the determination to grant an exception to all SNFs in a region or locale, we propose to communicate this decision through routine communication channels to SNFs and vendors, including but not limited to, issuing memos, emails, and notices on our SNF VBP Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html.

We note that if we finalize this policy, we would score any SNFs receiving ECEs on achievement and improvement for any remaining months during the performance period, provided the SNF had at least 25 eligible stays during both of those periods as we have proposed above. If a SNF should receive an approved ECE for 6 months of the performance period, for example, we would score the SNF on its achievement during the remaining 6 months on the Program's measure as long as the SNF met the proposed 25 eligible stay threshold during the performance period. We would also score the SNF on improvement as long as it met the proposed 25 eligible stay threshold during the applicable baseline period.

We welcome public comments on this proposal. We are also proposing to codify this proposal at §413.338(d)(4) of our regulations.

6. SNF Value-Based Incentive Payments

We refer readers to the FY 2018 SNF PPS final rule (82 FR 36616 through 36621) for discussion of the exchange function methodology that we have adopted for the Program, as well as the specific form of the exchange function (logistic, or S-shaped curve) that we finalized, and the payback percentage of 60 percent. We adopted these policies for FY 2019 and subsequent fiscal years.

As required by section 1888(h)(7) of the Act, we will inform each SNF of the

adjustments to its Medicare payments as a result of the SNF VBP Program that we will make not later than 60 days prior to the fiscal year involved. We will fulfill that requirement via SNF Performance Score Reports that we will circulate to SNFs using the QIES-CASPER system, which is also how we distribute the quarterly confidential feedback reports that we are required to provide to SNFs under section 1888(g)(5) of the Act. The SNF Performance Score Reports will contain the SNF's performance score, ranking, and value-based incentive payment adjustment factor that will be applied to claims submitted for the applicable fiscal year. Additionally, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36622 through 36623), the provision of the SNF Performance Score Report will trigger the Phase Two Review and Corrections Process, and SNFs will have 30 days from the date we post the report on the QIES-CASPER system to submit corrections to their SNF performance score and ranking to the SNFVBPinquiries@cms.hhs.gov mailbox.

Finally, as we discussed in the FY 2018 SNF PPS final rule (82 FR 36618), beginning with FY 2019 (October 1, 2018) payments, we intend to make the 2 percent reduction and the SNF-specific value-based incentive payment adjustment to SNF claims simultaneously. Beginning with FY 2019, we will identify the adjusted federal per diem rate for each SNF for claims under the SNF PPS. We will then reduce that amount by 2 percent by multiplying the per diem amount by 0.98, in accordance with the requirements in section 1888(h)(6) of the Act. We will then multiply the result of that calculation by each SNF's specific value-based incentive payment adjustment factor, which will be based on each SNF's performance score for the program year and will be calculated by the exchange function, to generate the value-based incentive payment amount that applies to the SNF for the fiscal year. Finally, we will add the value-based incentive payment amount to the reduced rate, resulting in a new adjusted federal per diem rate that applies to the SNF for the fiscal year.

At the time of the publication of this proposed rule, we will not have completed SNF performance score calculations for the FY 2019 program year. However, we intend to provide the range of value-based incentive payment adjustment factors applicable to the FY 2019 program year in the FY 2019 SNF PPS final rule.

We are proposing to codify the SNF VBP Program's payment adjustments at §413.337(f) of our regulations.

VII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare- and Medicaid-participating non-Federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[13] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

CMS is firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare- and Medicaid-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of

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[13] These statistics can be accessed at: https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php.

care, and enable reporting of electronically specified clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information on behalf of the Department of Health and Human Services.

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified to under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program (QPP) to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114-255), enacted in 2016, and amending section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, Congress directed that ONC "…for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally." In January 2018, ONC released a draft version of its proposal for the Trusted

Exchange Framework and Common Agreement,[14] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they do not remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for

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14 The draft version of the trusted Exchange Framework may be accessed at https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.

stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's

Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAH must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in that rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed

to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

We also published a final rule (81 FR 68688), on October 4, 2016, that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs, where we made a number of revisions based on the importance of effective communication between providers during transitions of care, such as transfers and discharges of residents to other facilities or providers, or to home. Among these revisions was a requirement that the transferring LTC facility must provide all necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another LTC facility, a hospice, home health agency, or another community-based provider or practitioner. We specified that necessary information must include the following:

- Contact information of the practitioner responsible for the care of the resident;
- Resident representative information including contact information;
- Advance directive information;
- Special instructions or precautions for ongoing care;
- The resident's comprehensive care plan goals; and
- All other necessary information, including a copy of the resident's discharge or transfer summary and any other documentation to ensure a safe and effective transition of care.

We note that the discharge summary mentioned above must include reconciliation of the resident’s medications, as well as a recapitulation of the resident's stay, a final summary of the resident's status, and the post-discharge plan of care. And in the preamble to the rule, we encouraged LTC facilities to electronically exchange this information if possible and to identify

opportunities to streamline the collection and exchange of resident information by using information that the facility is already capturing electronically.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?

- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?

- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?

- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?

- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all CMS efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the

Department of Veterans Affairs (VA), the National Institutes of Health (NIH), ONC, and the rest of the federal government, on this objective.

While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and

control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information CMS can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will

be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publically post the public comments received, or a summary of those public comments.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq*.), we are required to publish a 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs).

A. Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 41 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage. The wage rates provided in Table 41 are used to calculate the wages to derive burden estimates in this section.

TABLE 41: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse	29-1141	34.70	34.70	69.40
Health Information Technician	29-2071	19.93	19.93	39.86

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding the SNF PPS Assessment Schedule Under the Proposed PDPM

The following sets out the proposed requirements and burden associated with the MDS assessment schedule that would be effective October 1, 2019 under the SNF PPS in conjunction with implementation of the proposed PDPM. The proposed requirements and burden will be submitted to OMB for approval under control number 0938-1140 (CMS-10387).

Section V.C of this preamble proposes, effective October 1, 2019, to revise the current SNF PPS assessment schedule to require only two scheduled assessments (as opposed to the current requirement for five scheduled assessments) for each SNF stay: A 5-day scheduled PPS assessment and a discharge assessment.

The current 5-day scheduled PPS assessment would be used as the admission assessment under this rule's proposed PDPM and set the resident's case-mix classification for the resident's SNF stay. The PPS discharge assessment (which is already required for all SNF Part A residents) would serve as the discharge assessment and be used for monitoring purposes. This rule also

proposes to require SNFs to reclassify residents under the proposed PDPM using the Interim Payment Assessment (IPA) if certain criteria are met, as discussed in section V.D.1. of this preamble. Thus, the 5-day SNF PPS scheduled assessment would be the only PPS assessment required to classify a resident under the proposed PDPM for payment purposes, except when an IPA would be required as provided in section V.E.1. This would eliminate the requirement for the following assessments under the SNF PPS: 14-day scheduled PPS assessment, 30-day scheduled PPS assessment, 60-day scheduled PPS assessment, 90-day scheduled PPS assessment, Start of Therapy Other Medicare Required Assessment (OMRA), End of Therapy OMRA, and Change of Therapy OMRA.

In estimating the amount of time to complete a PPS assessment, we utilize the OMRA assessment, or the NO/SO item set (consistent with the currently approved PRA Supporting Statement at https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201703-0938-018- click on View Supporting Statement and Other Documents and then click OMB 0938-1140 Supporting Statement Revision_nonsub_V4-4-5-2017 (rev 04-07-2017 by OSORA PRA).docx) as a proxy for all assessments. In section V.D.3. of this preamble, we propose to add 18 items to the PPS discharge assessment in order to calculate and monitor the total amount of therapy provided during a SNF stay. The proposed items are listed in Table 35 under section V.D.3 of this proposed rule. Given that the PPS OMRA assessment has 272 items (as compared to 125 items currently on the PPS discharge assessment) we believe that the items that we propose to add to the PPS discharge assessment - while increasing burden for each of the respective assessments - is accounted for by using the longer PPS OMRA assessment as a proxy for the time required to complete all assessments.

When calculating the burden for each assessment, we estimate that it will take 40 minutes (0.6667 hours) for an RN to collect the information necessary for preparing the assessment, 10

minutes (0.1667 hours) for staff to code the responses, and 1 minute (0.0167 hours) for a health information technician to transmit the results. In total, we estimate that it would take 51 minutes (0.85 hours) to complete a single PPS assessment.

The ongoing burden associated with the proposed revisions to the SNF PPS assessment schedule is the time and effort it would take each of the 15,455 Medicare Part A SNFs to complete the 5-day PPS and discharge assessments. Based on FY 2017 data, we estimate that 2,406,401 5-day PPS assessments would be completed and submitted by Part A SNFs each year under the proposed PDPM. We are using the same number of assessments (2,406,401) as a proxy for the number of PPS discharge assessments that would be completed and submitted each year, since all residents who require a 5-day PPS assessment will also require a discharge assessment under the SNF PDPM.

We are using the Significant Change in Status Assessment (SCSA) as a proxy to estimate the number of IPAs as the criteria for completing an SCSA is similar to that for the proposed IPA. Based on FY 2017 data, 92,240 IPAs would be completed per year. We estimate that the total number of 5-day scheduled PPS assessments, IPAs, and PPS discharge assessments that would be completed across all facilities is 4,905,042 (2,406,401 + 92,240 + 2,406,401, respectively). For all assessments under the proposed SNF PDPM, we estimate a burden of 4,169,286 hours (4,905,042 assessments x 0.85 hr/assessment) at a cost of $274,878,554 (4,905,042 assessments x $56.04/assessment) (see calculation of the cost estimate for each assessment below).

Based on the same FY 2017 data, there were 5,833,476 non-discharge related assessments (scheduled and unscheduled PPS assessments) completed under the RUG- IV payment system. To this number we add the same proxy as above for the number of discharge assessments (2,406,401), since every resident under RUG-IV who required a 5-day scheduled

PPS assessment would also require a discharge assessment. This brings the total number of estimated assessments under RUG-IV to 8,239,877. Using the same wage and time estimates (per assessment), we estimate a burden of 7,003,895 hours (8,239,877 assessments x 0.85 hr/assessment) at a cost of $461,762,707 (8,239,877 assessments x $56.04/assessment).

When comparing the currently approved RUG-IV burden with the proposed PDPM burden, we estimate a savings of 2,834,609 administrative hours (7,003,895 RUG-IV hours - 4,169,286 proposed PDPM hours) or approximately 183 hours per provider per year (2,834,609 hours / 15,455 providers). As depicted in Table 42, we also estimate a cost savings of $186,884,153 ($461,762,707 RUG-IV costs - $274,878,554 proposed PDPM costs) or $12,092 per provider per year ($186,884,153 / 15,455 providers). This represents a significant decrease in administrative burden for providers under the proposed PDPM.

TABLE 42: PDPM Savings

Burden Reconciliation	Respondents	Responses (assessments)	Burden per Response (hours)	Total Annual Burden (hours)	Cost ($)
RUG-IV	15,455	8,239,877	0.85	7,003,895	461,762,707
Proposed PDPM	15,455	4,905,042	0.85	4,169,286	274,878,554
SAVINGS	No change	(3,334,835)	No change	(2,834,609)	(186,884,153)

When calculating the burden for each assessment, we estimate that it will take 40 minutes (0.6667 hours) at $69.40/hr for an RN to collect the information necessary for preparing the assessment, 10 minutes (0.1667 hours) at $54.63/hr (the average hourly wage for RN ($69.40/hr) and health information technician ($39.86/hr) for staff to code the responses, and 1 minute (0.0167 hours) at $39.86/hr for a health information technician to transmit the results. In total, we estimate that it would take 51 minutes (0.85 hours) to complete a single PPS assessment. Based on the adjusted hourly wages for the noted staff, we estimate that it would cost $56.04 to

prepare, code, and transmit each PPS assessment [($69.40/hr x 0.6667 hr) + ($54.63/hr x 0.1667 hr) + ($39.86/hr x 0.0167 hr)].

Finally, in section V.C.1.a of this preamble, we propose to add 3 items, as listed in Table 34 of this preamble, to the MDS 3.0 for Nursing Homes and Swing Bed Providers. Based on the small number of items being added and the small percentage of assessments that Swing Bed providers make up, we do not believe this action will cause any measurable adjustments to our currently approved burden estimates. Consequently, we are not revising any of those estimates.

2. ICRs Regarding the SNF VBP Program

In section VI.C.5.d. of this rule, we propose to adopt an Extraordinary Circumstances Exception (ECE) process for the SNF VBP. Because the same CMS Extraordinary Circumstances Exceptions (ECE) Request Form would be used across ten quality programs: Hospital IQR Program, Hospital Outpatient Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility Value-Based Purchasing Program - the form and its associated requirements/burden will be submitted to OMB for approval under one information collection request (CMS-10210, OMB control number: 0938-1022) and in association with our IPPS proposed rule (CMS-1694-P; RIN 0938-AT27). To avoid double counting we are not setting out the form's SNF-related burden in this rulemaking.

Separately, we are not proposing any new or revised SNF VBP measures in this proposed rule. Nor are we proposing any new or revised collection burden. Consequently, this proposed rule does not set out any new VBP-related collections of information that would be subject to OMB approval under the authority of the PRA.

3. ICRs for the SNF Quality Reporting Program (QRP)

This rule does not propose to add, remove, or revise any measures under the SNF QRP. Consequently, we are not revising the burden related to the Program's measures.

C. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS-1696-P) and, where applicable, the preamble section, and the ICR section. See this rule's DATES and ADDRESSES sections for the comment due date and for additional instructions.

IX. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

X. Economic Analyses

A. Regulatory Impact Analysis

1. Statement of Need

This proposed rule would update the FY 2018 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach on these issues. We note that we did not include the impacts of the proposed PDPM and related policies in the sections that follow, as we have included this discussion in section V.J. of this proposed rule.

2. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA, September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches

that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) as further discussed below. Also, the rule has been reviewed by OMB.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. OMB's implementation guidance, issued on April 5, 2017, explains that "Federal spending regulatory actions that cause only income transfers between taxpayers and program beneficiaries (for example, regulations associated with… Medicare spending) are considered 'transfer rules' and are not covered by EO 13771…. However… such regulatory actions may impose requirements apart from transfers… In those cases, the actions would need to be offset to the extent they impose more than de minimis costs. Examples of ancillary requirements that may require offsets include new reporting or recordkeeping requirements." As discussed in section VII of this proposed rule, we estimate that this proposed rule would lead to paperwork cost savings of approximately $187 million per year on an ongoing basis. This proposed rule is expected to be an EO 13771 deregulatory action, if finalized.

3. Overall Impacts

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate that the aggregate impact would be an increase of approximately $850 million in payments to SNFs in FY 2019, resulting from the SNF market basket update to the payment rates, as required by section 53111 of the BBA 2018. Absent the application of section 53111 of the BBA 2018, the aggregate impact from the 1.9 percentage point market basket increase factor would have been

approximately $670 million. We note that these impact numbers do not incorporate the SNF VBP reductions mentioned in section IX.A.6. of this proposed rule.

We would note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, very susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we update the FY 2018 payment rates by a factor equal to the market basket index percentage change adjusted by the MFP adjustment to determine the payment rates for FY 2019. As discussed previously, section 53111 of the BBA 2018 stipulates a market basket increase factor of 2.4 percent. The impact to Medicare is included in the total column of Table 43. In updating the SNF PPS rates for FY 2019, we made a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used for adjusting the federal rates).

The annual update set forth in this proposed rule applies to SNF PPS payments in FY 2019. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2019 SNF PPS payment impacts appear in Table 43. Using the most recently available data, in this case FY 2017, we apply the current FY 2018 wage index and labor-related share value to the number of payment days to simulate FY 2018 payments. Then, using the same FY 2017 data, we apply the proposed FY 2019 wage index and labor-related share value to simulate FY 2019 payments. We tabulate the resulting payments according to the classifications

in Table 43 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2018 payments to the simulated FY 2019 payments to determine the overall impact. The breakdown of the various categories of data Table 43 follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).
- The second column shows the number of facilities in the impact database.
- The third column shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The total impact of this change is 0 percent; however, there are distributional effects of the change.
- The fourth column shows the effect of all of the changes on the FY 2019 payments. The update of 2.4 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 2.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 43, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes proposed in this rule, providers in the urban Pacific region would experience a 3.4 percent increase in FY 2019 total payments.

TABLE 43: Projected Impact to the SNF PPS for FY 2019

	Number of Facilities FY 2019	Update Wage Data	Total Change
Group			
Total	15,455	0.0%	2.4%
Urban	11,031	0.0%	2.4%
Rural	4,424	0.1%	2.5%
Hospital-based urban	498	0.0%	2.4%
Freestanding urban	10,533	0.0%	2.4%
Hospital-based rural	551	0.0%	2.4%
Freestanding rural	3,873	0.1%	2.5%
Urban by region			
New England	789	-0.7%	1.7%
Middle Atlantic	1,479	0.0%	2.4%
South Atlantic	1,869	-0.2%	2.2%
East North Central	2,126	-0.4%	2.0%
East South Central	555	-0.3%	2.1%
West North Central	920	-0.4%	2.0%
West South Central	1,344	0.2%	2.6%
Mountain	525	-0.6%	1.8%
Pacific	1,419	1.0%	3.4%
Outlying	5	-0.7%	1.7%
Rural by region			
New England	135	-0.7%	1.7%
Middle Atlantic	215	0.2%	2.6%
South Atlantic	494	0.0%	2.4%
East North Central	930	0.2%	2.6%
East South Central	523	-0.5%	1.9%
West North Central	1,072	0.4%	2.8%
West South Central	733	0.8%	3.2%
Mountain	227	0.5%	2.9%
Pacific	95	-0.8%	1.5%
Ownership			
Government	1,011	-0.1%	2.3%
Profit	10,872	0.0%	2.4%
Non-Profit	3,572	-0.1%	2.3%

Note: The Total column includes the 2.4 percent market basket increase required by section 53111 of the BBA 2018. Additionally, we found no SNFs in rural outlying areas.

5. Estimated Impacts for the SNF QRP

With no proposals to add or remove measures in the SNF QRP, there are no impacts associated with the SNF QRP Program.

6. Estimated Impacts for the SNF VBP Program

Estimated impacts of the FY 2019 SNF VBP Program are based on historical data that appear in Table 44. We modeled SNFs' performance in the Program using SNFRM data from CY 2014 as the baseline period and FY 2016 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621). As required by section 1888(h)(6)(A) of the Act, we will reduce adjusted federal per diem rates determined under section 1888(e)(4)(G) of the Act, otherwise applicable to a skilled nursing facility for services furnished by such facility during FY 2019 by the applicable percent, which is defined in section 1888(h)(6)(B) of the Act, as 2 percent. We estimate the total reductions to payments required by section 1888(h)(6) of the Act, to be $527.4 million for FY 2019. Based on the 60 percent payback percentage, we estimate that we will disburse approximately $316.4 million in value-based incentive payments to SNFs in FY 2019, which means that the SNF VBP Program is estimated to result in approximately $211 million in savings to the Medicare program in FY 2019.

We also modeled the estimated impacts of the proposed scoring adjustment for low-volume SNFs based on historical data in Table 45. We estimate that the scoring adjustment policy proposal would redistribute an additional $6.7 million to the group of low volume SNFs.

We estimate that this proposal would result in increasing low-volume SNFs' value-based incentive payment percentages by approximately 0.99 percent, on average, from the value-based incentive payment percentage that they would receive in the absence of the low-volume adjustment. An increase in value-based incentive payment percentages by 0.99 percent is needed to bring low-volume SNFs back to the 2.0 percent that was withheld from their payments. We also estimate that if this proposal is finalized, we would pay an additional $6.7 million in

incentive payments to low-volume SNFs, which would increase the 60 percent payback percentage for FY 2019 by approximately 1.28 percent, making the new payback percentage for FY 2019 equal to 61.28 percent of the estimated $527.4 million in withheld funds for that fiscal year.

TABLE 44: Estimated FY 2019 SNF VBP Program Impacts Without a Low-Volume Scoring Adjustment

Category	Criterion	# of facilities	RSRR (mean)	Mean SNF Performance Score	Mean Incentive Multiplier (60% Payback)	% of Proposed Payback
Group	**Total**	**15,460**	0.18874	40.982	1.163%	99.9%*
	Urban	10,995	0.18826	40.538	1.154%	83.8%
	Rural	4,465	0.18612	40.433	1.139%	16.0%
Urban by Region	**Total**	**10,995**	--	---	--	--
	01=Boston	793	0.18941	37.53033	1.063%	4.8%
	02=New York	905	0.18929	40.50641	1.148%	11.5%
	03=Philadelphia	1,120	0.18586	44.99993	1.310%	10.0%
	04=Atlanta	1,878	0.19245	37.29765	1.050%	13.1%
	05=Chicago	2,325	0.18683	42.32786	1.213%	16.1%
	06=Dallas	1,363	0.19166	34.59615	0.939%	6.3%
	07=Kansas City	658	0.18916	39.14296	1.099%	2.7%
	08=Denver	319	0.17823	53.44707	1.618%	2.9%
	09=San Francisco	1,296	0.18666	39.95157	1.132%	12.4%
	10=Seattle	338	0.17752	55.34239	1.664%	4.1%
Rural by Region	**Total**	**4,465**	--	---	--	--
	01=Boston	135	0.18176	50.72243	1.510%	0.9%
	02=New York	87	0.18414	49.10573	1.494%	0.5%
	03=Philadelphia	274	0.18686	42.10613	1.216%	1.3%
	04=Atlanta	882	0.19040	36.35979	1.013%	3.3%
	05=Chicago	1,100	0.18350	45.84850	1.313%	4.7%
	06=Dallas	783	0.19100	34.12362	0.917%	1.9%
	07=Kansas City	789	0.18557	41.35057	1.136%	1.4%
	08=Denver	268	0.18049	46.96957	1.341%	0.8%
	09=San Francisco	62	0.16434	54.12133	1.670%	0.6%
	10=Seattle	85	0.17587	56.60310	1.683%	0.7%
Ownership Type	**Total**	**15,462**	--	---	--	--
	Government	1,017	0.18332	43.477	1.245%	6.2%
	Profit	10,867	0.18905	39.176	1.102%	71.2%
	Non-Profit	3,578	0.18458	45.067	1.307%	22.6%
No. of Beds	**Total**	**15,462**	--	---	--	--
	1st Quartile:	3,898	0.18463	40.881	1.128%	22.7%
	2nd Quartile:	3,834	0.18715	40.891	1.167%	23.5%
	3rd Quartile:	3,945	0.18947	40.203	1.144%	25.2%
	4th Quartile:	3,785	0.18932	41.339	1.197%	28.7%

* This category does not add to 100% because a small number of SNFs did not have urban/rural designations in our data.

TABLE 45: Estimated SNF VBP Program Impacts Including Effects of the Proposed Low-Volume Scoring Adjustment

Category	Criterion	# of facilities	RSRR (mean)	Mean SNF Performance Score	Mean Incentive Multiplier (60% Payback)	% of Proposed Payback
Group	**Total**	**12,845**	0.18912	41.371	1.192%	99.9%*
	Urban	9,604	0.18957	40.956	1.177%	84.4%
	Rural	3,241	0.18779	41.011	1.181%	15.4%
Urban by Region	**Total**	**9,604**	--	---	--	--
	01=Boston	713	0.19089	37.26777	1.059%	4.9%
	02=New York	836	0.19029	40.90383	1.165%	11.8%
	03=Philadelphia	1,040	0.18601	45.31896	1.325%	10.1%
	04=Atlanta	1,767	0.19332	37.28735	1.052%	13.3%
	05=Chicago	1,961	0.18784	43.06368	1.246%	16.0%
	06=Dallas	1,134	0.19416	34.53275	0.949%	6.1%
	07=Kansas City	510	0.19057	39.26278	1.132%	2.6%
	08=Denver	241	0.17832	57.62596	1.790%	2.9%
	09=San Francisco	1,098	0.18908	40.80722	1.176%	12.5%
	10=Seattle	304	0.17808	56.67839	1.713%	4.2%
Rural by Region	**Total**	**3,241**	--	---	--	--
	01=Boston	115	0.18133	51.89294	1.568%	0.9%
	02=New York	77	0.18366	50.48193	1.569%	0.5%
	03=Philadelphia	240	0.18789	42.12621	1.218%	1.3%
	04=Atlanta	764	0.19283	36.51452	1.032%	3.3%
	05=Chicago	818	0.18397	47.85089	1.399%	4.5%
	06=Dallas	557	0.19355	34.00868	0.952%	1.7%
	07=Kansas City	421	0.18634	42.64769	1.236%	1.2%
	08=Denver	132	0.18000	52.38900	1.544%	0.7%
	09=San Francisco	48	0.17780	61.50419	1.931%	0.6%
	10=Seattle	69	0.17628	60.70084	1.836%	0.7%
Ownership Type	**Total**	**12,847**	--	---	--	--
	Government	688	0.18529	46.450	1.380%	5.2%
	Profit	9,250	0.19039	39.526	1.127%	72.0%
	Non-Profit	2,909	0.18597	46.038	1.353%	22.9%
No. of Beds	**Total**	**12,847**	--	---	--	--
	1st Quartile:	3,222	0.18760	42.466	1.226%	24.6%
	2nd Quartile:	3,221	0.18878	40.971	1.175%	24.4%
	3rd Quartile:	3,197	0.19048	40.242	1.153%	23.3%
	4th Quartile:	3,207	0.18963	41.800	1.212%	27.7%

* This category does not add to 100% because a small number of SNFs did not have urban/rural designations in our data.

7. Alternatives Considered

As described in this section, we estimate that the aggregate impact for FY 2019 under the SNF PPS would be an increase of approximately $850 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as required by section 53111 of the BBA 2018. Absent application of section 53111 of the BBA 2018, the market basket increase factor of 1.9 percent would have resulted in an aggregate increase in payments to SNFs of approximately $670 million.

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY; accordingly, we are not pursuing alternatives for this process.

As discussed in Section VI.C.5.c., we also considered an alternative SNF VBP low-volume scoring policy. This alternative scoring assignment would result in a value-based incentive payment percentage of 1.2 percent, or 60 percent of the 2 percent withhold. This amount would match low-volume SNFs' incentive payment percentages with the finalized SNF VBP Program payback percentage of 60 percent, and would represent a smaller adjustment to low-volume SNFs' incentive payment percentages than the proposed policy described above.

We estimate that this alternative would redistribute an additional $1 million with respect to FY 2019 services to low-volume SNFs. We also estimate that this alternative would increase the 60 percent payback percentage for FY 2019 by approximately 0.18 percent of the approximately $527.4 million of the total withheld from SNFs' payments, which would result in a payback percentage of 60.18 percent of the estimated $527.4 million in withheld funds for that Program year. We estimate that this alternative would pay back SNFs about $5.7 million less than the proposed low-volume scoring methodology adjustment in total estimated payments on an annual basis. However, as with the proposal above, the specific amount by which the payback percentage would increase for each Program year would vary based on the number of low-volume SNFs that we identify for each Program year and the distribution of all SNFs' performance scores for that Program year.

8. Accounting Statement

As required by OMB Circular A-4 (available online at www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf), in Tables 46 and 47, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule for FY 2019. Table 46 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this proposed rule, based on the data for 15,455 SNFs in our database. Tables 44, 45, and 47 provide our best estimate of the possible changes in Medicare payments under the SNF VBP as a result of the policies in this proposed rule.

TABLE 46: Accounting Statement: Classification of Estimated Expenditures, from the 2018 SNF PPS Fiscal Year to the 2019 SNF PPS Fiscal Year

Category	Transfers
Annualized Monetized Transfers	$850 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

* The net increase of $850 million in transfer payments is a result of the market basket increase of $850 million.

TABLE 47: Accounting Statement: Classification of Estimated Expenditures for the FY 2019 SNF VBP Program

Category	Transfers
Annualized Monetized Transfers	$316.4 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

*This estimate does not include the two percent reduction to SNFs' Medicare payments (estimated to be $527.4 million) required by statute.

9. Conclusion

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate the overall estimated payments for SNFs in FY 2019 are projected to increase by approximately $850 million, or 2.4 percent, compared with those in FY 2018. We estimate that in FY 2019 under RUG-IV, SNFs in urban and rural areas would experience, on average, a 2.4 percent increase and 2.5 percent increase, respectively, in estimated payments compared with FY 2018. Providers in the urban Pacific region would experience the largest estimated increase in payments of approximately 3.4 percent. Providers in the rural Pacific region would experience the smallest estimated increase in payments of 1.5 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by reason of their non-profit status or by having revenues of $27.5 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as

that term is used in the RFA, according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $27.5 million or less in any 1 year. (For details, see the Small Business Administration's website at http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards). In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate that the aggregate impact for FY 2019 would be an increase of $850 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 43 that providers would experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2019 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2017 Report to Congress (available at http://medpac.gov/docs/default-source/reports/mar17_medpac_ch8.pdf), MedPAC states that Medicare covers approximately 11 percent of total patient days in freestanding facilities and 21 percent of facility revenue (March 2017 MedPAC Report to Congress, 202). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 43. As indicated in Table 43, the effect on facilities is projected to be an aggregate positive impact of 2.4 percent for FY 2019. As the overall impact on the industry as a whole, and thus on small

entities specifically, is less than the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities for FY 2019.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This proposed rule would affect small rural hospitals that (1) furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2018 (82 FR 36530)), the category of small rural hospitals would be included within the analysis of the impact of this proposed rule on small entities in general. As indicated in Table 43, the effect on facilities for FY 2019 is projected to be an aggregate positive impact of 2.4 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small rural hospitals for FY 2019.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. This proposed rule will impose no mandates on state, local, or tribal governments or on the private sector.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This proposed rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

E. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

F. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this

assumption.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $105.16 per hour, including overhead and fringe benefits https://www.bls.gov/oes/current/oes_nat.htm . Assuming an average reading speed, we estimate that it would take approximately 4 hours for the staff to review half of this proposed rule. For each SNF that reviews the rule, the estimated cost is $420.64 (4 hours x $105.16). Therefore, we estimate that the total cost of reviewing this regulation is $103,740 ($420.64 x 247 reviewers).

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 411

Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D-1 through 1860D-42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w-101 through 1395w-152, 1395hh, and 1395nn).

§411.15 [Amended]

2. Section 411.15 is amended in paragraph (p)(3)(iv) by removing the phrase "by midnight of the day of departure" and adding in its place the phrase "before the following midnight".

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

3. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883 and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106-113, 113 Stat. 1501A-332; sec. 3201 of Public Law 112-96, 126 Stat. 156; sec. 632 of Public Law 112-240, 126 Stat. 2354; sec. 217 of Public Law 113-93, 129 Stat. 1040; and sec. 204 of Public Law 113-295, 128 Stat. 4010; and sec. 808 of Public Law 114-27, 129 Stat. 362.

4. Section 413.337 is amended by revising paragraph (d)(1)(v) and adding paragraphs (d)(1)(vi) and (vii) and (f) to read as follows:

§413.337 Methodology for calculating the prospective payment rates.

* * * * *

(d) * * *

(1) * * *

(v) For each subsequent fiscal year, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved, except as provided in paragraphs (d)(1)(vi) and (vii) of this section.

(vi) For fiscal year 2018, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF market basket index percentage change of 1 percent (after application of paragraphs (d)(2) and (3) of this section).

(vii) For fiscal year 2019, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF market basket index percentage change of 2.4 percent (after application of paragraphs (d)(2) and (3) of this section).

* * * * *

(f) *Adjustments to payment rates under the SNF Value-Based Purchasing Program.* Beginning with payment for services furnished on October 1, 2018, the adjusted Federal per diem rate (as defined in §413.338(a)(2)) otherwise applicable to a SNF for the fiscal year is reduced by the applicable percent (as defined in §413.338(a)(3)). The resulting amount is then adjusted by the value-based incentive payment amount (as defined in §413.338(a)(14)) based on the SNF's performance score for that fiscal year under the SNF Value-Based Purchasing Program, as calculated under §413.338.

5. Section 413.338 is amended by—

a. Adding paragraphs (a)(16) and (17);

b. Revising paragraph (c)(2)(i); and

c. Adding paragraphs (d)(1)(iv) and (d)(3) and (4).

The additions and revision read as follows:

§413.338 Skilled Nursing Facility Value-Based Purchasing

(a) * * *

(16) *Low-volume SNF* means a SNF with fewer than 25 eligible stays included in the SNF readmission measure denominator during the performance period for a fiscal year.

(17) *Eligible stay* means, for purposes of the SNF readmission measure, an index SNF admission that would be included in the denominator of that measure.

* * * * *

(c) * * *.

(2) * * *.

(i) *Total amount available for a fiscal year*. The total amount available for value-based incentive payments for a fiscal year is at least 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS, and will be increased as appropriate for each fiscal year to account for the assignment of a performance score to low-volume SNFs under paragraph (d)(3) of this section.

(d) * * *.

(1) * * *.

(iv) CMS will not award points for improvement to a SNF that has fewer than 25 eligible stays during the baseline period.

* * * * *

(3) If CMS determines that a SNF is a low-volume SNF with respect to a fiscal year, CMS will assign a performance score to the SNF for the fiscal year that, when used to calculate

the value-based incentive payment amount (as defined in paragraph (a)(14) of this section), results in a value-based incentive payment amount that is equal to the adjusted Federal per diem rate (as defined in paragraph (a)(2) of this section) that would apply to the SNF for the fiscal year without application of §413.337(f).

(4) *Exception requests.* (i) A SNF may request and CMS may grant exceptions to the SNF Value-Based Purchasing Program's requirements under this section for one or more calendar months when there are certain extraordinary circumstances beyond the control of the SNF.

(ii) A SNF may request an exception within 90 days of the date that the extraordinary circumstances occurred by sending an email to SNFVBPinquiries@cms.hhs.gov that includes a completed Extraordinary Circumstances Request form (available on the SNF VBP section of QualityNet at https://www.qualitynet.org/) and any available evidence of the impact of the extraordinary circumstances on the care that the SNF furnished to patients, including, but not limited to, photographs, newspaper, and other media articles.

(iii) Except as provided in paragraph (d)(4)(iv) of this section, CMS will not consider an exception request unless the SNF requesting such exception has complied fully with the requirements in this paragraph (d).

(iv) CMS may grant exceptions to SNFs without a request if it determines that an extraordinary circumstance affects an entire region or locale.

(v) CMS will calculate a SNF performance score for a fiscal year for a SNF for which it has granted an exception request that does not include its performance on the SNF readmission measure during the calendar months affected by the extraordinary circumstance.

* * * * *

6. Section 413.360 is amended by adding paragraph (b)(3) and revising paragraphs (d)(1)

and (4) to read as follows:

§413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

* * * * *

(b) * * *

(3) CMS may remove a quality measure from the SNF QRP based on one or more of the following factors:

(i) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better resident outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.

(v) A measure that is more proximal in time to desired resident outcomes for the particular topic is available.

(vi) A measure that is more strongly associated with desired resident outcomes for the particular topic is available.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

* * * * *

(d) * * *

(1) SNFs that do not meet the requirements in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the United States Postal Service, or via an e-mail from the Medicare Administrative Contractor (MAC). A SNF may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

* * * * *

(4) CMS will notify SNFs, in writing, of its final decision regarding any reconsideration request through at least one of the following notification methods: QIES ASAP system, the United States Postal Service, or via email from the Medicare Administrative Contractor (MAC).

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

6. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§424.20 [Amended]

7. Section 424.20 is amended in paragraph (a)(1)(i) by removing the language "a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in §409.3 of this chapter; or" and adding in its place the language "a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in §409.3 of this chapter, or for a new condition that arose while the individual was receiving care in the SNF or swing-bed hospital for a condition for which he or she received inpatient care in a participating or qualified hospital; or".

CMS-1696-P

Dated: April 17, 2018.

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Seema Verma

Administrator,

Centers for Medicare & Medicaid Services.

Dated: April 19, 2018.

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Alex M. Azar II,

Secretary,

Department of Health and Human Services.

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