CMS-1645-P

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

CMS-1645-P

RIN 0938-AS75

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research

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) 2017. In addition, it includes a proposal to specify a potentially preventable readmission measure for the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), and other proposals for that program aimed at implementing value-based purchasing for SNFs. Additionally, this proposed rule proposes additional polices and measures in the Skilled Nursing Facility Quality Reporting Program (SNF QRP). This proposed rule also includes an update on the SNF Payment Models Research (PMR) project.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 20, 2016.

ADDRESSES: In commenting, please refer to file code CMS-1645-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to

http://www.regulations.gov. Within the search bar, enter the Regulation Identifier Number associated with this regulation, 0938-AS44, and then click on the "Comment Now" box

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-1645-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-1645-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. Centers for Medicare & Medicaid Services

Department of Health and Human Services

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, S.W.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. Centers for Medicare & Medicaid Services

Department of Health and Human Services

7500 Security Boulevard,

Baltimore, MD 21244-1850

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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.

Stephanie Frilling, (410) 786-4507, for information related to skilled nursing facility value-based purchasing.

Charlayne Van, (410) 786-8659, for information related to skilled nursing facility quality

reporting.

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.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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

As discussed in the FY 2016 SNF PPS final rule (80 FR 46390), 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.

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VIII. Economic Analyses

Regulation Text

Acronyms

In addition, because of the many terms to which we refer by acronym in this proposed rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

AIDS	Acquired Immune Deficiency Syndrome
ARD	Assessment reference date
BBA	Balanced Budget Act of 1997, Pub. L. 105-33
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554
CAH	Critical access hospital
CASPER	Certification and Survey Provider Enhanced Reporting
CBSA	Core-based statistical area
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services
FFS	Fee-for-service
FR	Federal Register
FY	Fiscal year
HCPCS	Healthcare Common Procedure Coding System
HIQR	Hospital Inpatient Quality Reporting

HOQR	Hospital Outpatient Quality Reporting
HRRP	Hospital Readmissions Reduction Program
HVBP	Hospital Value-Based Purchasing
IGI	IHS (Information Handling Services) Global Insight, Inc.
IMPACT	Improving Medicare Post-Acute Care Transformation Act of 2014, Pub. L. 113-185
IPPS	Inpatient prospective payment system
IRF	Inpatient Rehabilitation Facility
LTC	Long-term care
LTCH	Long-term care hospital
MAP	Measures Application Partnership
MDS	Minimum data set
MFP	Multifactor productivity
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173
MSA	Metropolitan statistical area
NF	Nursing facility
NQF	National Quality Forum
OMB	Office of Management and Budget
PAC	Post-acute care
PAMA	Protecting Access to Medicare Act of 2014, Pub. L 113-93
PMR	Payment Models Research
PPS	Prospective Payment System
PQRS	Physician Quality Reporting System
QIES	Quality Improvement Evaluation System

QIES ASAP	Quality Improvement and Evaluation System Assessment Submission and Processing
QRP	Quality Reporting Program
RAI	Resident assessment instrument
RAVEN	Resident assessment validation entry
RFA	Regulatory Flexibility Act, Pub. L. 96-354
RIA	Regulatory impact analysis
RUG-III	Resource Utilization Groups, Version 3
RUG-IV	Resource Utilization Groups, Version 4
RUG-53	Refined 53-Group RUG-III Case-Mix Classification System
SCHIP	State Children's Health Insurance Program
sDTI	Suspected deep tissue injuries
SNF	Skilled nursing facility
SNF QRP	Skill nursing facility quality reporting program
SNFRM	Skilled Nursing Facility 30-Day All-Cause Readmission Measure
STM	Staff time measurement
STRIVE	Staff time and resource intensity verification
TEP	Technical expert panel
UMRA	Unfunded Mandates Reform Act, Pub. L. 104-4
VBP	Value-based purchasing

I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for FY 2017 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.). This proposed rule also includes an update on the SNF PMR project. In addition, it proposes to specify a potentially preventable readmission measure for the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program, and makes other proposals related to that Program's implementation for FY 2019. We are also proposing four new quality and resource use measures for the SNF QRP and are proposing new SNF review and correction procedures for performance data that is to be publicly reported.

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 2016 (80 FR 46390) which reflects the SNF market basket index, as adjusted by the multifactor productivity (MFP) adjustment for FY 2017. We also propose for the SNF VBP Program to specify a potentially preventable readmission measure, define performance standards, and adopt a scoring methodology, among other policies. We are also proposing to adopt and implement four new quality and resource use measures for the SNF QRP and are proposing new SNF review and correction procedures for performance data that is to be publicly reported as we continue to implement this program and meet the requirements of the IMPACT Act.

C. Summary of Cost and Benefits

Provision Description	Total Transfers
Proposed FY 2017 SNF PPS payment rate update.	The overall economic impact of this proposed rule would be an estimated increase of $800 million in aggregate payments to SNFs during FY 2017.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA, 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 physician 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_07302013.pdf.

Section 215(a) of PAMA added section 1888(g) to the Act requiring the Secretary to specify an all-cause all-condition hospital readmission measure and a resource use measure, 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(a) of the IMPACT Act added section 1899B to the Act that, among other things, requires SNFs to report standardized data for measures in specified quality and resource use domains. In addition, the IMPACT Act added section 1888(e)(6) to the Act, which requires the Secretary to implement a quality

reporting program for SNFs, which includes a requirement that SNFs report certain data to receive their full payment under the SNF PPS.

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 2016 (80 FR 46390, August 4, 2015).

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 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 2017.

III. SNF PPS Rate Setting Methodology and FY 2017 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 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. We use the SNF market basket index, adjusted in the manner described below, to update the federal rates on an annual basis. In the SNF PPS final rule for FY 2014 (78 FR 47939 through 47946), we revised and rebased the market basket, which included updating the base year from FY 2004 to FY 2010.

For the FY 2017 proposed rule, the FY 2010-based SNF market basket growth rate is estimated to be 2.6 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2016 forecast with historical data through fourth quarter 2015. In section III.B.5. of this proposed rule, we discuss the specific application of this adjustment to the forthcoming annual update of the SNF PPS payment rates.

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. For the federal rates set forth in this proposed rule, we use the percentage change in the SNF market basket index to compute the update factor for FY 2017. This is based on the IGI first quarter 2016 forecast (with historical data through the fourth quarter 2015) of the FY 2017 percentage increase in the FY 2010-based SNF market basket index for routine, ancillary, and capital-related expenses, which is used to compute the update factor in this proposed rule. 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. Finally, 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 2015 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.5 percentage points, while the actual increase for FY 2015 was 2.3 percentage points, resulting in the actual increase being 0.2 percentage point lower than 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 2017 market basket percentage change of 2.6 percent would be not adjusted to account for the forecast error correction. Table 1 shows the forecasted and actual market basket amounts for FY 2015.

TABLE 1: Difference Between the Forecasted and Actual Market Basket Increases for FY 2015

Index	Forecasted FY 2015 Increase*	Actual FY 2015 Increase**	FY 2015 Difference
SNF	2.5	2.3	0.2

*Published in **Federal Register**; based on second quarter 2014 IGI forecast (2010-based index).
**Based on the first quarter 2016 IGI forecast, with historical data through the fourth quarter 2015 (2010-based index).

4. Multifactor Productivity Adjustment

Section 3401(b) of the 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 productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the Affordable Care Act, sets forth the definition of this productivity adjustment. The statute defines the productivity 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 MFP adjustment). 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) (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 for a FY being less than such payment rates for the preceding FY. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

For the FY 2017 update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2017, which is 0.5 percent. Consistent with section 1888(e)(5)(B)(i) of the Act and §413.337(d)(2) of the regulations, the market basket percentage for FY 2017 for the SNF PPS is based on IGI's first quarter 2016 forecast of the SNF market basket update, which is estimated to be 2.6 percent. In accordance with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act) and

§413.337(d)(3), this market basket percentage is then reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2017) of 0.5 percent, which is calculated as described above and based on IGI's first quarter 2016 forecast. The resulting MFP-adjusted SNF market basket update is equal to 2.1 percent, or 2.6 percent less 0.5 percentage point.

5. Market Basket Update Factor for FY 2017

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 2017 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, 2015 through September 30, 2016 to the average market basket level for the period of October 1, 2016 through September 30, 2017. This process yields a percentage change in the market basket of 2.6 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 2015 SNF market basket percentage change and the actual FY 2015 SNF market basket percentage change (FY 2015 is the most recently available FY for which there is historical data) did not exceed the 0.5 percentage point threshold, the FY 2017 market basket percentage change of 2.6 percent would not be adjusted by the forecast error correction.

For FY 2017, section 1888(e)(5)(B)(ii) of the Act 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, 2017) of 0.5 percent, as described in section III.B.4. of this proposed rule. The resulting net SNF market basket update would equal 2.1 percent, or 2.6

percent less the 0.5 percentage point MFP adjustment. We propose that if more recent data become available (for example, a more recent estimate of the FY 2010-based SNF market basket and/or MFP adjustment), we would use such data, if appropriate, to determine the FY 2017 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the FY 2017 SNF PPS final rule.

We 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 for FY 2017 from average prices for FY 2016. We would further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 2 and 3 reflect the updated components of the unadjusted federal rates for FY 2017, prior to adjustment for case-mix.

TABLE 2: FY 2017 Unadjusted Federal Rate Per Diem Urban

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$174.71	$131.61	$17.33	$89.16

TABLE 3: FY 2017 Unadjusted Federal Rate Per Diem Rural

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$166.91	$151.74	$18.52	$90.82

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 2006-2007 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 (MMA, Pub. L. 108-173) 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 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 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 limited number of SNF residents that qualify for this add-on, there is a significant increase in payments. For example, using FY 2014 data (which still used ICD-9-CM coding), we identified fewer than 4,800 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). 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 2017, an urban facility with a resident with AIDS in RUG-IV group "HC2" would have a case-mix adjusted per diem payment of $436.69 (see Table 4) 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 $995.65.

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 payment rates set forth in this proposed rule reflect the use of the RUG-IV case-mix classification system from October 1, 2016, through September 30, 2017. We list the proposed case-mix adjusted RUG-IV payment rates, provided separately for urban and rural SNFs, in Tables 4 and 5 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 4 and 5 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).

TABLE 4: 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	$466.48	$246.11		$89.16	$801.75
RUL	2.57	1.87	$449.00	$246.11		$89.16	$784.27
RVX	2.61	1.28	$455.99	$168.46		$89.16	$713.61
RVL	2.19	1.28	$382.61	$168.46		$89.16	$640.23
RHX	2.55	0.85	$445.51	$111.87		$89.16	$646.54
RHL	2.15	0.85	$375.63	$111.87		$89.16	$576.66
RMX	2.47	0.55	$431.53	$72.39		$89.16	$593.08
RML	2.19	0.55	$382.61	$72.39		$89.16	$544.16
RLX	2.26	0.28	$394.84	$36.85		$89.16	$520.85
RUC	1.56	1.87	$272.55	$246.11		$89.16	$607.82
RUB	1.56	1.87	$272.55	$246.11		$89.16	$607.82
RUA	0.99	1.87	$172.96	$246.11		$89.16	$508.23
RVC	1.51	1.28	$263.81	$168.46		$89.16	$521.43
RVB	1.11	1.28	$193.93	$168.46		$89.16	$451.55
RVA	1.10	1.28	$192.18	$168.46		$89.16	$449.80
RHC	1.45	0.85	$253.33	$111.87		$89.16	$454.36
RHB	1.19	0.85	$207.90	$111.87		$89.16	$408.93
RHA	0.91	0.85	$158.99	$111.87		$89.16	$360.02

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RMC	1.36	0.55	$237.61	$72.39		$89.16	$399.16
RMB	1.22	0.55	$213.15	$72.39		$89.16	$374.70
RMA	0.84	0.55	$146.76	$72.39		$89.16	$308.31
RLB	1.50	0.28	$262.07	$36.85		$89.16	$388.08
RLA	0.71	0.28	$124.04	$36.85		$89.16	$250.05
ES3	3.58		$625.46		$17.33	$89.16	$731.95
ES2	2.67		$466.48		$17.33	$89.16	$572.97
ES1	2.32		$405.33		$17.33	$89.16	$511.82
HE2	2.22		$387.86		$17.33	$89.16	$494.35
HE1	1.74		$304.00		$17.33	$89.16	$410.49
HD2	2.04		$356.41		$17.33	$89.16	$462.90
HD1	1.60		$279.54		$17.33	$89.16	$386.03
HC2	1.89		$330.20		$17.33	$89.16	$436.69
HC1	1.48		$258.57		$17.33	$89.16	$365.06
HB2	1.86		$324.96		$17.33	$89.16	$431.45
HB1	1.46		$255.08		$17.33	$89.16	$361.57
LE2	1.96		$342.43		$17.33	$89.16	$448.92
LE1	1.54		$269.05		$17.33	$89.16	$375.54
LD2	1.86		$324.96		$17.33	$89.16	$431.45
LD1	1.46		$255.08		$17.33	$89.16	$361.57
LC2	1.56		$272.55		$17.33	$89.16	$379.04
LC1	1.22		$213.15		$17.33	$89.16	$319.64
LB2	1.45		$253.33		$17.33	$89.16	$359.82
LB1	1.14		$199.17		$17.33	$89.16	$305.66
CE2	1.68		$293.51		$17.33	$89.16	$400.00
CE1	1.50		$262.07		$17.33	$89.16	$368.56
CD2	1.56		$272.55		$17.33	$89.16	$379.04
CD1	1.38		$241.10		$17.33	$89.16	$347.59
CC2	1.29		$225.38		$17.33	$89.16	$331.87
CC1	1.15		$200.92		$17.33	$89.16	$307.41
CB2	1.15		$200.92		$17.33	$89.16	$307.41
CB1	1.02		$178.20		$17.33	$89.16	$284.69
CA2	0.88		$153.74		$17.33	$89.16	$260.23
CA1	0.78		$136.27		$17.33	$89.16	$242.76
BB2	0.97		$169.47		$17.33	$89.16	$275.96
BB1	0.90		$157.24		$17.33	$89.16	$263.73
BA2	0.70		$122.30		$17.33	$89.16	$228.79
BA1	0.64		$111.81		$17.33	$89.16	$218.30
PE2	1.50		$262.07		$17.33	$89.16	$368.56
PE1	1.40		$244.59		$17.33	$89.16	$351.08
PD2	1.38		$241.10		$17.33	$89.16	$347.59
PD1	1.28		$223.63		$17.33	$89.16	$330.12
PC2	1.10		$192.18		$17.33	$89.16	$298.67
PC1	1.02		$178.20		$17.33	$89.16	$284.69
PB2	0.84		$146.76		$17.33	$89.16	$253.25

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
PB1	0.78		$136.27		$17.33	$89.16	$242.76
PA2	0.59		$103.08		$17.33	$89.16	$209.57
PA1	0.54		$94.34		$17.33	$89.16	$200.83

TABLE 5: 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	$445.65	$283.75		$90.82	$820.22
RUL	2.57	1.87	$428.96	$283.75		$90.82	$803.53
RVX	2.61	1.28	$435.64	$194.23		$90.82	$720.69
RVL	2.19	1.28	$365.53	$194.23		$90.82	$650.58
RHX	2.55	0.85	$425.62	$128.98		$90.82	$645.42
RHL	2.15	0.85	$358.86	$128.98		$90.82	$578.66
RMX	2.47	0.55	$412.27	$83.46		$90.82	$586.55
RML	2.19	0.55	$365.53	$83.46		$90.82	$539.81
RLX	2.26	0.28	$377.22	$42.49		$90.82	$510.53
RUC	1.56	1.87	$260.38	$283.75		$90.82	$634.95
RUB	1.56	1.87	$260.38	$283.75		$90.82	$634.95
RUA	0.99	1.87	$165.24	$283.75		$90.82	$539.81
RVC	1.51	1.28	$252.03	$194.23		$90.82	$537.08
RVB	1.11	1.28	$185.27	$194.23		$90.82	$470.32
RVA	1.10	1.28	$183.60	$194.23		$90.82	$468.65
RHC	1.45	0.85	$242.02	$128.98		$90.82	$461.82
RHB	1.19	0.85	$198.62	$128.98		$90.82	$418.42
RHA	0.91	0.85	$151.89	$128.98		$90.82	$371.69
RMC	1.36	0.55	$227.00	$83.46		$90.82	$401.28
RMB	1.22	0.55	$203.63	$83.46		$90.82	$377.91
RMA	0.84	0.55	$140.20	$83.46		$90.82	$314.48
RLB	1.50	0.28	$250.37	$42.49		$90.82	$383.68
RLA	0.71	0.28	$118.51	$42.49		$90.82	$251.82
ES3	3.58		$597.54		$18.52	$90.82	$706.88
ES2	2.67		$445.65		$18.52	$90.82	$554.99
ES1	2.32		$387.23		$18.52	$90.82	$496.57
HE2	2.22		$370.54		$18.52	$90.82	$479.88
HE1	1.74		$290.42		$18.52	$90.82	$399.76
HD2	2.04		$340.50		$18.52	$90.82	$449.84
HD1	1.60		$267.06		$18.52	$90.82	$376.40
HC2	1.89		$315.46		$18.52	$90.82	$424.80
HC1	1.48		$247.03		$18.52	$90.82	$356.37
HB2	1.86		$310.45		$18.52	$90.82	$419.79
HB1	1.46		$243.69		$18.52	$90.82	$353.03
LE2	1.96		$327.14		$18.52	$90.82	$436.48

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
LE1	1.54		$257.04		$18.52	$90.82	$366.38
LD2	1.86		$310.45		$18.52	$90.82	$419.79
LD1	1.46		$243.69		$18.52	$90.82	$353.03
LC2	1.56		$260.38		$18.52	$90.82	$369.72
LC1	1.22		$203.63		$18.52	$90.82	$312.97
LB2	1.45		$242.02		$18.52	$90.82	$351.36
LB1	1.14		$190.28		$18.52	$90.82	$299.62
CE2	1.68		$280.41		$18.52	$90.82	$389.75
CE1	1.50		$250.37		$18.52	$90.82	$359.71
CD2	1.56		$260.38		$18.52	$90.82	$369.72
CD1	1.38		$230.34		$18.52	$90.82	$339.68
CC2	1.29		$215.31		$18.52	$90.82	$324.65
CC1	1.15		$191.95		$18.52	$90.82	$301.29
CB2	1.15		$191.95		$18.52	$90.82	$301.29
CB1	1.02		$170.25		$18.52	$90.82	$279.59
CA2	0.88		$146.88		$18.52	$90.82	$256.22
CA1	0.78		$130.19		$18.52	$90.82	$239.53
BB2	0.97		$161.90		$18.52	$90.82	$271.24
BB1	0.90		$150.22		$18.52	$90.82	$259.56
BA2	0.70		$116.84		$18.52	$90.82	$226.18
BA1	0.64		$106.82		$18.52	$90.82	$216.16
PE2	1.50		$250.37		$18.52	$90.82	$359.71
PE1	1.40		$233.67		$18.52	$90.82	$343.01
PD2	1.38		$230.34		$18.52	$90.82	$339.68
PD1	1.28		$213.64		$18.52	$90.82	$322.98
PC2	1.10		$183.60		$18.52	$90.82	$292.94
PC1	1.02		$170.25		$18.52	$90.82	$279.59
PB2	0.84		$140.20		$18.52	$90.82	$249.54
PB1	0.78		$130.19		$18.52	$90.82	$239.53
PA2	0.59		$98.48		$18.52	$90.82	$207.82
PA1	0.54		$90.13		$18.52	$90.82	$199.47

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 2017, 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 2017, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013 (FY 2013 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106-554, enacted on December 21, 2000) 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.

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 2017 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 2017, 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 2017, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. The proposed wage index applicable to FY 2017 is set forth in Tables A and B available on the CMS Web site 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 2014 (78 FR 47944 through 47946), we finalized a proposal to revise the labor-related share to reflect the relative importance of the FY 2010-based SNF market basket cost weights for the following cost categories: wages and salaries; employee benefits; the labor-related portion of nonmedical professional fees; administrative and facilities support 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 2017. 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 2017 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2017 in four steps. First, we compute the FY 2017 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 2017 price

index level for that cost category by the total market basket price index level. Third, we determine the FY 2017 relative importance for each cost category by multiplying this ratio by the base year (FY 2010) weight. Finally, we add the FY 2017 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, the labor-related portion of non-medical professional fees, administrative and facilities support services, all other: labor-related services, and a portion of capital-related expenses) to produce the FY 2017 labor-related relative importance. Table 6 summarizes the proposed updated labor-related share for FY 2017, compared to the labor-related share that was used for the FY 2016 SNF PPS final rule.

TABLE 6: Labor-Related Relative Importance, FY 2016 and FY 2017

	Relative importance, labor-related, FY 2016 15:2 forecast[1]	**Relative importance, labor-related, FY 2017 16:1 forecast[2]**
Wages and salaries	48.8	48.8
Employee benefits	11.3	11.2
Nonmedical Professional fees: labor-related	3.5	3.4
Administrative and facilities support services	0.5	0.5
All Other: Labor-related services	2.3	2.3
Capital-related (.391)	2.7	2.7
Total	69.1	68.9

[1] Published in the **Federal Register**; based on second quarter 2015 IGI forecast
[2] Based on first quarter 2016 IGI forecast, with historical data through fourth quarter 2015.

Tables 7 and 8 show the RUG-IV case-mix adjusted federal rates by labor-related and non-labor-related components.

TABLE 7: 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	801.75	$552.41	$249.34
RUL	784.27	$540.36	$243.91
RVX	713.61	$491.68	$221.93
RVL	640.23	$441.12	$199.11

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RHX	646.54	$445.47	$201.07
RHL	576.66	$397.32	$179.34
RMX	593.08	$408.63	$184.45
RML	544.16	$374.93	$169.23
RLX	520.85	$358.87	$161.98
RUC	607.82	$418.79	$189.03
RUB	607.82	$418.79	$189.03
RUA	508.23	$350.17	$158.06
RVC	521.43	$359.27	$162.16
RVB	451.55	$311.12	$140.43
RVA	449.80	$309.91	$139.89
RHC	454.36	$313.05	$141.31
RHB	408.93	$281.75	$127.18
RHA	360.02	$248.05	$111.97
RMC	399.16	$275.02	$124.14
RMB	374.70	$258.17	$116.53
RMA	308.31	$212.43	$95.88
RLB	388.08	$267.39	$120.69
RLA	250.05	$172.28	$77.77
ES3	731.95	$504.31	$227.64
ES2	572.97	$394.78	$178.19
ES1	511.82	$352.64	$159.18
HE2	494.35	$340.61	$153.74
HE1	410.49	$282.83	$127.66
HD2	462.90	$318.94	$143.96
HD1	386.03	$265.97	$120.06
HC2	436.69	$300.88	$135.81
HC1	365.06	$251.53	$113.53
HB2	431.45	$297.27	$134.18
HB1	361.57	$249.12	$112.45
LE2	448.92	$309.31	$139.61
LE1	375.54	$258.75	$116.79
LD2	431.45	$297.27	$134.18
LD1	361.57	$249.12	$112.45
LC2	379.04	$261.16	$117.88
LC1	319.64	$220.23	$99.41
LB2	359.82	$247.92	$111.90
LB1	305.66	$210.60	$95.06
CE2	400.00	$275.60	$124.40
CE1	368.56	$253.94	$114.62
CD2	379.04	$261.16	$117.88
CD1	347.59	$239.49	$108.10
CC2	331.87	$228.66	$103.21
CC1	307.41	$211.81	$95.60
CB2	307.41	$211.81	$95.60
CB1	284.69	$196.15	$88.54
CA2	260.23	$179.30	$80.93
CA1	242.76	$167.26	$75.50
BB2	275.96	$190.14	$85.82

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
BB1	263.73	$181.71	$82.02
BA2	228.79	$157.64	$71.15
BA1	218.30	$150.41	$67.89
PE2	368.56	$253.94	$114.62
PE1	351.08	$241.89	$109.19
PD2	347.59	$239.49	$108.10
PD1	330.12	$227.45	$102.67
PC2	298.67	$205.78	$92.89
PC1	284.69	$196.15	$88.54
PB2	253.25	$174.49	$78.76
PB1	242.76	$167.26	$75.50
PA2	209.57	$144.39	$65.18
PA1	200.83	$138.37	$62.46

TABLE 8: 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	820.22	$565.13	$255.09
RUL	803.53	$553.63	$249.90
RVX	720.69	$496.56	$224.13
RVL	650.58	$448.25	$202.33
RHX	645.42	$444.69	$200.73
RHL	578.66	$398.70	$179.96
RMX	586.55	$404.13	$182.42
RML	539.81	$371.93	$167.88
RLX	510.53	$351.76	$158.77
RUC	634.95	$437.48	$197.47
RUB	634.95	$437.48	$197.47
RUA	539.81	$371.93	$167.88
RVC	537.08	$370.05	$167.03
RVB	470.32	$324.05	$146.27
RVA	468.65	$322.90	$145.75
RHC	461.82	$318.19	$143.63
RHB	418.42	$288.29	$130.13
RHA	371.69	$256.09	$115.60
RMC	401.28	$276.48	$124.80
RMB	377.91	$260.38	$117.53
RMA	314.48	$216.68	$97.80
RLB	383.68	$264.36	$119.32
RLA	251.82	$173.50	$78.32
ES3	706.88	$487.04	$219.84
ES2	554.99	$382.39	$172.60
ES1	496.57	$342.14	$154.43
HE2	479.88	$330.64	$149.24
HE1	399.76	$275.43	$124.33
HD2	449.84	$309.94	$139.90

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
HD1	376.40	$259.34	$117.06
HC2	424.80	$292.69	$132.11
HC1	356.37	$245.54	$110.83
HB2	419.79	$289.24	$130.55
HB1	353.03	$243.24	$109.79
LE2	436.48	$300.73	$135.75
LE1	366.38	$252.44	$113.94
LD2	419.79	$289.24	$130.55
LD1	353.03	$243.24	$109.79
LC2	369.72	$254.74	$114.98
LC1	312.97	$215.64	$97.33
LB2	351.36	$242.09	$109.27
LB1	299.62	$206.44	$93.18
CE2	389.75	$268.54	$121.21
CE1	359.71	$247.84	$111.87
CD2	369.72	$254.74	$114.98
CD1	339.68	$234.04	$105.64
CC2	324.65	$223.68	$100.97
CC1	301.29	$207.59	$93.70
CB2	301.29	$207.59	$93.70
CB1	279.59	$192.64	$86.95
CA2	256.22	$176.54	$79.68
CA1	239.53	$165.04	$74.49
BB2	271.24	$186.88	$84.36
BB1	259.56	$178.84	$80.72
BA2	226.18	$155.84	$70.34
BA1	216.16	$148.93	$67.23
PE2	359.71	$247.84	$111.87
PE1	343.01	$236.33	$106.68
PD2	339.68	$234.04	$105.64
PD1	322.98	$222.53	$100.45
PC2	292.94	$201.84	$91.10
PC1	279.59	$192.64	$86.95
PB2	249.54	$171.93	$77.61
PB1	239.53	$165.04	$74.49
PA2	207.82	$143.19	$64.63
PA1	199.47	$137.43	$62.04

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 2017 (federal rates effective October 1, 2016), 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 2016 to the weighted average wage adjustment factor for FY 2017. For this calculation, we would use the same FY 2015 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 2017 would be 1.0000.

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), available online at www.whitehouse.gov/omb/bulletins/b03-04.html, 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 one-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 one-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. 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). In addition, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. 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. A copy of this bulletin may be obtained on the Web site at https://www.whitehouse.gov/sites/default/files/omb/bulletins/2015/15-01.pdf. As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), we again wish to clarify that this and all subsequent SNF PPS rules and notices are considered to incorporate any such 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. As noted above, the proposed wage index applicable to FY 2017 is set forth in Tables A and B available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

E. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ described below, Table 9 shows the adjustments made to the federal per diem rates to compute the provider's actual per diem PPS payment. We derive the Labor and Non-labor columns from Table 7. The wage index used in this example is based on the proposed wage index, which may be found in Table A as referenced above. As illustrated in Table 9, SNF XYZ's total PPS payment would equal $46,782.60.

TABLE 9: Adjusted Rate Computation Example
SNF XYZ: Located in Frederick, MD (Urban CBSA 43524)
Wage Index: 0.9820
(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	$491.68	0.982	$482.83	$221.93	$704.76	$704.76	14	$9,866.64
ES2	$394.78	0.982	$387.67	$178.19	$565.86	$565.86	30	$16,975.80
RHA	$248.05	0.982	$243.59	$111.97	$355.56	$355.56	16	$5,688.96
CC2*	$228.66	0.982	$224.54	$103.21	$327.75	$747.27	10	$7,472.70
BA2	$157.64	0.982	$154.80	$71.15	$225.95	$225.95	30	$6,778.50
							100	$46,782.60

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

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 66-group RUG-IV case-mix classification system to assist in making certain SNF level of care determinations.

In accordance with section 1888(e)(4)(H)(ii) of the Act and the regulations at §413.345, we include in each update of the federal payment rates in the **Federal Register** the designation of those specific RUGs under the 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 five-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. In this proposed rule, we would continue to designate the upper 52 RUG-IV groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG-IV categories:

- Rehabilitation plus Extensive Services.
- Ultra High Rehabilitation.
- Very High Rehabilitation.
- High Rehabilitation.
- Medium Rehabilitation.
- Low Rehabilitation.
- Extensive Services.
- Special Care High.
- Special Care Low.
- Clinically Complex.

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 beneficiary's assignment to one of the upper 52 RUG-IV groups (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) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor 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. 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_07302013.pdf. In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113, enacted on November 29, 1999) 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, we noted that the Congress declined to 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 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, 2016). 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, 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. 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 Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

V. Other Issues

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

1. Background

Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) authorizes the SNF VBP Program by adding sections 1888(g) and (h) to the Act. These sections provide structure for the development of the SNF VBP Program, including, among other things, the requirements of only two measures—an all-cause, all-condition hospital readmission measure, which is to be replaced as soon as practicable by an all-condition risk-adjusted potentially preventable hospital readmission measure—and confidential and public reporting requirements for the SNF VBP Program. We began development of the SNF VBP Program in the FY 2016 SNF PPS final rule with, among other things, the adoption of an all-cause, all-condition hospital readmission measure, as required under section 1888(g)(1) of the Act. We will continue the process in this proposed rule with our proposal for an all-condition risk-adjusted potentially preventable hospital readmission measure for SNFs, which the Secretary is required to specify no later than October 1, 2016 under section 1888(g)(2) of the Act. The Act requires that the SNF VBP 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 toward transforming how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovations instead of merely 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).

2. Measures

a. SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510)

Per the requirement at section 1888(g)(1) of the Act, in the FY 2016 SNF PPS final rule (80 FR 46419), we finalized our proposal to specify the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) as the SNF all-cause, all-condition hospital readmission measure for the SNF VBP Program. The SNFRM assesses the risk-standardized rate of all-cause, all-condition, unplanned inpatient hospital readmissions of Medicare fee-for-service (FFS) SNF patients within 30 days of discharge from an admission to an inpatient prospective payment system (IPPS) hospital, CAH, or psychiatric hospital. The measure is claims-based, requiring no additional data collection or submission burden for SNFs. For additional details on the SNFRM, including our responses to public comments, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46411 through 46419).

b. Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR)

We are proposing to specify the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) as the SNF all-condition risk-adjusted potentially preventable hospital readmission measure to meet the requirements of section 1888(g)(2) of the Act. This proposed measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital. Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable. This proposed measure is claims-based, requiring no additional data collection or submission burden for SNFs.

Hospital readmissions among the Medicare population, including beneficiaries that utilize post-acute care, are common, costly, and often preventable.[1] [2] The Medicare Payment Advisory Commission (MedPAC) and a study by Jencks et al. estimated that 17 to 20 percent of Medicare beneficiaries discharged from the hospital were readmitted within 30 days. MedPAC found that more than 75 percent of 30-day and 15-day readmissions and 84 percent of 7-day readmissions were considered potentially preventable.[3] In addition, MedPAC calculated that annual Medicare spending on potentially preventable readmissions would be $12B for 30-day, $8B for 15-day, and $5B for 7-day readmissions.[4] For hospital readmissions from SNFs, MedPAC deemed 76 percent of readmissions as potentially avoidable – associated with $12B in Medicare expenditures.[5] Mor et al. analyzed 2006 Medicare claims and SNF assessment data (Minimum Data Set), and reported a 23.5 percent readmission rate from SNFs, associated with $4.3B in expenditures.[6]

We have addressed the high rates of hospital readmissions in the acute care setting, as well as in PAC by developing the SNF 30-Day All-Cause Readmission Measure (NQF #2510), as well as similar measures for other PAC providers (NQF #2502 for IRFs and NQF #2512 for LTCHs).[7] These measures are endorsed by the National Quality Forum (NQF), and the NQF-endorsed measure (NQF #2510) was adopted for the SNF VBP program in the FY 2016 SNF PPS final rule (80 FR 46411 through 46419). These NQF-endorsed measures assess all-cause

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1 Friedman, B., and Basu, J.: The rate and cost of hospital readmissions for preventable conditions. Med. Care Res. Rev. 61(2):225-240, 2004. doi:10.1177/1077558704263799

2 Jencks, S.F., Williams, M.V., and Coleman, E.A.: Rehospitalizations among patients in the Medicare Fee-for-Service Program. N. Engl. J. Med. 360(14):1418-1428, 2009. doi:10.1016/j.jvs.2009.05.045

3 MedPAC: Payment policy for inpatient readmissions, in Report to the Congress: Promoting Greater Efficiency in Medicare. Washington, D.C., pp. 103-120, 2007. Available from http://www.medpac.gov/documents/reports/Jun07_EntireReport.pdf

4 *Ibid.*

5 *Ibid.*

6 Mor, V., Intrator, O., Feng, Z., et al.: The revolving door of rehospitalization from SNFs. Health Aff. 29(1):57-64, 2010. doi:10.1377/hlthaff.2009.0629

7 National Quality Forum: All-Cause Admissions and Readmissions Measures. pp. 1-319, April 2015. Available from http://www.qualityforum.org/Publications/2015/04/All-Cause_Admissions_and_Readmissions_Measures_-_Final_Report.aspx

unplanned readmissions.

Several general methods and algorithms have been developed to assess potentially avoidable or preventable hospitalizations and readmissions for the Medicare population. These include the Agency for Healthcare Research and Quality's (AHRQ) Prevention Quality Indicators, approaches developed by MedPAC, and proprietary approaches, such as the 3M™ algorithm for Potentially Preventable Readmissions (PPR).[8] [9] [10] Recent work led by Kramer et al. for MedPAC identified 13 conditions for which readmissions were deemed as potentially preventable among SNF and IRF populations[11] [12]; however, these conditions did not differ by PAC setting or readmission window (that is, readmissions during the PAC stay or post-PAC discharge). Although much of the existing literature addresses hospital readmissions more broadly and potentially avoidable hospitalizations for specific settings like skilled nursing facilities, these findings are relevant to the development of potentially preventable readmission measures for PAC.[13] [14] [15]

Based on the evidence discussed above and to meet PAMA requirements, we are proposing to specify this measure, entitled, SNF 30-Day Potentially Preventable Readmission

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8 Goldfield, N.I., McCullough, E.C., Hughes, J.S., et al.: Identifying potentially preventable readmissions. Health Care Finan. Rev. 30(1):75-91, 2008. Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195042/

9 National Quality Forum: Prevention Quality Indicators Overview. 2008.

10 MedPAC: Online Appendix C: Medicare Ambulatory Care Indicators for the Elderly. pp. 1-12, prepared for Chapter 4, 2011. Available from http://www.medpac.gov/documents/reports/Mar11_Ch04_APPENDIX.pdf?sfvrsn=0

11 Kramer, A., Lin, M., Fish, R., et al.: Development of Inpatient Rehabilitation Facility Quality Measures: Potentially Avoidable Readmissions, Community Discharge, and Functional Improvement. pp. 1-42, 2015. Available from http://www.medpac.gov/documents/contractor-reports/development-of-inpatient-rehabilitation-facility-quality-measures-potentially-avoidable-readmissions-community-discharge-and-functional-improvement.pdf?sfvrsn=0

12 Kramer, A., Lin, M., Fish, R., et al.: Development of Potentially Avoidable Readmission and Functional Outcome SNF Quality Measures. pp. 1-75, 2014. Available from http://www.medpac.gov/documents/contractor-reports/mar14_snfqualitymeasures_contractor.pdf?sfvrsn=0

13 Allaudeen, N., Vidyarthi, A., Maselli, J., et al.: Redefining readmission risk factors for general medicine patients. J. Hosp. Med. 6(2):54-60, 2011. doi:10.1002/jhm.805

14 [4] Gao, J., Moran, E., Li, Y.-F., et al.: Predicting potentially avoidable hospitalizations. Med. Care 52(2):164-171, 2014. doi:10.1097/MLR.0000000000000041

15 Walsh, E.G., Wiener, J.M., Haber, S., et al.: Potentially avoidable hospitalizations of dually eligible Medicare and Medicaid beneficiaries from nursing facility and home-and community-based services waiver programs. J. Am. Geriatr. Soc. 60(5):821-829, 2012. doi:10.1111/j.1532-5415.2012.03920.x

Measure (SNFPPR), for the SNF VBP Program. The SNFPPR measure was developed by CMS to harmonize with the NQF-endorsed SNF 30-Day All-Cause Readmission Measure (NQF #2510)[16] adopted in the FY 2016 SNF final rule (80 FR 46411 through 46419) and the Hospital-Wide Risk-Adjusted All-Cause Unplanned Readmission Measure (NQF #1789) (Hospital-Wide Readmission or HWR measure[17]), finalized for the Hospital IQR Program in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53521 through 53528). Although these existing measures focus on all-cause unplanned readmissions and the proposed SNFPPR measure assesses potentially preventable hospital readmissions, the SNFPPR will use the same statistical approach, the same time window as NQF measure #2510 (that is, 30 days post-hospital discharge), and a similar set of patient characteristics for risk adjustment. As appropriate, the proposed potentially preventable hospital readmission measure for SNFs is being harmonized with similar measures being proposed for LTCHs, IRFs, and HHAs to meet the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113-185).

The SNFPPR measure estimates the risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries that occur within 30 days of discharge from the prior proximal hospitalization. This is a departure from readmission measures in other PAC settings, such as the two measures proposed in the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program, one of which assesses readmissions that take place during the IRF stay and the other that assesses readmissions within 30 days following discharge from the IRF. The proposed measure here is distinct because section

16 National Quality Forum: All-Cause Admissions and Readmissions Measures. pp. 1-319, April 2015. National Quality Forum: All-Cause Admissions and Readmissions Measures. pp. 1-319, April 2015. Available from http://www.qualityforum.org/Publications/2015/04/All-Cause_Admissions_and_Readmissions_Measures_-_Final_Report.aspx

17 Available by searching for "1789" at http://www.qualityforum.org/QPS/QPSTool.aspx.

1888(h)(2) of the Act requires that only a single quality measure be implemented in the SNF VBP program at one time. A purely within-stay measure (that is, a measure that assesses readmission rates only when those readmissions occurred during a SNF stay) would perversely incentivize the premature discharge of residents from SNFs to avoid penalty. Conversely, limiting the measure to readmissions that occur within 30-days post-discharge from the SNF would not capture readmissions that occur during the SNF stay. In order to qualify for this proposed measure, the SNF admission must take place within 1 day of discharge from a prior proximal hospital stay. The prior proximal hospital stay is defined as an inpatient admission to an acute care hospital (including IPPS, CAH, or a psychiatric hospital). Because the measure denominator is based on SNF admissions, a single Medicare beneficiary could be included in the measure multiple times within a given year. Readmissions counted in this measure are identified by examining Medicare FFS claims data for readmissions to either acute care hospitals (IPPS or CAH) that occur within 30 days of discharge from the prior proximal hospitalization, regardless of whether the readmission occurs during the SNF stay or takes place after the patient is discharged from the SNF. Because patients differ in complexity and morbidity, the measure is risk-adjusted for case-mix. Our approach for defining potentially preventable readmissions is described below.

Potentially Preventable Readmission Measure Definition*:* We conducted a comprehensive environmental scan, analyzed claims data, and obtained input from a technical expert panel (TEP) to develop a working conceptual definition and list of conditions for which hospital readmissions may be considered potentially preventable. The Ambulatory Care Sensitive Conditions (ACSC)/Prevention Quality Indicators (PQI), developed by AHRQ, served as the starting point in this work. For the purposes of the SNFPPR measure, the definition of potentially preventable readmissions differs based on whether the resident is admitted to the SNF (referred to as "within-stay") or in the post-SNF discharge period; however, there is considerable

overlap of the definitions. For patients readmitted to a hospital during within the SNF stay, potentially preventable readmissions (PPR) should be avoidable with sufficient medical monitoring and appropriate treatment. The within-stay list of PPR conditions includes the following, which are categorized by 4 clinical rationale groupings: (1) Inadequate management of chronic conditions; (2) Inadequate management of infections; (3) Inadequate management of other unplanned events; and (4) Inadequate injury prevention. For individuals in the post the post-SNF discharge period, a potentially preventable readmission refers to a readmission in which the probability of occurrence could be minimized with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care. Our list of PPR conditions in the post-SNF discharge period includes the following, categorized by 3 clinical rationale groupings: (1) Inadequate management of chronic conditions; (2) Inadequate management of infections; and (3) Inadequate management of other unplanned events. Additional details regarding the definitions of potentially preventable readmissions are available in our Measure Specification (available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html).

This proposed measure focuses on readmissions that are potentially preventable and also unplanned. Similar to the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510), this measure uses the CMS Planned Readmission Algorithm to define planned readmissions. In addition to the CMS Planned Readmission Algorithm, this measure incorporates procedures that are considered planned in post-acute care settings, as identified in consultation with TEPs. Full details on the planned readmissions criteria used, including the additional procedures considered planned for post-acute care, can be found in the Measure Specifications (available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html)

This proposed measure assesses potentially preventable readmission rates while accounting for patient or resident demographics, principal diagnosis in the prior hospital stay, comorbidities, and other patient factors. The model also estimates a facility-specific effect, common to patients or residents treated in each facility. This proposed measure is calculated for each SNF based on the ratio of the predicted number of risk-adjusted, unplanned, potentially preventable hospital readmissions that occurred within 30 days of discharge from the prior proximal hospitalization, including the estimated facility effect, to the estimated predicted number of risk-adjusted, unplanned hospital readmissions for the same individuals receiving care at the average SNF. A ratio above 1.0 indicates a higher than expected readmission rate (worse), while a ratio below 1.0 indicates a lower than expected readmission rate (better). This ratio is referred to as the standardized risk ratio or SRR. The SRR is then multiplied by the overall national raw rate of potentially preventable readmissions for all SNF stays. The resulting rate is the risk-standardized readmission rate (RSRR) of potentially preventable readmissions. The full methodology is detailed in the Measure Specifications (available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html).[18]

Eligible SNF stays in the measure are assessed until: (1) the 30-day period ends; or (2) the patient is readmitted to an acute care hospital (IPPS or CAH). If the readmission is classified as unplanned and potentially preventable, it is counted as a readmission in the measure calculation. If the readmission is planned or not preventable, the readmission is not counted in the measure rate.

Readmission rates are risk-adjusted for case-mix characteristics. The risk adjustment

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18 Note to reviewers: the specifications will be posted at this link by the time the proposed rule is displayed.

modeling estimates the effects of patient/resident characteristics, comorbidities, and select health care variables on the probability of readmission. More specifically, the risk-adjustment model for SNFs accounts for sociodemographic characteristics (age, sex, original reason for entitlement), principal diagnosis during the prior proximal hospital stay, body system specific surgical indicators, comorbidities, length of stay during the resident's prior proximal hospital stay, intensive care utilization, end-stage renal disease status, and number of prior acute care hospitalizations in the preceding 365 days. This measure is calculated using one full calendar year of data. The full measure specifications and results of the reliability testing can be found in the Measure Specifications (available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html).[19]

Our measure development contractor convened a TEP, which provided input on the technical specifications of this measure, including the development of an approach to define potentially preventable hospital readmissions for a number of PAC settings, including SNFs. Details from the TEP meetings, including TEP members' ratings of conditions proposed as being potentially preventable, are available in the TEP Summary Report available on the CMS Web site (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). We also solicited stakeholder feedback on the development of this measure through a public comment period held from November 2 through December 1, 2015. A summary of the public comments we received is also available on the CMS Web site (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).

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19 Note to reviewers: the specifications will be posted at this link by the time the proposed rule is displayed

In addition to our TEP and public comment feedback, we also considered input from the Measures Application Partnership (MAP) on the SNFPPR. The MAP is composed of multi-stakeholder groups convened by the NQF. The MAP provides input on the measures we are considering for implementation in certain quality reporting and pay-for-performance programs. In general, the MAP has noted the need for care transition measures in PAC/LTC performance measurement programs and stated that setting-specific admission and readmission measures would address this need.[20] We included the SNFPPR measure being proposed for the SNF VBP Program in this proposed rule in the List of Measures under Consideration (MUC List) for December 1, 2015.[21]

The MAP encouraged continued development of the proposed measure in the SNF VBP Program to meet the mandate of PAMA. Specifically, the MAP stressed the need to promote shared accountability and ensure effective care transitions. More information about the MAP's recommendations for this measure is available at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx. At the time, the risk-adjustment model was still under development. Following completion of that development work, we were able to test for measure validity and reliability as available in the measure specifications document provided above. Testing results are within range for similar outcome measures finalized in public reporting and value-based purchasing programs, including the SNFRM finalized for this this program.

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20 National Quality Forum: Measure Applications Partnership Pre-Rulemaking Report: 2013 Recommendations of Measures Under Consideration by HHS. pp. 1-394, February 2013. Available from https://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

We invite public comment on our proposal to adopt this measure, the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR).

Section 1888(h)(2)(B) of the Act requires the Secretary to apply the all-condition risk-adjusted potentially preventable hospital readmission measure specified under paragraph (g)(2) instead of the measure specified under paragraph (g)(1) as soon as practicable. We intend to propose the timing for the change to the paragraph (g)(2) measure in future rulemaking. We seek comment on when we should propose this change for the SNF VBP Program.

3. Performance Standards

a. Background

Sections 1888(h)(3)(A) of the Act requires the Secretary to establish performance standards for the SNF VBP Program. Under paragraph (h)(3)(B), the performance standards must include levels of achievement and improvement, and under paragraph (h)(3)(C), must be established and announced not later than 60 days prior to the beginning of the performance period for the FY involved.

In the FY 2016 SNF PPS final rule (80 FR 46419 through 46422), we summarized public comments we received on possible approaches to calculating performance standards under the SNF VBP Program. We specifically sought comment on the approaches that we have adopted for other Medicare VBP programs such as the Hospital VBP Program (Hospital VBP Program), the Hospital-Acquired Conditions Reduction Program (HAC Reduction Program), the Hospital Readmissions Reduction Program (HRRP), and the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). We also sought comment on the best possible approach to measuring improvement, particularly given the SNF VBP Program's limitation to one measure for each program year.

b. Proposed Performance Standards Calculation Methodology

We believe that an essential goal of the SNF VBP program is to provide incentives for all

SNFs to improve the quality of care that they furnish to their residents. In determining what level of SNF performance would be appropriate to select as the performance standard for the quality measures specified under the SNF VBP program, we focused on selecting levels that would challenge SNFs to improve continuously or to maintain high levels of performance. To achieve this aim, we analyzed SNFRM data and examined how different achievement performance standards would impact SNFs' scores under the proposed scoring methodology described further below. As more data becomes available, we will continue to assess the appropriateness of these performance standards for the SNF VBP program and, if necessary, propose to refine these standards' definitions and calculation methodologies to better incentivize the provision of high-quality care.

(1) Proposed Achievement Performance Standard and Benchmark

Beginning with the FY 2019 SNF VBP program, we propose to define the achievement performance standard (which we will refer to as the "achievement threshold") for quality measures specified under the SNF VBP program as the 25th percentile of national SNF performance on the quality measure during the applicable baseline period. We believe this achievement threshold definition represents an achievable standard of excellence and will reward SNFs appropriately for their performance on the quality measures specified for the SNF VBP program. We further believe this achievement threshold definition will provide strong incentives for SNFs to improve their performance on the measures specified for the SNF VBP Program continuously, and will result in a wide range of SNF measure scores that can be used in public reporting. We also seek comment on whether we should consider adopting either the 50^{th} or 15^{th} percentiles of national SNFs' performance on the quality measure during the applicable baseline period. We seek comment on data or other analysis that we should consider regarding the impact on SNFs' financial viability and service delivery to beneficiaries at either the higher or lower alternative standard. For example, while the 50^{th} percentile would represent a more challenging

threshold for care quality improvement, that standard would align with the Hospital VBP Program and would likely result in higher value-based incentive payments to top-performing SNFs than other definitions, though the actual distribution of value-based incentive payments would depend on all SNFs' performance and on the statutory rules governing their distribution. Such a standard would likely result in lower value-based incentive payments to lower-performing SNFs, which could create substantial payment disparities among participating SNFs. Conversely, the 15th percentile would likely result in higher value-based incentive payments for lower-performing SNFs than other thresholds, with the corresponding result of lower value-based incentive-payments for top-performing SNFs compared to other thresholds.

We further propose to define the "benchmark" for quality measures specified under the SNF VBP program as the mean of the top decile of SNF performance on the quality measure during the applicable baseline period. We believe this definition represents demonstrably high but achievable standards of excellence; in other words, the benchmark will reflect observed scores for the group of highest-performing SNFs on a given measure. This proposed benchmark policy aligns with that used by the Hospital VBP Program. As stated in the FY 2016 SNF PPS final rule (80 FR 46419 through 46420), we believe the Hospital VBP Program's performance standards methodology is a well-understood methodology under which health care providers and suppliers can be rewarded both for providing high-quality care and for improving their performance over time. We therefore believe it is appropriate to align with the Hospital VBP Program in setting benchmarks for the SNF VBP Program.

We also propose that SNFs would receive points along an achievement range, which is the scale between the achievement threshold and the benchmark. Under this proposal, SNFs would receive achievement points if they meet or exceed the achievement threshold for the specified measure, and could increase their achievement score based on higher levels of performance. (We describe the proposed scoring methodology, including how we propose to

award points for both achievement and improvement, in the scoring methodology section of this proposed rule). This proposed achievement range policy aligns with that used by the Hospital VBP Program. We refer readers to the FY 2016 SNF PPS final rule (80 FR 46419 through 46420) for a discussion of the rationale behind aligning SNF VBP Program policies with the Hospital VBP Program. As stated in that rule, we believe that the Hospital VBP Program's performance standards methodology is well-understood and would allow us to reward SNFs both for providing high-quality care and for improving their performance over time. We therefore believe it is appropriate to align with the Hospital VBP Program in setting benchmarks for the SNF VBP Program.

At this time, we do not have the complete CY 2015 data set necessary to calculate a numerical value for the proposed achievement threshold for the SNFRM. However, we are able to estimate this numerical value based on the most recent four quarters of SNFRM data available and have provided this estimate in Table 10. We intend to publish the final performance standards using complete data from CY 2015 in the FY 2017 SNF PPS final rule. For clarity, and as discussed further below, we have inverted the SNFRM rate so that a higher rate represents better performance.

TABLE 10: Interim FY 2019 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	**0.79551**	**0.83915**

We welcome public comment on the proposed definitions for achievement performance standards, as well as our intention to publish the final achievement threshold and benchmark for the FY 2019 Program year in the FY 2017 SNF PPS final rule.

(2) Proposed Improvement Performance Standard

Beginning with the FY 2019 SNF VBP program, we propose to define the improvement performance standard (which we will refer to as the "improvement threshold") for quality

measures specified under the SNF VBP program as each specific SNF's performance on the specified measure during the applicable baseline period. As discussed further below, we will measure SNFs' performance during both the proposed performance and baseline periods, and will award improvement points by comparing SNFs' performance to the improvement threshold. We believe this improvement performance standard ensures that SNFs will be adequately incentivized to improve continuously their performance on the quality measures specified under the SNF VBP Program, and appropriately balances our view that we should both reward SNFs for high performance and encourage improved performance over time.

We welcome public comment on this proposal.

(3) Publication of Performance Standard Values

Section 1888(h)(3)(C) of the Act requires the Secretary to establish and announce the performance standards for a given SNF VBP program year not later than 60 days prior to the beginning of the performance period for the FY involved. Based on the proposed performance period of CY 2017 for the FY 2019 SNF VBP Program, we believe that we must establish and announce performance standards for the FY 2019 Program not later than November 1, 2016. We intend to establish and announce performance standards for the Program in the annual SNF PPS rule, which is effective on October 1 of each year.

However, finalizing numerical values of these performance standards is often logistically difficult because it requires the collection and analysis of large amounts of quality measure data in a short period of time. For example, the data file for a full year of SNF claims data is typically completed around May of the following year. To calculate a numerical value for a performance standard, we must perform multiple levels of analyses on the data to ensure that all appropriate SNFs and patients are included in measure calculations; perform the measure calculations themselves; and then use those calculations to determine the numerical value for the performance standards. If any individual step of this process is delayed, it may preclude us from publishing

finalized numerical values for the finalized performance standards in the applicable SNF PPS final rule, which is typically displayed publicly by August 1 of each year.

To retain the flexibility needed to ensure that numerical values published for the finalized performance standards are accurate, we are proposing to publish these numerical values no later than 60 days prior to the beginning of the performance period but, if necessary, outside of notice-and-comment rulemaking. As noted, we intend to publish numerical values for those performance standards in the final rule when practicable. However, in instances in which we cannot complete the necessary analyses in time to include them in the SNF PPS final rule, we propose to publish the numerical values for the performance standards on the QualityNet Web site used by SNFs to receive VBP information as soon as practicable but in no event later than the statutorily required 60 days prior to the beginning of the performance period for the fiscal year involved. In this instance, we would notify SNFs and the public of the publication of the performance standards using a listserv email and posting on the QualityNet News portion of the Web site.

We welcome public comment on this proposal.

4. FY 2019 Performance Period and Baseline Period

a. Background

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46422) for discussion of the considerations that we intended to take into account when specifying a performance period under the SNF VBP Program. We also explained our view that the SNF VBP Program necessitates adoption of a baseline period, similar to those adopted under the Hospital VBP Program and ESRD QIP, which we would use to establish performance standards and measure improvement.

We received public comments on this topic, and we refer readers to the FY 2016 SNF PPS final rule for a summary of those comments and our responses. We considered those comments when developing our performance and baseline period proposals for this proposed

rule.

b. Proposed FY 2019 Performance Period

In considering various performance periods that could apply for the FY 2019 SNF VBP Program, we recognized that we must balance the length of the performance period used to collect quality measure data and the amount of data needed to calculate reliable, valid measure rates with the need to finalize a performance period through notice and comment rulemaking. We are therefore proposing to adopt CY 2017 (January 1, 2017 through December 31, 2017) as the performance period for the FY 2019 SNF VBP Program, with a 90-day run out period immediately thereafter for claims processing, based on the following considerations.

We strive to link performance furnished by SNFs as closely as possible to the payment 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. As such, we anticipate that our annual performance period end date must provide sufficient time for SNFs to submit claims for the patients included in our measure population. Based on past experience with claims processing in other quality reporting and value-based purchasing programs, this time lag between care delivered to patients who are included in readmission measures and application of a payment consequence linked to reporting or performance on those measures has historically been close to one year. We also recognize that other factors contribute to the delay between data collection and payment impacts, including: the processing time needed to calculate measure rates using multiple sources of claims needed for statistical modeling; time for determining achievement and improvement scores; time for providers to review their measure rates and included patients; and processing time needed to determine whether a payment adjustment needs to be made to a provider's reimbursement rate under the applicable PPS based on its performance. Further, our preference is to adopt at least a 12-month period as the performance period, consistent with our

view that using a full year's performance period provides sufficient levels of data accuracy and reliability for scoring SNF performance on the SNFRM and SNFPPR. We also believe that adopting a 12-month period for the performance period supports the direction provided of section 1888(g)(3) of the Act that the quality measures specified under the SNF VBP Program shall be designed to achieve a high level of reliability and validity. Specifically, we believe using a full year of claims data better ensures that the variation found among SNF performance on the measures is due to real differences between SNFs, and not within-facility variation due to issues such as seasonality. Additionally, we believe that adopting 12-month performance and baseline periods enables us to measure SNFs' performance on the specified measures in sequence, which we believe is necessary in order to measure SNFs on both achievement and improvement, as required by section 1888(h)(3)(B) of the Act.

Finally, we also considered the time necessary to calculate SNF-specific performance on the SNFRM after the conclusion of the performance period and to develop and provide SNF VBP scoring reports, including the requirement under section 1888(h)(7) of the Act that we inform each SNF of the adjustments to the SNF's payments as a result of the program not later than 60 days prior to the FY involved. Based on the requirements and concerns discussed above, we believe a 12-month time period is the only operationally feasible performance period for the SNF VBP Program.

We welcome public comment on this proposal.

c. Proposed FY 2019 Baseline Period

As we have done in the Hospital VBP Program and the ESRD QIP, we are proposing to adopt a baseline period for use in the SNF VBP Program.

We propose to adopt calendar year 2015 claims (January 1, 2015 through December 31, 2015) as the baseline period for the FY 2019 SNF VBP Program and to use that baseline period as the basis for calculating performance standards. We will allow for a 90-day claims run out

following the last date of discharge (December 31, 2015) before incorporating the 2015 claims in our database into the measure calculation.

We welcome public comment on this proposal.

5. Proposed SNF VBP Performance Scoring

a. Background

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46422 through 46425) for a discussion of other Medicare VBP scoring methodologies, including the methodologies used by the Hospital VBP Program and HAC Reduction Program. We also discussed policy considerations related to the Hospital Readmission Reduction Program and the ESRD QIP in the performance standards section of that final rule (80 FR 46420 through 46421). We also discussed the potential application of an exchange function (80 FR 46424 through 46425) to translate SNF performance scores into value-based incentive payments under the SNF VBP Program.

We considered those issues, as well as comments we received on these issues, when developing our performance scoring policy below.

b. Proposed SNF VBP Program Scoring Methodology

Section 1888(h)(4)(A) of the Act requires the Secretary develop a methodology for assessing the total performance of each SNF based on the performance standards established under section 1888(h)(3) of the Act for the measure applied under section 1888(h)(2) of the Act. Section 1888(h)(3)(B) of the Act further requires that these performance standards include levels of achievement and improvement and that, in calculating a facility's SNF performance score, the Secretary use the higher of either improvement or achievement.

After carefully reviewing and evaluating a number of scoring methodologies for the SNF VBP Program, we propose to adopt a scoring model for the SNF VBP Program similar conceptually to that used by the Hospital VBP Program and the ESRD QIP, with certain

modifications to allow us to better differentiate between SNFs' performance on the quality measures specified under the SNF VBP Program.[22] We believe this hybrid appropriately accounts for the SNF VBP Program's statutory limitation to a single measure, will maintain consistency and alignment with other VBP programs already in place, and in doing so, better enable SNFs to understand the SNF VBP Program. Specifically, we propose to implement a 0 to 100 point scale for achievement scoring and a 0 to 90 point scale for improvement scoring. In addition, as discussed above, we are proposing to set the achievement threshold for the SNF VBP Program at the 25th percentile of SNF national performance on the quality measure during the baseline period rather than the 50th percentile achievement threshold used in the Hospital VBP Program, though as noted above, we are also seeking comment on whether or not we should consider adopting the 50^{th} percentile or the 15^{th} percentile.

We believe using wider scales of 0 to 100 points and 0 to 90 points instead of the 0 to 10 and 0 to 9 scales used in the Hospital VBP Program and ESRD QIP will allow us to calculate more granular performance scores for individual SNFs and provide greater differentiation between facilities' performance. We further believe that setting the achievement threshold for the SNF VBP Program at the 25th percentile of national SNF performance on the quality measure during the baseline period is preferable to the Hospital VBP Program's achievement threshold of the 50th percentile of national facility performance for this Program because it accounts for the statutory requirement that the SNF VBP Program include only one quality measure at a time. Unlike the Hospital VBP Program, which contains many measures across multiple domains, the SNF VBP Program is limited by statute to a single quality measure at a time. As a result, a hospital participating in the Hospital VBP Program could perform below the

22 We refer readers to the FY 2013 IPPS final rule for a discussion of the Hospital VBP Program scoring methodology (76 FR 2466 through 2470).

50th percentile of national performance on one or more measures without experiencing a dramatic drop in its Total Performance Score because the hospital's performance on other measures would contribute to its total performance score. By contrast, if the SNF VBP Program used an achievement threshold of the 50th percentile of national SNF performance, approximately one-half of all SNFs nationwide would automatically receive 0 achievement points assuming no national improvement trends between baseline and performance periods. While these SNFs could still receive improvement points, we believe it is preferable to set a lower achievement threshold that would award the majority of SNFs at least some achievement points, thereby enabling us to differentiate performance among the lower-performing half of SNFs, and enabling SNFs to continually increase their achievement score based on higher levels of performance. As stated above, as more data becomes available, we will continue to assess the appropriateness of this achievement threshold for the SNF VBP program and, if necessary, propose to refine these standards' definitions and calculation methodologies to better incentivize the provision of high-quality care.

For these reasons, we propose to adopt the following scoring methodology beginning with the FY 2019 SNF VBP Program.

(1) Proposed Scoring of SNF Performance on the SNFRM

Because the SNF VBP Program uses only one measure to incentivize and assess facility performance and improvement, we believe it is important to ensure that SNFs and the public are able to understand these measure scores easily. SNFRM rates represent the percentage of qualifying patients at a facility that were readmitted within the risk window for the measure. As a result, lower SNFRM rates indicate lower rates of readmission, and are therefore an indicator of higher quality care. For example, a SNFRM rate of 0.14159 means that approximately 14.2 percent of qualifying patients discharged from that SNF were readmitted during the risk window. We understand that the use of a "lower is better" rate could cause confusion among SNFs and the

public. Therefore, we propose to calculate scores under the Program by first inverting SNFRM rates using the following calculation:

$$\boldsymbol{SNFRM\ Inverted\ Rate = 1 - Facility's\ SNFRM\ Rate}$$

This calculation inverts SNFs' SNFRM rates such that higher SNFRM performance reflects better performance on the SNFRM. As a result, the same SNFRM rate presented above (0.14159) would result in a SNFRM inverted rate of 0.85841, which means that approximately 86 percent of qualifying patients discharged from that SNF were not readmitted during the risk window. We believe this inversion is important to incentivize improvement in a clear and understandable manner, and will also simplify public reporting of SNF performance for use in consumer, family, and caregiver decision-making. Further, under this proposal, all SNFRM inverted rates would be rounded to the fifth significant digit.

We welcome public comment on this proposal.

(2) Scoring SNFs' Performance Based on Achievement

We propose that a SNF would earn an achievement score of 0 to 100 points based on where its performance on the specified measure fell relative to the achievement threshold (which we propose above to define for the quality measures specified under the SNF VBP program as the 25th percentile of SNF performance on the quality measure during the applicable baseline period) and the benchmark (which we propose to define as the mean of the top decile of SNF performance on the measure during the baseline period). As with the Hospital VBP Program, we propose to award points to SNFs based on their performance as follows:

- If a SNF's SNFRM inverted rate was equal to or greater than the benchmark, the SNF would receive 100 points for achievement;
- If a SNF's SNFRM inverted rate was less than the achievement threshold (that is, the lower bound of the achievement range), the SNF would receive 0 points for achievement.
- If a SNF's SNFRM inverted rate was equal to or greater than the achievement

threshold, but less than the benchmark, we would award between 0 and 100 points to the SNF according to the following formula:

$$\boldsymbol{SNF\ Achievement\ Score} = \left(\left[\boldsymbol{9\ x}\ \left(\frac{(\boldsymbol{SNF's\ Perf.Period\ Inverted\ Rate - Achievement\ Threshold})}{(\boldsymbol{Benchmark - Achievement\ Threshold})}\right)\right] + .\boldsymbol{5}\right)\boldsymbol{x\ 10}$$

The results of this formula would be rounded to the nearest whole number.

The SNF achievement score would therefore range between 0 and 100 points, with a higher achievement score indicating higher performance.

We welcome public comment on this proposal.

(3) Scoring SNF Performance Based on Improvement

We propose that a SNF would earn an improvement score of 0 to 90 points based on how much its performance on the specified measure during the performance period improved from its performance on the measure during the baseline period. Under this proposal, a unique improvement range would be established for each SNF that defines the distance between the SNF's baseline period score and the national benchmark for the measure (which we propose to define as the mean of the top decile of SNF performance on the measure during the baseline period). We would then calculate a SNF improvement score for each SNF depending on its performance period score:

- If the SNF's performance period score was equal to or lower than its improvement threshold, the SNF would receive 0 points for improvement.
- If the SNF's performance period score was equal to or higher than the benchmark, the SNF would receive 90 points for improvement.
- If the SNF's performance period score was greater than its improvement threshold, but less than the benchmark, we would award between 0 and 90 points for improvement according to the following formula:

$$\textbf{\textit{SNF Improvement Score}}$$

$$= \left(\left[\mathbf{10}\,\boldsymbol{x}\left(\frac{(\textbf{\textit{SNF Perf. Period Inverted Rate}} - \textbf{\textit{SNF Baseline Period Inverted Rate}})}{(\textbf{\textit{Benchmark}} - \textbf{\textit{SNF Baseline Period Inverted Rate}})}\right)\right] - .\mathbf{5}\right)\ \mathbf{x\ 10}$$

The results of this formula would be rounded to the nearest whole number.

We welcome public comment on this proposal.

(4) Establishing SNF Performance Scores

Consistent with sections 1888(h)(3)(B) and 1888(h)(4)(A) of the Act, we propose to use the higher of a SNF's achievement and improvement scores to serve as the SNF's performance score for a given year of the SNF VBP Program. The resulting SNF performance score would be used as the basis for ranking SNF performance on the quality measures specified under the SNF VBP Program and establishing the value-based incentive payment percentage for each SNF for a given FY.

(5) Examples of the Proposed FY 2019 SNF VBP Program Scoring Methodology

In this section, we provide two examples to illustrate the proposed scoring methodology for the FY 2019 SNF VBP Program using hypothetical SNFs A, B, and C. The benchmark calculated for the SNFRM for all of these hypotheticals is 0.83915 (the mean of the top decile of SNF performance on the SNFRM in 2014), and the achievement threshold is 0.79551 (the 25th percentile of national SNF performance on the SNFRM in 2014). We note that, as discussed previously, our proposal for scoring SNF performance on the SNFRM inverts the measure rates so that a higher rate represents better performance.

Figure AA shows the scoring for SNF A. SNF A's SNFRM rate of 0.15025 means that approximately 15 percent of qualifying patients discharged from SNF A were readmitted during the 30-day risk window. Under the proposed SNFRM scoring methodology, SNF A's SNFRM inverted rate would be calculated as follows:

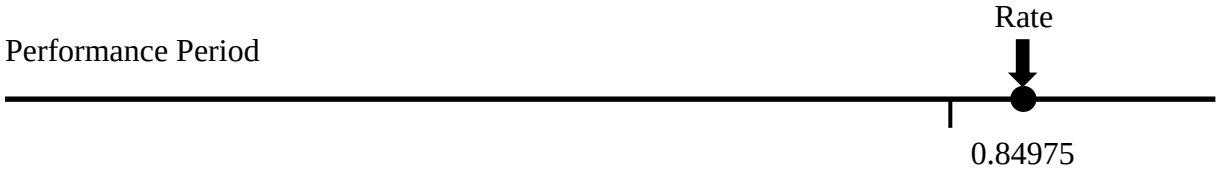
$$\textbf{\textit{Facility A SNFRM Inverted Rate}} = \mathbf{1 - 0.15025}$$

As a result of this calculation, Facility A's SNFRM inverted rate would be 0.84975 on the

SNFRM for the performance period. This result indicates that approximately 85 percent of SNF A's qualifying patients were not readmitted during the 30-day risk window. Because SNF A's SNFRM inverted rate of 0.84975 exceeds the benchmark (that is, the mean of the top decile of facility performance, or 0.83915), SNF A would receive 100 points for achievement. Because SNF A has earned the maximum number of points possible for the SNFRM, its improvement score would not be calculated.

FIGURE AA: SNF A Performance Scoring

SNF A Performance



SNF A Earns: 100 points for achievement performance exceeding the benchmark during the performance period
SNF A's SNF Performance Score: 100 points

Figure BB shows the scoring for SNF B. As can be seen below, SNF B's performance on the SNFRM went from 0.21244, for a SNFRM inverted rate of 0.78756 (below the achievement threshold) in the baseline period to 0.18322, for a SNFRM inverted rate of 0.81668 (above the achievement threshold) in the performance period. Applying the achievement scoring methodology proposed above, SNF B would earn [49] achievement points for this measure, calculated as follows:

$$\boldsymbol{SNF\ Achievement\ Score} = \left(\left[\mathbf{9}\ \boldsymbol{x}\ \left(\frac{(\mathbf{0.81668} - \mathbf{0.79551})}{(\mathbf{0.83915} - \mathbf{0.79551})}\right)\right] + \mathbf{.5}\right)\ \boldsymbol{x}\ \mathbf{10}$$

$$\boldsymbol{SNF\ Achievement\ Score} = \left(\left[9\ x\ \left(\frac{(0.02117)}{(0.04364)}\right)\right] + .5\right)\ x\ 10$$

$$\boldsymbol{SNF\ Achievement\ Score} = ([9\ x\ (0.48511)] + .5)\ x\ 10$$

$$\boldsymbol{SNF\ Achievement\ Score} = ([4.3659] + .5)\ x\ 10$$

$$\boldsymbol{SNF\ Achievement\ Score} = 4.8659\ x\ 10$$

$$\boldsymbol{SNF\ Achievement\ Score} = 49$$

However, because SNF B's performance during the performance period is greater than its performance during the baseline period, but below the benchmark, we would calculate an improvement score as well. According to the improvement scale, based on SNF B's improved SNFRM inverted rate from 0.78756 to 0.81668, SNF B would receive 51 improvement points, calculated as follows:

$$\boldsymbol{SNF\ Improvement\ Score} = \left(\left[10\ x\ \left(\frac{(0.81668 - 0.78756)}{(0.83915 - 0.78756)}\right)\right] - .5\right)\ x\ 10$$

$$\boldsymbol{SNF\ Improvement\ Score} = \left(\left[10\ x\ \left(\frac{(0.02912)}{(0.05159)}\right)\right] - .5\right)\ x\ 10$$

$$\boldsymbol{SNF\ Improvement\ Score} = ([10\ x\ (0.56445)] - .5)\ x\ 10$$

$$\boldsymbol{SNF\ Improvement\ Score} = ([5.6445] - .5)\ x\ 10$$

$$\boldsymbol{SNF\ Improvement\ Score} = 5.1445\ x\ 10$$

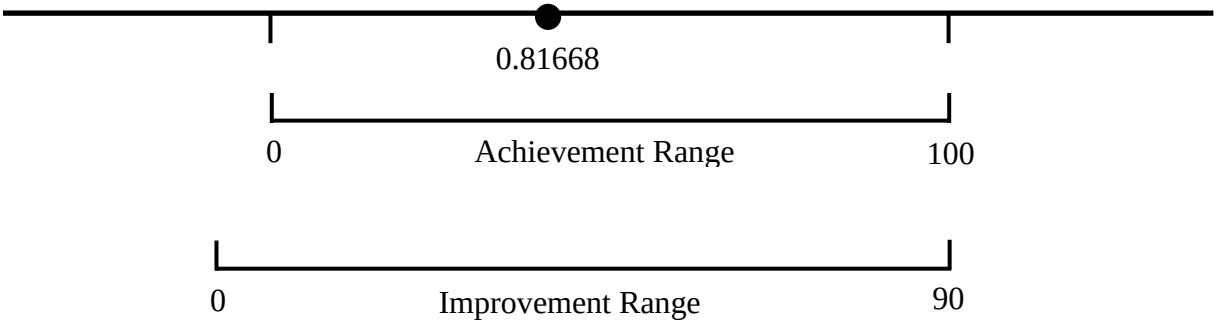
$$\boldsymbol{SNF\ Improvement\ Score} = 51$$

FIGURE BB: SNF B Performance Scoring

SNF B Performance

Baseline Period

Performance Period

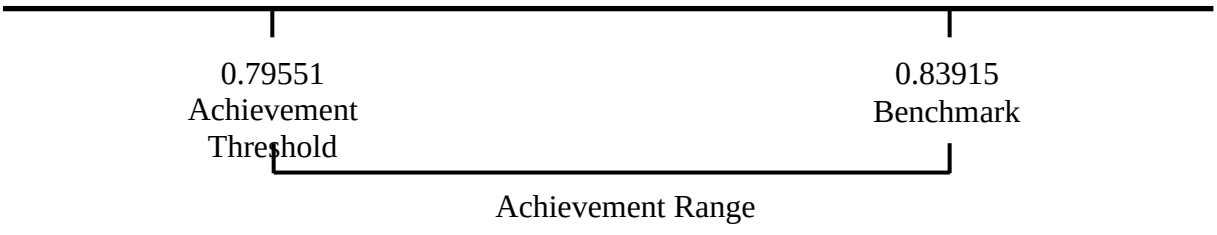


SNF B Earns: 49 points for achievement performance
51 points for improvement performance

SNF B SNF Performance Score: Higher of achievement or improvement
51 points

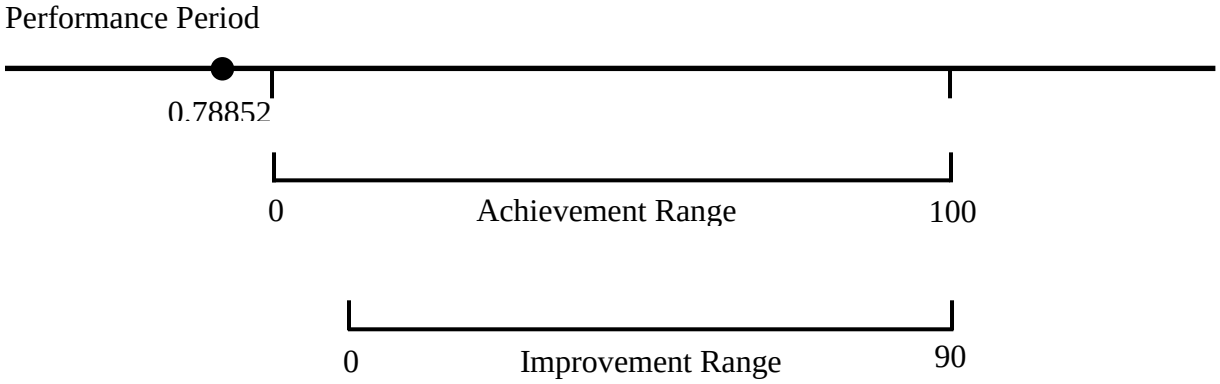
In Figure CC, SNF C's performance on the SNFRM drops from 0.19487, for a SNFRM inverted rate of 0.80513, in the baseline period to 0.21148, for a SNFRM inverted rate 0.78852, in the performance period (a decline of 0.01661). Because this SNF's performance during the performance period is lower than the achievement threshold of 0.79551, it receives 0 points based on achievement. It would also receive 0 points for improvement, because its performance during the performance period is lower than its performance period during the baseline period. In this example, SNF C would receive 0 points for its SNF performance score.

FIGURE CC: SNF C Performance Scoring



SNF C Performance

Baseline Period



SNF C Earns: 0 points for achievement performance
0 points for improvement performance

SNF C SNF Performance Score: Higher of achievement or improvement
0 points

6. SNF Value-Based Incentive Payments

a. Background

Paragraphs (5), (6), (7), and (8) of section 1888(h) outline several requirements for value-based incentive payments under the SNF VBP Program. Section 1888(h)(5)(A) of the Act requires that the Secretary increase the adjusted Federal per diem rate for skilled nursing facilities by the value-based incentive payment amount determined under subsection (h)(5)(B). That amount is to be determined by the product of the adjusted Federal per diem rate and the value-based incentive payment percentage specified under subsection (h)(5)(C) of such section for each SNF for a FY.

Section 1888(h)(5)(C) requires that the value-based incentive payment percentage be based on the SNF performance score and must be appropriately distributed so that the highest-ranked SNFs receive the highest payments, the lowest-ranked SNFs receive the lowest payments, and that the payment rate for services furnished by SNFs in the lowest 40 percent of the rankings be less than would otherwise apply. Finally, the total amount of value-based incentive payments

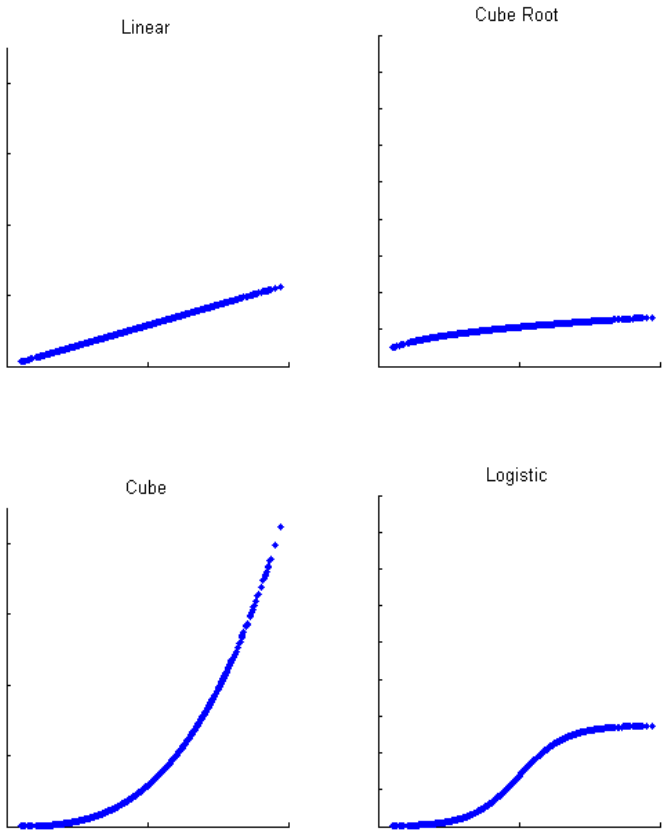
must be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for the FY specified under section 1888(h)(6) of the Act, as estimated by the Secretary. As discussed further below, we will propose to adopt in future rulemaking an exchange function to ensure that the total amount of value-based incentive payments made under the program each year meets those criteria.

Section 1888(h)(7) of the Act requires the Secretary, not later than 60 days prior to the fiscal year involved, to inform each SNF of the adjustments to its Medicare payments for services furnished by the SNF during the FY. Section 1888(h)(8) of the Act requires that the value-based incentive payment and payment reduction only apply for the FY involved, and not be taken into account in making payments to a SNF in a subsequent year.

b. Request for Comment on Exchange Function

As we discussed in the FY 2016 SNF PPS final rule (80 FR 46424 through 46425), we use a linear exchange function to translate a hospital's Total Performance Score under the Hospital VBP Program into the percentage multiplier to be applied to each Medicare discharge claim submitted by the hospital during the applicable FY. We intend to adopt a similar methodology to translate SNF performance scores into value-based incentive payment percentages under the SNF VBP Program. When considering that methodology, we sought public comments on the appropriate form and slope of the exchange function to determine how best to reward high performance and encourage SNFs to improve the quality of care provided to Medicare beneficiaries. As illustrated in Figure DD, we considered the following four mathematical exchange function options: Straight line (linear); concave curve (cube root function); convex curve (cube function); and S-shape (logistic function).

FIGURE DD: Exchange Function Options.



We received numerous public comments on the FY 2016 SNF PPS proposed rule, and we seek further public comments to inform our policies on this topic. For example, one commenter suggested that a linear exchange function would be the most transparent option for SNFs, which would assist in their quality improvement efforts. We request additional public comments on the specific form of the exchange function that we should propose in the future, including any additional forms beyond the four examples that we have illustrated above, and any considerations we should take into account when selecting an exchange function form that would best support quality improvement in SNFs.

Additionally, we will determine the precise slope of the exchange function after the performance period has concluded, because the distribution of SNFs' performance scores will form the basis for value-based incentive payments under the program. However, two additional considerations will affect the exchange function's slope. As required in section 1888(h)(5)(C)(ii)(II)(cc) of the Act, SNFs in the lowest 40 percent of the ranking determined

under paragraph (4)(B) must receive a payment that is less than the payment rate for such services that would otherwise apply. Additionally, as described in this section, section 1888(h)(5)(C)(ii)(III) of the Act requires that the total amount of value-based incentive payments under the Program be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of reductions to SNFs' payments for the FY, as estimated by the Secretary. We intend to ensure that both of these requirements, as well as all other statutory requirements under the Program, are fulfilled when we specify the exchange function's slope.

We welcome public comments on this topic.

7. SNF VBP Reporting

a. Confidential Feedback Reports

Section 1888(g)(5) of the Act requires that we provide quarterly confidential feedback reports to SNFs on their performance on the measures specified under sections 1888(g)(1) and (2) of the Act. Section 1888(g)(5) of the Act also requires that we begin providing those reports on October 1, 2016.

In order to meet the statutory deadline, we are developing the feedback reports, operational systems, and implementation guidance related to those reports. We intend to provide these reports to SNFs via the QIES system CASPER files currently used by SNFs to report quality performance. We welcome public comments on the appropriateness of the QIES system, and any considerations we should take into account when designing and providing these feedback reports.

b. Proposed Two-Phase SNF VBP Data Review and Correction Process

(1) Background

Section 1888(g)(6) of the Act requires the Secretary to establish procedures to make public performance information on the measures specified under paragraphs (1) and (2) of such section. The procedures must ensure that a SNF has the opportunity to review and submit

corrections to the information that will be made public for the facility prior to its being made public. This public reporting is also required by statute to begin no later than October 1, 2017. Additionally, section 1888(h)(9) of the Act requires the Secretary to make available to the public information regarding SNFs' performance under the SNF VBP Program, specifically including each SNF's performance score and the ranking of SNFs for each fiscal year.

Accordingly, we are proposing to adopt a two-phase review and correction process for (1) SNFs' measure data that will be made public under section 1888(g)(6) of the Act, which will consist of each SNFs' performance on the measures specified under sections 1888(g)(1) and (2) of the Act, and (2) SNFs' performance information that will be made public under section 1888(h)(9).

(2) Phase One: Review and Correction of SNFs' Quality Measure Information

We view the quarterly confidential feedback reports described above as one possible means to provide SNFs an opportunity to review and provide corrections to their performance information. However, collecting SNF measure data and calculating measure performance scores takes a number of months following the end of a measurement period. Because it is not feasible to provide SNFs with an updated measure rate for each quarterly report or engage in review and corrections on a quarterly basis, we propose to use one of the four reports each year to provide SNFs an opportunity to review their data slated for public reporting. In this specific quarterly report, we intend to provide SNFs: (1) a count of readmissions; (2) the number of eligible stays at the SNF; (3) the SNF's risk-standardized readmissions ratio; and (4) the national SNF measure performance rate. In addition, we intend to provide the patient-level information used in calculating the measure rate. However, we seek comment on what patient-level information would be most useful to SNFs, and how we should make this information available if requested. We intend to address the topic of what specific information will be provided if requested in this specific quarterly report in future rulemaking, where we intend to propose a

process for SNFs' requests for patient-level data. We intend to notify SNFs of this report's release via listserv email and posting on the QualityNet News portion of the Web site.

Therefore, we propose to fulfill the statutory requirement that SNFs have an opportunity to review and correct information that is to be made public under section 1888(g)(6) of the Act by providing SNFs with an annual confidential feedback report that we intend to provide via the QIES system CASPER files. We further propose that SNFs must, if they believe the report's contents to be in error, submit a correction request to SNFVBPinquiries@cms.hhs.gov with the following information:

- SNF's CMS Certification Number (CCN).
- SNF Name.
- The correction requested and the SNF's basis for requesting the correction. More specifically, the SNF must identify the error for which it is requesting correction, and explain its reason for requesting the correction. The SNF must also submit documentation or other evidence, if available, supporting the request. Additionally, any requests made during phase one of the proposed process will be limited to the quality measure information at issue.

We further propose that SNFs must make any correction requests within 30 days of posting the feedback report via the QIES system CASPER files, not counting the posting date itself. For example, if we provide reports on October 1, 2017, SNFs must review those reports and submit any correction requests by October 31, 2017. We will not consider any requests for correction to quality measure data that are received after the close of the first phase of the proposed review and correction process. As discussed further below, any corrections sought during phase two of the proposed process will be limited to the SNF performance score calculation and the ranking.

We will review all timely phase one correction requests that we receive and will provide responses to SNFs that have requested corrections as soon as practicable.

(3) Phase Two: Review and Correction of SNF Performance Scores and Ranking

As required by section 1888(h)(7) of the Act, we intend to inform each SNF of its payment adjustments as a result of the SNF VBP Program not later than 60 days prior to the fiscal year involved. For the FY 2019 SNF VBP Program, we intend to notify SNFs of those payment adjustments via a SNF performance score report not later than 60 days prior to October 1, 2018. We intend to address the specific contents of that report in future rulemaking.

In that report, however, we also intend to provide SNFs with their SNF performance scores and ranking. By doing so, we intend to use the performance score report's provision to SNFs as the beginning of the second phase of the proposed review and correction process. By completing phase one, SNFs will have an opportunity to verify that their quality measure data are fully accurate and complete, and as a result, phase two will be limited only to corrections to the SNF performance score's calculation and the SNF's ranking. Any requests to correct quality measure data that are received during phase two will be denied.

We intend to set out specific requirements for phase two of the proposed review and correction process in future rulemaking. To inform those proposals, we seek comments on what information would be most useful for us to provide to SNFs to facilitate their review of their SNF performance scores and ranking. As with the phase one process, we intend to adopt a 30-day time period for phase two review and corrections, beginning with the date on which we provide SNF performance score reports.

We welcome public comments on this proposed two-phase review and correction process.

c. SNF VBP Public Reporting

Section 1888(h)(9)(A) of the Act requires that we make available to the public on the Nursing Home Compare website or its successor information regarding the performance of individual SNFs with respect to a FY, including the performance score for each SNF for the FY,

and each SNF's ranking, as determined under paragraph (4)(B) of such section. Additionally, section 1888(h)(9)(B) of the Act requires that we periodically post aggregate information on the SNF VBP Program on the Nursing Home Compare website or its successor, including the range of SNF performance scores, and the number of SNFs receiving value-based incentive payments and the range and total amount of those payments.

We intend to address this topic in future rulemaking. However, we welcome public comments on the best means by which to display the SNF-specific and aggregate performance information for public consumption.

d. Ranking SNF Performance

Section 1888(h)(4)(B) of the Act requires ranking the SNF performance scores determined under paragraph (A) of such section from low to high. Additionally, and as discussed in this section, we are required to publish the ranking of SNF performance scores for a FY on Nursing Home Compare or a successor Web site.

To meet these requirements, we propose to order SNF performance scores from low to high and publish those rankings on both the Nursing Home Compare and QualityNet Web sites. However, because SNF performance scores will not be calculated until after the performance period concludes after CY 2017 (that is, during CY 2018), and because SNFs must be provided their value-based incentive payment adjustments not later than 60 days prior to the FY involved, we intend to publish the ranking for FY 2019 SNF VBP payment implications after August 1, 2018.

We welcome public comments on the most appropriate format and website for the ranking's publication.

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

1. Background and Statutory Authority

We seek to promote higher quality and more efficient health care for Medicare beneficiaries, and our efforts are furthered by QRPs coupled with public reporting of that information.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) added section 1899B to the Act that imposed new data reporting requirements for certain PAC providers, including SNFs, and required that the Secretary implement a SNF quality reporting program (SNF QRP). Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the time frames specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the time frames specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and on standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary must reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points. The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals.

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429) for information on the and requirements of the IMPACT Act

In the FY 2016 SNF PPS final rule, we finalized the general timeline and sequencing of activities under the SNF QRP. Please refer to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429) for more information on these topics.

In addition, in implementing the SNF QRP and IMPACT Act requirements in the FY 2016 SNF PPS final rule, we established our approach for identifying cross-setting measures and processes for the adoption of measures including the application and purpose of the Measures Application Partnership (MAP) and the notice and comment rulemaking process. For more information on these topics, please refer to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429).

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

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431) for a detailed discussion of the considerations we apply in measure selection for the SNF QRP, such as alignment with the CMS Quality Strategy,[23] which incorporates the three broad aims of the National Quality Strategy:[24] Overall, we strive to promote high quality and efficiency in the delivery of health care to the beneficiaries we serve. Performance improvement leading to the highest quality health care requires continuous evaluation to identify and address performance gaps and reduce the unintended consequences that may arise in treating a large, vulnerable, and aging population. QRPs, coupled with public reporting of quality information, are critical to the advancement of health care quality improvement efforts. Valid, reliable, and relevant quality measures are fundamental to the effectiveness of our QRPs. Therefore, selection of quality measures is a priority for CMS in all of its QRPs.

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23 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html
24 http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm

In this proposed rule, we propose to adopt for the SNF QRP one measure that we are specifying under section 1899B(c)(1)(C) of the Act to meet the Medication Reconciliation domain: (1)Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care Skilled Nursing Facility Quality Reporting Program. Further, we are proposing to adopt for the SNF QRP three measures to meet the resource use and other measure domains identified in section 1899B(d)(1) of the Act: (1) Medicare Spending per Beneficiary- Post-Acute Care Skilled Nursing Facility Quality Reporting Program; (2) Discharge to Community- Post Acute Care Skilled Nursing Facility Quality Reporting Program; and (3) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program.

In our selection and specification of measures, we employ a transparent process in which we seek input from stakeholders and national experts and engage in a process that allows for pre-rulemaking input on each measure, as required by section 1890A of the Act.

To meet this requirement, we provided the following opportunities for stakeholder input. Our measure development contractor convened technical expert panels (TEPs) that included stakeholder experts and patient representatives on July 29, 2015 for the Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, on August 25, 2015, September 25, 2015, and October 5, 2015 for the Discharge to Community-PAC SNF QRP, on August 12 and 13, 2015 and October 14, 2015 for the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP, and on October 29 and 30, 2015 for the Medicare Spending per Beneficiary measures. In addition, we released draft quality measure specifications for public comment on the Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP from September 18, 2015 to October 6, 2015, for the Discharge to Community-PAC SNF QRP from November 9, 2015 to December 8, 2015, for the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP from November 2, 2015 to

December 1, 2015, and for the Medicare Spending per Beneficiary measures from January 13, 2016 to February 5, 2016. Further, we implemented a public mailbox, PACQualityInitiative@cms.hhs.gov, for the submission of public comments. This PAC mailbox is accessible on our post-acute care quality initiatives Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html.

Additionally, we sought public input from the MAP PAC, Long-Term Care Workgroup during the annual in-person meeting held December 14 and 15, 2015. The final map report is available at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx. The MAP is composed of multi-stakeholder groups convened by the NQF, our current contractor under section 1890(a) of the Act, tasked to provide input on the selection of quality and efficiency measures described in section 1890(b)(7)(B) of the Act.

The MAP reviewed each measure proposed in this rule for use in the SNF QRP. For more information on the MAP, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46430 through 46431). Further, for more information on the MAP's recommendations, we refer readers to the MAP 2015-2016 Considerations for Implementing Measures in Federal Programs public report at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

3. Policy for Retaining SNF QRP Measures Adopted for Future Payment Determinations

In the FY 2016 SNF PPS final rule (80 FR 46431 through 46432), we finalized our policy for measure removal and also finalized that when we adopt a measure for the SNF QRP for a

payment determination, this measure will be automatically retained in the SNF QRP for all subsequent payment determinations unless we propose to remove, suspend, or replace the measure. We are not proposing any new policies related to measure retention or removal. For further information on how measures are considered for removal, suspension, or replacement, please refer to the FY 2016 SNF PPS Final Rule (80 FR 46431 through 46432).

4. Process for Adoption of Changes to SNF QRP Measures

In the FY 2016 SNF PPS final rule (80 FR 46432), we finalized our policy pertaining to the process for adoption of non-substantive and substantive changes to SNF QRP measures. We are not proposing in this proposed rule to make any changes to this policy.

5. Quality Measures Previously Finalized for Use in the SNF QRP

The SNF QRP quality measures for the FY 2018 payment determinations and subsequent years are presented in Table 12. Measure specifications for the previously adopted measures adapted from non-SNF settings are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html under the downloads section at the bottom of the page.

TABLE 12: Quality Measures Previously Finalized for Use in the SNF QRP

Measure Title and NQF #	SNF PPS Final Rule	Data Collection Start Date	Annual Payment Determination: Initial and Subsequent APU Years
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)	Adopted in the FY 2016 SNF PPS Final Rule (80 FR 46433 through 46440)	October 1, 2016	FY 2018 and subsequent years
Application of the NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	Adopted in the FY 2016 SNF PPS Final Rule (80 FR 46440 through 46444)	October 1, 2016	FY 2018 and subsequent years
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	Adopted in the FY 2016 SNF PPS Final Rule (80 FR 46444 through 46453)	October 1, 2016	FY 2018 and subsequent years

6. SNF QRP Quality, Resource Use and Other Measures for FY 2018 Payment Determinations and Subsequent Years

For the FY 2018 payment determination and subsequent years, in addition to the quality measures identified in Table 12 that we are retaining under our policy described in section V.B.3., we are proposing three new measures for the SNF QRP. These three proposed measures were developed to meet the requirements of the IMPACT Act. They are: (1) Medicare Spending per Beneficiary-PAC SNF QRP; (2) Discharge to Community-PAC SNF QRP; and (3) Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP. The measures are described in more detail below.

For the risk adjustment of the resource use and other measures, we understand the important role that sociodemographic status plays in the care of patients. However, we continue to have concerns about holding providers to different standards for the outcomes of their patients of diverse sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of sociodemographic status on providers' results on our measures.

The NQF is currently undertaking a 2-year trial period in which new measures and measures undergoing maintenance review will be assessed to determine if risk-adjusting for sociodemographic factors is appropriate. For 2-years, NQF will conduct a trial of temporarily allowing inclusion of sociodemographic factors in the risk-adjustment approach for some performance measures. At the conclusion of the trial, NQF will issue recommendations on future permanent inclusion of sociodemographic factors. During the trial, measure developers are expected to submit information such as analyses and interpretations as well as performance scores with and without sociodemographic factors in the risk adjustment model.

Furthermore, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program as directed by the IMPACT Act. We will closely examine the findings of the ASPE reports and related Secretarial recommendations and consider how they apply to our quality programs at such time as they are available.

We are inviting public comment on how socioeconomic and demographic factors should be used in risk adjustment for the resource use and other measures.

a. Proposal to Address the IMPACT Act Domain of Resource Use and Other Measures: Total Estimated MSPB-PAC SNF QRP

We are proposing an MSPB-PAC SNF QRP measure for inclusion in the SNF QRP for the FY 2018 payment determination and subsequent years. Section 1899B(d)(1)(A) of the Act requires the Secretary to specify resource use measures, including total estimated Medicare spending per beneficiary, on which PAC providers consisting of SNFs, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs) are required to submit necessary data specified by the Secretary.

Rising Medicare expenditures for post-acute care as well as wide variation in spending for these services underlines the importance of measuring resource use for providers rendering these services. Between 2001 and 2013, Medicare PAC spending grew at an annual rate of 6.1 percent and doubled to $59.4 billion, while payments to inpatient hospitals grew at an annual rate of 1.7 percent over this same period.[25] A study commissioned by the Institute of Medicine found that variation in PAC spending explains 73 percent of variation in total Medicare spending across the United States.[26]

We reviewed the NQF's consensus-endorsed measures and were unable to identify any NQF-endorsed resource use measures for PAC settings. As such, we are proposing this MSPB-PAC SNF measure under the Secretary's authority to specify non-NQF-endorsed measures under section 1899B(e)(2)(B) of the Act. Given the current lack of resource use measures for PAC settings, our proposed MSPB-PAC SNF measure has the potential to provide valuable information to SNF providers on their relative Medicare spending in delivering services to approximately 1.7 million Medicare beneficiaries.[27]

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25 MedPAC, "A Data Book: Health Care Spending and the Medicare Program," (2015). 114
26 Institute of Medicine, "Variation in Health Care Spending: Target Decision Making, Not Geography," (Washington, DC: National Academies 2013). 2
[27] 2013 figures. MedPAC, "Medicare Payment Policy," Report to the Congress (2015). xvii-xviii

The proposed MSPB-PAC SNF episode-based measure will provide actionable and transparent information to support SNF providers' efforts to promote care coordination and deliver high quality care at a lower cost to Medicare. The MSPB-PAC SNF measure holds SNF providers accountable for the Medicare payments within an "episode of care" (episode), which includes the period during which a patient is directly under the SNF's care, as well as a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF. MSPB-PAC SNF episodes, constructed according to the methodology described below, have high levels of Medicare spending with substantial variation. In FY 2014, Medicare FFS beneficiaries experienced 1,534,773 MSPB-PAC episodes triggered by admission to a SNF. The mean payment-standardized, risk-adjusted episode spending for these episodes is $26,279. There is substantial variation in the Medicare payments for these MSPB-PAC SNF episodes - ranging from approximately $6,090 at the 5th percentile to approximately $60,050 at the 95th percentile. This variation is partially driven by variation in payments occurring following SNF treatment.

Evaluating Medicare payments during an episode creates a continuum of accountability between providers and has the potential to improve post-treatment care planning and coordination. While some stakeholders throughout the measure development process supported the measures and felt that measuring Medicare spending was critical for improving efficiency, others believed that resource use measures did not reflect quality of care in that they do not take into account patient outcomes or experience beyond those observable in claims data. However, SNFs involved in the provision of high-quality PAC care as well as appropriate discharge planning and post-discharge care coordination would be expected to perform well on this measure since beneficiaries would likely experience fewer costly adverse events (for example, avoidable hospitalizations, infections, and emergency room usage). Further, it is important that

the cost of care be explicitly measured so that, in conjunction with other quality measures, we can recognize providers that are involved in the provision of high quality care at lower cost.

We have undertaken development of MSPB-PAC measures for each of the four PAC settings. We are proposing an LTCH-specific MSPB-PAC measure in the FY 2017 IPPS/LTCH proposed rule published elsewhere in this issue of the **Federal Register** and an IRF-specific MSBP-PAC measure in the FY 2017 IRF PPS proposed rule published elsewhere in this issue of the **Federal Register**. We intend to propose a HHA-specific MSBP-PAC measure through future notice-and-comment rulemaking. The four setting-specific MSPB-PAC measures are closely aligned in terms of episode construction and measure calculation. Each of the MSPB-PAC measures assess Medicare Part A and Part B spending within an episode, and the numerator and denominator are defined similarly for each of the MSPB-PAC measures. However, developing setting-specific measures allows us to account for differences between settings in payment policy, the types of data available, and the underlying health characteristics of beneficiaries.

The MSPB-PAC measures mirror the general construction of the inpatient prospective payment system (IPPS) hospital MSPB measure that was finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51618 through 51627). It was endorsed by the NQF on December 6, 2013 and has been used in the Hospital Value-Based Purchasing (VBP) Program (NQF #2158) since FY 2015.[28] The hospital MSPB measure was originally established under the authority of section 1886(o)(2)(B)(ii) of the Act. The hospital MSPB measure evaluates hospitals' Medicare spending relative to the Medicare spending for the national median hospital within a hospital

[28] QualityNet, "Measure Methodology Reports: Medicare Spending Per Beneficiary (MSPB) Measure," (2015). http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772053996

MSPB episode. It assesses Medicare Part A and Part B payments for services performed by hospitals and other healthcare providers within a hospital MSPB episode, which is comprised of the periods immediately prior to, during, and following a patient's hospital stay.[29, 30] Similarly, the MSPB-PAC measures assess all Medicare Part A and Part B payments for fee-for-service (FFS) claims with a start date during the episode window (which, as discussed in this section, is the time period during which Medicare FFS Part A and Part B services are counted towards the MSPB-PAC SNF episode). There are however differences between the MSPB-PAC measures, as proposed, and the hospital MSPB measure to reflect differences in payment policies and the nature of care provided in each PAC setting. For example, the MSPB-PAC measures exclude a limited set of services (for example, for clinically unrelated services) provided to a beneficiary during the episode window while the hospital MSPB measure does not exclude any services

MSPB-PAC episodes may begin within 30 days of discharge from an inpatient hospital as part of a patient's trajectory from an acute to a PAC setting. A SNF stay beginning within 30 days of discharge from an inpatient hospital will therefore be included once in the hospital's MSPB measure, and once in the SNF provider's MSPB-PAC measure. Aligning the hospital MSPB and MSPB-PAC measures in this way creates continuous accountability and aligns incentives to improve care planning and coordination across inpatient and PAC settings.

We have sought and considered the input of stakeholders throughout the measure development process for the MSPB-PAC measures. We convened a TEP consisting of 12 panelists with combined expertise in all of the PAC settings on October 29 and 30, 2015 in Baltimore, Maryland. A follow-up email survey was sent to TEP members on November 18,

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[29] QualityNet, "Measure Methodology Reports: Medicare Spending Per Beneficiary (MSPB) Measure," (2015). http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772053996
[30] FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51619).

2015 to which seven responses were received by December 8, 2015. The MSPB-PAC TEP Summary Report is available at 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. The measures were also presented to the MAP Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup on December 15, 2015. As the MSPB-PAC measures were under development, there were three voting options for members: encourage continued development, do not encourage further consideration, and insufficient information.[31] The MAP PAC/LTC workgroup voted to "encourage continued development" for each of the MSPB-PAC measures.[32] The MAP PAC/LTC workgroup's vote of "encourage continued development" was affirmed by the MAP Coordinating Committee on January 26, 2016.[33] The MAP's concerns about the MSPB-PAC measures, as outlined in their final report "MAP 2016 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care" and Spreadsheet of Final Recommendations, were taken into consideration during the measure development process and are discussed as part of our responses to public comments, described below.[34, 35]

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[31] National Quality Forum, Measure Applications Partnership, "Process and Approach for MAP Pre-Rulemaking Deliberations, 2015-2016" (February 2016) http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81693

[32] National Quality Forum, Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup, "Meeting Transcript - Day 2 of 2" (December 15, 2015) 104-106 http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81470

[33] National Quality Forum, Measure Applications Partnership, "Meeting Transcript – Day 1 of 2" (January 26, 2016) 231-232 http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81637

[34] National Quality Forum, Measure Applications Partnership, "MAP 2016 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care" Final Report, (February 2016) http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx

[35] National Quality Forum, Measure Applications Partnership, "Spreadsheet of MAP 2016 Final Recommendations" (February 1, 2016) http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81593

Since the MAP's review and recommendation of continued development, CMS has continued to refine risk adjustment models and conduct measure testing for the IMPACT Act measures in compliance with the MAP's recommendations. The proposed IMPACT Act measures are both consistent with the information submitted to the MAP and support the scientific acceptability of these measures for use in quality reporting programs.

In addition, a public comment period, accompanied by draft measures specifications, was originally open from January 13 to 27, 2016 and twice extended to January 29 and February 5. A total of 45 comments on the MSPB-PAC measures were received during this 3.5 week period. The comments received also covered each of the MAP's concerns as outlined in their Final Recommendations.[36] The MSPB-PAC Public Comment Summary Report is available at 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 and contains the public comments (summarized and verbatim), along with our responses including statistical analyses. If finalized, the MSPB-PAC SNF measure, along with the other MSPB-PAC measures, as applicable, would be submitted for NQF endorsement.

To calculate the MSPB-PAC SNF measure for each SNF provider, we first define the construction of the MSPB-PAC SNF episode, including the length of the episode window as well as the services included in the episode. Next, we apply the methodology for the measure calculation. The specifications are discussed further in this section. More detailed specifications for the proposed MSPB-PAC measures, including the MSPB-PAC SNF measure that we are proposing in this proposed rule, is available at https://www.cms.gov/Medicare/Quality-

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[36] National Quality Forum, Measure Applications Partnership, "Spreadsheet of MAP 2016 Final Recommendations" (February 1, 2016) http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81593

Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

(1) Episode Construction

An MSPB-PAC SNF episode begins at the episode trigger, which is defined as the patient's admission to a SNF. This admitting facility is the attributed provider, for whom the MSPB-PAC SNF measure is calculated. The episode window is the time period during which Medicare FFS Part A and Part B services are counted towards the MSPB-PAC SNF episode. Because Medicare FFS claims are already reported to the Medicare program for payment purposes, SNF providers will not be required to report any additional data to CMS for calculation of this measure. Thus, there will be no additional data collection burden from the implementation of this measure.

The episode window is comprised of a treatment period and an associated services period. The treatment period begins at the trigger (that is, on the day of admission to the SNF) and ends on the day of discharge from that SNF. Readmissions to the same facility occurring within 7 or fewer days do not trigger a new episode, and instead are included in the treatment period of the original episode. When two sequential stays at the same SNF occur within 7 or fewer days of one another, the treatment period ends on the day of discharge for the latest SNF stay. The treatment period includes those services that are provided directly or reasonably managed by the SNF provider that are directly related to the beneficiary's care plan. The associated services period is the time during which Medicare Part A and Part B services (with certain exclusions) are counted towards the episode. The associated services period begins at the episode trigger and ends 30 days after the end of the treatment period. The distinction between the treatment period and the associated services period is important because clinical exclusions of services may differ for each period. Certain services are excluded from the MSPB-PAC SNF episodes because they are clinically unrelated to SNF care, and/or because SNF providers may

have limited influence over certain Medicare services delivered by other providers during the episode window. These limited service-level exclusions are not counted towards a given SNF provider's Medicare spending to ensure that beneficiaries with certain conditions and complex care needs receive the necessary care. Certain services that have been determined by clinicians to be outside of the control of a SNF provider include planned hospital admissions, management of certain preexisting chronic conditions (for example, dialysis for end-stage renal disease (ESRD), and enzyme treatments for genetic conditions), treatment for preexisting cancers, organ transplants, and preventive screenings (for example, colonoscopy and mammograms). Exclusion of such services from the MSPB-PAC SNF episode ensures that facilities do not have disincentives to treat patients with certain conditions or complex care needs.

An MSPB-PAC episode may begin during the associated services period of an MSPB-PAC SNF episode in the 30 days post-treatment. One possible scenario occurs where a SNF provider discharges a beneficiary who is then admitted to a HHA within 30 days. The HHA claim would be included once as an associated service for the attributed provider of the first MSPB-PAC SNF episode and once as a treatment service for the attributed provider of the second MSPB-PAC HHA episode. As in the case of overlap between hospital and PAC episodes discussed earlier, this overlap is necessary to ensure continuous accountability between providers throughout a beneficiary's trajectory of care, as both providers share incentives to deliver high quality care at a lower cost to Medicare. Even within the SNF setting, one MSPB-PAC SNF episode may begin in the associated services period of another MSPB-PAC SNF episode in the 30 days post-treatment. The second SNF claim would be included once as an associated service for the attributed SNF provider of the first MSPB-PAC SNF episode and once as a treatment service for the attributed SNF provider of the second MSPB-PAC SNF episode. Again, this ensures that SNF providers have the same incentives throughout both MSPB-PAC SNF episodes to deliver quality care and engage in patient-focused care planning and coordination. If the

second MSPB-PAC SNF episode were excluded from the second SNF provider's MSPB-PAC SNF measure, that provider would not share the same incentives as the first SNF provider of first MSPB-PAC SNF episode. The MSPB-PAC SNF measure is designed to benchmark the resource use of each attributed provider against what their spending is expected to be as predicted through risk adjustment. As discussed further in this section, the measure takes the ratio of observed spending to expected spending for each episode and then takes the average of those ratios across all of the attributed provider's episodes. The measure is not a simple sum of all costs across a provider's episodes, thus mitigating concerns about double counting.

(2) Measure Calculation

Medicare payments for Part A and Part B claims for services included in MSPB-PAC SNF episodes, defined according to the methodology above, are used to calculate the MSPB-PAC SNF measure. Measure calculation involves determination of the episode exclusions, the approach for standardizing payments for geographic payment differences, the methodology for risk adjustment of episode spending to account for differences in patient case mix, and the specifications for the measure numerator and denominator.

(a) Exclusion Criteria

In addition to service-level exclusions that remove some payments from individual episodes, we exclude certain episodes in their entirety from the MSPB-PAC SNF measure to ensure that the MSPB-PAC SNF measure accurately reflects resource use and facilitates fair and meaningful comparisons between SNF providers. The proposed episode-level exclusions are as follows:

- Any episode that is triggered by a SNF claim outside the 50 states, D.C., Puerto Rico, and U.S. Territories.

- Any episode where the claim(s) constituting the attributed SNF provider's treatment have a standard allowed amount of zero or where the standard allowed amount cannot be calculated.

- Any episode in which a beneficiary is not enrolled in Medicare FFS for the entirety of a 90-day lookback period (that is, a 90-day period prior to the episode trigger) plus episode window (including where the beneficiary dies), or is enrolled in Part C for any part of the lookback period plus episode window.

- Any episode in which a beneficiary has a primary payer other than Medicare for any part of the 90-day lookback period plus episode window.

- Any episode where the claim(s) constituting the attributed SNF provider's treatment include at least one related condition code indicating that it is not a prospective payment system bill.

(b) Standardization and Risk Adjustment

Section 1899B(d)(2)(C) of the Act requires that the MSPB-PAC measures are adjusted for the factors described under section 1886(o)(2)(B)(ii) of the Act, which include adjustment for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate. Medicare payments included in the MSPB-PAC SNF QRP measure are payment standardized and risk-adjusted. Payment standardization removes sources of payment variation not directly related to clinical decisions and facilitates comparisons of resource use across geographic areas. We propose to use the same payment standardization methodology as that used in the NQF-endorsed hospital MSPB measure. This methodology removes geographic payment differences, such as wage index and geographic practice cost index (GPCI), incentive

payment adjustments, and other add-on payments that support broader Medicare program goals including indirect graduate medical education (IME) and hospitals serving a disproportionate share of uninsured patients (DSH).[37]

Risk adjustment uses patient claims history to account for case-mix variation and other factors that affect resource use but are beyond the influence of the attributed SNF provider. To assist with risk adjustment, we create mutually exclusive and exhaustive clinical case mix categories using the most recent institutional claim in the 60 days prior to the start of the MSPB-PAC SNF episode. The beneficiaries in these clinical case mix categories have a greater degree of clinical similarity than the overall SNF patient population, and allow us to more accurately estimate Medicare spending. Our proposed MSPB-PAC SNF model, adapted for the SNF setting from the NQF-endorsed hospital MSPB measure uses a regression framework with a 90-day hierarchical condition category (HCC) lookback period and covariates including the clinical case mix categories, HCC indicators, age brackets, indicators for originally disabled, ESRD enrollment, and long-term care status, and selected interactions of these covariates where sample size and predictive ability make them appropriate. We sought and considered public comment regarding the treatment of hospice services occurring within the MSPB-PAC SNF episode window. Given the comments received, we propose to include the Medicare spending for hospice services but risk adjust for them, such that MSPB-PAC SNF episodes with hospice are compared to a benchmark reflecting other MSPB-PAC SNF episodes with hospice. We believe that this strikes a balance between the measure's intent of evaluating Medicare spending and

37 QualityNet, "CMS Price (Payment) Standardization – Detailed Methods" (Revised May 2015) https://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350

ensuring that providers do not have incentives against the appropriate use of hospice services in a patient-centered continuum of care.

We understand the important role that sociodemographic factors, beyond age, play in the care of patients. However, we continue to have concerns about holding providers to different standards for the outcomes of their patients of diverse sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of sociodemographic status on providers' results on our measures.

The NQF is currently undertaking a 2-year trial period in which new measures and measures undergoing maintenance review will be assessed to determine if risk-adjusting for sociodemographic factors is appropriate. For 2 years, NQF will conduct a trial of temporarily allowing inclusion of sociodemographic factors in the risk-adjustment approach for some performance measures. At the conclusion of the trial, NQF will issue recommendations on future permanent inclusion of sociodemographic factors. During the trial, measure developers are expected to submit information such as analyses and interpretations as well as performance scores with and without sociodemographic factors in the risk adjustment model.

Furthermore, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program as required by the IMPACT Act. We will closely examine the findings of the ASPE reports and related Secretarial recommendations and consider how they apply to our quality programs at such time as they are available.

While we conducted analyses on the impact of age by sex on the performance of the MSPB-PAC SNF risk-adjustment model, we are not proposing to adjust the MSPB-PAC SNF measure for socioeconomic and demographic factors at this time. As this MSPB-PAC SNF

measure will be submitted for NQF endorsement, we prefer to await the results of this trial and study before deciding whether to risk adjust for socioeconomic and demographic factors. We will monitor the results of the trial, studies, and recommendations. We are inviting public comment on how socioeconomic and demographic factors should be used in risk adjustment for the MSPB-PAC SNF measure.

(c) Measure Numerator and Denominator

The MPSB-PAC SNF measure is a payment-standardized, risk-adjusted ratio that compares a given SNF provider's Medicare spending against the Medicare spending of other SNF providers within a performance period. Similar to the hospital MSPB measure, the ratio allows for ease of comparison over time as it obviates the need to adjust for inflation or policy changes.

The MSPB-PAC SNF measure is calculated as the ratio of the MSPB-PAC Amount for each SNF provider divided by the episode-weighted median MSPB-PAC Amount across all SNF providers. To calculate the MSPB-PAC Amount for each SNF provider, one calculates the average of the ratio of the standardized episode spending over the expected episode spending (as predicted in risk adjustment), and then multiplies this quantity by the average episode spending level across all SNF providers nationally. The denominator for a SNF provider's MSPB-PAC SNF measure is the episode-weighted national median of the MSPB-PAC Amounts across all SNF providers. An MSPB-PAC SNF measure of less than 1 indicates that a given SNF provider's resource use is less than that of the national median SNF provider during a performance period. Mathematically, this is represented in equation (A) below:

$$(A)\ MSPB\text{-}PAC\ SNF\ Measure_{\ j} = \frac{MSPB\text{-}PAC\ Amount_j}{National\ Median\ MSPB\text{-}PAC\ Amount} = \frac{\left(\frac{1}{n_j}\sum_{i\in\{I_j\}}\frac{Y_{ij}}{\widehat{Y_{ij}}}\right)\left(\frac{1}{n}\sum_j\sum_{i\in\{I_j\}}Y_{ij}\right)}{\begin{array}{c}Episode\text{-}Weighted\ Median\ of\\ SNF\ Providers'\ MSPB\text{-}PAC\ Amount\end{array}}$$

where

- Y_{ij} = attributed standardized spending for episode *i* and provider *j*
- $\widehat{Y}_{ij}$ = expected standardized spending for episode *i* and provider *j*, as predicted from risk adjustment
- n_j = number of episodes for provider *j*
- n = total number of episodes nationally
- $i \in \{I_j\}$ = all episodes *i* in the set of episodes attributed to provider *j*.

(3) Data Sources

The MSPB-PAC SNF resource use measure is an administrative claims-based measure. It uses Medicare Part A and Part B claims from FFS beneficiaries and Medicare eligibility files.

(4) Cohort

The measure cohort includes Medicare FFS beneficiaries with a SNF treatment period ending during the data collection period.

(5) Reporting

If this proposed measure is finalized, we intend to provide initial confidential feedback to providers, prior to public reporting of this measure, based on Medicare FFS claims data from discharges in CY 2016. We intend to publicly report this measure using claims data from discharges in CY 2017.

We propose a minimum of 20 episodes for reporting and inclusion in the SNF QRP. For the reliability calculation, as described in the measure specifications identified at 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, we used data from FY 2014. The reliability results support the 20 episode case minimum, and 100.00 percent of SNF providers had moderate or high reliability (above 0.4).

We invite public comment on our proposal to adopt the measure, MSPB-PAC SNF

Measure for the SNF QRP.

b. Proposal to Address the IMPACT Act Domain of Resource Use and Other Measures: Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program

Sections 1899B(d)(1)(B) and 1899B(a)(2)(E)(ii) of the Act require the Secretary to specify a measure to address the domain of discharge to community by SNFs, LTCHs, and IRFs by October 1, 2016, and HHAs by January 1, 2017. We are proposing to adopt the measure, Discharge to Community-PAC SNF QRP, for the SNF QRP for the FY 2018 payment determination and subsequent years as a Medicare FFS claims-based measure to meet this requirement.

This proposed measure assesses successful discharge to the community from a SNF setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge from the SNF. Specifically, this proposed measure reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. The term "community", for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.[38,39] This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the discharge to community

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[38] Further description of patient discharge status codes can be found, for example, at the following Web page: https://med.noridianmedicare.com/web/jea/topics/claim-submission/patient-status-codes.

[39] This definition is not intended to suggest that board and care homes, assisted living facilities, or other settings included in the definition of "community" for the purpose of this measure are the most integrated setting for any particular individual or group of individuals under the Americans with Disabilities Act (ADA) and Section 504.

outcome, the approach to risk adjustment, and the measure calculation.

Discharge to a community setting is an important health care outcome for many residents for whom the overall goals of post-acute care include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Returning to the community is also an important outcome for many residents who are not expected to make functional improvement during their SNF stay, and for residents who may be expected to decline functionally due to their medical condition. The discharge to community outcome offers a multi-dimensional view of preparation for community life, including the cognitive, physical, and psychosocial elements involved in a discharge to the community.[40,41]

In addition to being an important outcome from a resident and family perspective, patients and residents discharged to community settings, on average, incur lower costs over the recovery episode, compared with those discharged to institutional settings.[42,43] Given the high costs of care in institutional settings, encouraging SNFs to prepare residents for discharge to community, when clinically appropriate, may have cost-saving implications for the Medicare program.[44] Also, providers have discovered that successful discharge to community was a major driver of their ability to achieve savings, where capitated payments for post-acute care were in place.[45] For residents who require long-term care due to persistent disability, discharge to

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[40] El-Solh AA, Saltzman SK, Ramadan FH, Naughton BJ. Validity of an artificial neural network in predicting discharge destination from a postacute geriatric rehabilitation unit. Archives of physical medicine and rehabilitation. 2000;81(10):1388-1393.
[41] Tanwir S, Montgomery K, Chari V, Nesathurai S. Stroke rehabilitation: availability of a family member as caregiver and discharge destination. *European journal of physical and rehabilitation medicine.* 2014;50(3):355-362.
[42] Dobrez D, Heinemann AW, Deutsch A, Manheim L, Mallinson T. Impact of Medicare's prospective payment system for inpatient rehabilitation facilities on stroke patient outcomes. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists.* 2010;89(3):198-204.
[43] Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System. Final Report. RTI International;2009.
[44] *Ibid.*
[45] Doran JP, Zabinski SJ. Bundled payment initiatives for Medicare and non-Medicare total joint arthroplasty patients at a community hospital: bundles in the real world. The journal of arthroplasty. 2015;30(3):353-355.

community could result in lower long-term care costs for Medicaid and for residents' out-of-pocket expenditures.[46]

Analyses conducted for ASPE on PAC episodes, using a 5 percent sample of 2006 Medicare claims, revealed that relatively high average, unadjusted Medicare payments are associated with discharge to institutional settings from IRFs, SNFs, LTCHs or HHAs, as compared with payments associated with discharge to community settings.[47] Average, unadjusted Medicare payments associated with discharge to community settings ranged from $0 to $4,017 for IRF discharges, $0 to $3,544 for SNF discharges, $0 to $4,706 for LTCH discharges, and $0 to $992 for HHA discharges. In contrast, payments associated with discharge to non-community settings were considerably higher, ranging from $11,847 to $25,364 for IRF discharges, $9,305 to $29,118 for SNF discharges, $12,465 to $18,205 for LTCH discharges, and $7,981 to $35,192 for HHA discharges.[48]

Measuring and comparing facility-level discharge to community rates is expected to help differentiate among facilities with varying performance in this important domain, and to help avoid disparities in care across resident groups. Variation in discharge to community rates has been reported within and across post-acute settings; across a variety of facility-level characteristics, such as geographic location (for example, regional location, urban or rural location), ownership (for example, for-profit or nonprofit), and freestanding or hospital-based units; and across patient-level characteristics, such as race and gender.[49,50,51,52,53,54] Discharge to

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[46] Newcomer RJ, Ko M, Kang T, Harrington C, Hulett D, Bindman AB. Health Care Expenditures After Initiating Long-term Services and Supports in the Community Versus in a Nursing Facility. Medical Care. 2016; 54(3):221-228.
[47] Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System. Final Report. RTI International;2009.
[48] *Ibid.*
[49] Reistetter TA, Karmarkar AM, Graham JE, et al. Regional variation in stroke rehabilitation outcomes. *Archives of physical medicine and rehabilitation.* 2014;95(1):29-38.

community rates in the IRF setting have been reported to range from about 60 to 80 percent.[55,56,57,58,59,60] Longer-term studies show that rates of discharge to community from IRFs have decreased over time as IRF length of stay has decreased.[61,62] Greater variation in discharge to community rates is seen in the SNF setting, with rates ranging from 31 to 65 percent.[63,64,65,66] In the SNF Medicare FFS population, using CY 2013 national claims data, we found that approximately 44 percent of residents were discharged to the community. A multi-center study of 23 LTCHs demonstrated that 28.8 percent of 1,061 patients who were ventilator-dependent on

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[50] El-Solh AA, Saltzman SK, Ramadan FH, Naughton BJ. Validity of an artificial neural network in predicting discharge destination from a postacute geriatric rehabilitation unit. Archives of physical medicine and rehabilitation. 2000;81(10):1388-1393.
[51] March 2015 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission;2015.
[52] Bhandari VK, Kushel M, Price L, Schillinger D. Racial disparities in outcomes of inpatient stroke rehabilitation. *Archives of physical medicine and rehabilitation.* 2005;86(11):2081-2086.
[53] Chang PF, Ostir GV, Kuo YF, Granger CV, Ottenbacher KJ. Ethnic differences in discharge destination among older patients with traumatic brain injury. *Archives of physical medicine and rehabilitation.* 2008;89(2):231-236.
[54] Berges IM, Kuo YF, Ostir GV, Granger CV, Graham JE, Ottenbacher KJ. Gender and ethnic differences in rehabilitation outcomes after hip-replacement surgery. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists.* 2008;87(7):567-572.
[55] Galloway RV, Granger CV, Karmarkar AM, et al. The Uniform Data System for Medical Rehabilitation: report of patients with debility discharged from inpatient rehabilitation programs in 2000-2010. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists.* 2013;92(1):14-27.
[56] Morley MA, Coots LA, Forgues AL, Gage BJ. Inpatient rehabilitation utilization for Medicare beneficiaries with multiple sclerosis. *Archives of physical medicine and rehabilitation.* 2012;93(8):1377-1383.
[57] Reistetter TA, Graham JE, Deutsch A, Granger CV, Markello S, Ottenbacher KJ. Utility of functional status for classifying community versus institutional discharges after inpatient rehabilitation for stroke. *Archives of physical medicine and rehabilitation.* 2010;91(3):345-350.
[58] Gagnon D, Nadeau S, Tam V. Clinical and administrative outcomes during publicly-funded inpatient stroke rehabilitation based on a case-mix group classification model. *Journal of rehabilitation medicine.* 2005;37(1):45-52.
[59] DaVanzo J, El-Gamil A, Li J, Shimer M, Manolov N, Dobson A. *Assessment of patient outcomes of rehabilitative care provided in inpatient rehabilitation facilities (IRFs) and after discharge.* Vienna, VA: Dobson DaVanzo & Associates, LLC;2014.
[60] Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation.* 2015;96(7):1310-1318.
[61] Galloway RV, Granger CV, Karmarkar AM, et al. The Uniform Data System for Medical Rehabilitation: report of patients with debility discharged from inpatient rehabilitation programs in 2000-2010. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists.* 2013;92(1):14-27.
[62] Mallinson T, Deutsch A, Bateman J, et al. Comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after hip fracture repair. *Archives of physical medicine and rehabilitation.* 2014;95(2):209-217.
[63] El-Solh AA, Saltzman SK, Ramadan FH, Naughton BJ. Validity of an artificial neural network in predicting discharge destination from a postacute geriatric rehabilitation unit. *Archives of physical medicine and rehabilitation.* 2000;81(10):1388-1393.
[64] Hall RK, Toles M, Massing M, et al. Utilization of acute care among patients with ESRD discharged home from skilled nursing facilities. *Clinical journal of the American Society of Nephrology : CJASN.* 2015;10(3):428-434.
[65] Stearns SC, Dalton K, Holmes GM, Seagrave SM. Using propensity stratification to compare patient outcomes in hospital-based versus freestanding skilled-nursing facilities. *Medical care research and review : MCRR.* 2006;63(5):599-622.
[66] Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation.* 2005;86(3):442-448.

admission were discharged to home.[67] A single-center study revealed that 31 percent of LTCH hemodialysis patients were discharged to home.[68] One study noted that 64 percent of beneficiaries who were discharged from the home health episode did not use any other acute or post-acute services paid by Medicare in the 30 days after discharge.[69] However, significant numbers of patients were admitted to hospitals (29 percent) and lesser numbers to SNFs (7.6 percent), IRFs (1.5 percent), home health (7.2 percent) or hospice (3.3 percent).[70]

Discharge to community is an actionable health care outcome, as targeted interventions have been shown to successfully increase discharge to community rates in a variety of post-acute settings.[71,72,73,74] Many of these interventions involve discharge planning or specific rehabilitation strategies, such as addressing discharge barriers and improving medical and functional status.[75,76,77,78] The effectiveness of these interventions suggests that improvement in discharge to community rates among post-acute care residents is possible through modifying

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[67] Scheinhorn DJ, Hassenpflug MS, Votto JJ, et al. Post-ICU mechanical ventilation at 23 long-term care hospitals: a multicenter outcomes study. *Chest.* 2007;131(1):85-93.
[68] Thakar CV, Quate-Operacz M, Leonard AC, Eckman MH. Outcomes of hemodialysis patients in a long-term care hospital setting: a single-center study. *American journal of kidney diseases: the official journal of the National Kidney Foundation.* 2010;55(2):300-306.
[69] Wolff JL, Meadow A, Weiss CO, Boyd CM, Leff B. Medicare home health patients' transitions through acute and post-acute care settings. *Medical care.* 2008;46(11):1188-1193.
[70] *Ibid.*
[71] Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation.* 2015;96(7):1310-1318.
[72] Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation.* 2005;86(3):442-448.
[73] Berkowitz RE, Jones RN, Rieder R, et al. Improving disposition outcomes for patients in a geriatric skilled nursing facility. *Journal of the American Geriatrics Society.* 2011;59(6):1130-1136.
[74] Kushner DS, Peters KM, Johnson-Greene D. Evaluating use of the Siebens Domain Management Model during inpatient rehabilitation to increase functional independence and discharge rate to home in stroke patients. *PM & R : the journal of injury, function, and rehabilitation.* 2015;7(4):354-364.
[75] Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation.* 2015;96(7):1310-1318.
[76] Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation.* 2005;86(3):442-448.
[77] Berkowitz RE, Jones RN, Rieder R, et al. Improving disposition outcomes for patients in a geriatric skilled nursing facility. *Journal of the American Geriatrics Society.* 2011;59(6):1130-1136.
[78] Kushner DS, Peters KM, Johnson-Greene D. Evaluating use of the Siebens Domain Management Model during inpatient rehabilitation to increase functional independence and discharge rate to home in stroke patients. *PM & R: the journal of injury, function, and rehabilitation.* 2015;7(4):354-364.

provider-led processes and interventions.

A TEP convened by our measure development contractor was strongly supportive of the importance of measuring discharge to community outcomes, and implementing the proposed measure, Discharge to Community-PAC SNF QRP in the SNF QRP. The panel provided input on the technical specifications of this proposed measure, including the feasibility of implementing the measure, as well as the overall measure reliability and validity. A summary of the TEP proceedings is available on the PAC Quality Initiatives Downloads and Videos Web site at 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.

We also solicited stakeholder feedback on the development of this measure through a public comment period held from November 9, 2015, through December 8, 2015. Several stakeholders and organizations, including the MedPAC, among others, supported this measure for implementation. The public comment summary report for the proposed measure is available on the CMS Web site at 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.

The NQF-convened MAP met on December 14 and 15, 2015, and provided input on the use of this proposed Discharge to Community-PAC SNF QRP measure in the SNF QRP. The MAP encouraged continued development of the proposed measure to meet the mandate of the IMPACT Act. The MAP supported the alignment of this proposed measure across PAC settings, using standardized claims data. More information about the MAP's recommendations for this measure is available at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

Since the MAP's review and recommendation of continued development, we have continued to refine risk-adjustment models and conduct measure testing for this measure, as recommended by the MAP. This proposed measure is consistent with the information submitted to the MAP and is scientifically acceptable for current specification in the SNF QRP. As discussed with the MAP, we fully anticipate that additional analyses will continue as we submit this measure to the ongoing measure maintenance process.

We reviewed the NQF's consensus-endorsed measures and were unable to identify any NQF-endorsed resource use or other measures for post-acute care focused on discharge to community. In addition, we are unaware of any other post-acute care measures for discharge to community that have been endorsed or adopted by other consensus organizations. Therefore, we are proposing the measure, Discharge to Community-PAC SNF QRP, under the Secretary's authority to specify non-NQF-endorsed measures under section 1899B(e)(2)(B) of the Act.

We are proposing to use data from the Medicare FFS claims and Medicare eligibility files to calculate this proposed measure. We are proposing to use data from the "Patient Discharge Status Code" on Medicare FFS claims to determine whether a resident was discharged to a community setting for calculation of this proposed measure. In all PAC settings, we tested the accuracy of determining discharge to a community setting using the "Patient Discharge Status Code" on the PAC claim by examining whether discharge to community coding based on PAC claim data agreed with discharge to community coding based on PAC assessment data. We found excellent agreement between the two data sources in all PAC settings, ranging from 94.6 percent to 98.8 percent. Specifically, in the SNF setting, using 2013 data, we found 94.6 percent agreement in discharge to community codes when comparing discharge status codes on claims and the Discharge Status (A2100) on the Minimum Data Set (MDS) 3.0 discharge assessment, when the claims and MDS assessment had the same discharge date. We further examined the accuracy of the "Patient Discharge Status Code" on the PAC claim by assessing how frequently

discharges to an acute care hospital were confirmed by follow-up acute care claims. We discovered that 88 percent to 91 percent of IRF, LTCH, and SNF claims with acute care discharge status codes were followed by an acute care claim on the day of, or day after, PAC discharge. We believe these data support the use of the claims "Patient Discharge Status Code" for determining discharge to a community setting for this measure. In addition, this measure can feasibly be implemented in the SNF QRP because all data used for measure calculation are derived from Medicare FFS claims and eligibility files, which are already available to CMS.

Based on the evidence discussed above, we are proposing to adopt the measure, Discharge to Community-PAC SNF QRP, for the SNF QRP for FY 2018 payment determination and subsequent years. This proposed measure is calculated using one year of data. We are proposing a minimum of 25 eligible stays in a given SNF for public reporting of the proposed measure for that SNF. Since Medicare FFS claims data are already reported to the Medicare program for payment purposes, and Medicare eligibility files are also available, SNFs will not be required to report any additional data to CMS for calculation of this measure. The proposed measure denominator is the risk-adjusted expected number of discharges to community. The proposed measure numerator is the risk-adjusted estimate of the number of residents who are discharged to the community, do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. The measure is risk-adjusted for variables such as age and sex, principal diagnosis, comorbidities, ventilator status, ESRD status, and dialysis, among other variables. For technical information about this proposed measure, including information about the measure calculation, risk adjustment, and denominator exclusions, refer to the document titled, Proposed Measure Specifications for Measures Proposed in the FY 2017 SNF QRP NPRM available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-

Technical-Information.html.

If this proposed measure is finalized, we intend to provide initial confidential feedback to SNFs, prior to public reporting of this measure, based on Medicare FFS claims data from discharges in CY 2016. We intend to publicly report this measure using claims data from discharges in CY 2017. We plan to submit this proposed measure to the NQF for consideration for endorsement.

We are inviting public comment on our proposal to adopt the measure, Discharge to Community-PAC SNF QRP, for the SNF QRP.

c. Proposal to Address the IMPACT Act Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program.

Sections 1899B(a)(2)(E)(ii) and 1899B(d)(1)(C) of the Act require the Secretary to specify measures to address the domain of all-condition risk-adjusted potentially preventable hospital readmission rates by SNFs, LTCHs, and IRFs by October 1, 2016, and HHAs by January 1, 2017. We are proposing the measure Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP as a Medicare FFS claims-based measure to meet this requirement for the FY 2018 payment determination and subsequent years.

The proposed measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post-SNF discharge. The SNF admission must have occurred within up to 30 days of discharge from a prior proximal hospital stay which is defined as an inpatient admission to an acute care hospital (including IPPS, CAH, or a psychiatric hospital). Hospital readmissions include readmissions to a short-stay acute care hospitals or an LTCH, with a diagnosis considered to be unplanned and potentially preventable. This proposed measure is claims-based, requiring no additional data collection or submission burden for SNFs. Because the measure denominator is based on SNF

admissions, each Medicare beneficiary may be included in the measure multiple times within the measurement period. Readmissions counted in this measure are identified by examining Medicare FFS claims data for readmissions to either acute care hospitals (IPPS or CAH) or LTCHs that occur during a 30-day window beginning two days after SNF discharge. This measure is conceptualized uniformly across the PAC settings, in terms of the measure definition, the approach to risk adjustment, and the measure calculation. Our approach for defining potentially preventable hospital readmissions is described in more detail below.

Hospital readmissions among the Medicare population, including beneficiaries that utilize PAC, are common, costly, and often preventable.[79,80] MedPAC and a study by Jencks et al. estimated that 17 to 20 percent of Medicare beneficiaries discharged from the hospital were readmitted within 30 days. MedPAC found that more than 75 percent of 30-day and 15-day readmissions and 84 percent of 7-day readmissions were considered "potentially preventable."[81] In addition, MedPAC calculated that annual Medicare spending on potentially preventable readmissions would be $12 billion for 30-day, $8 billion for 15-day, and $5 billion for 7-day readmissions.[82] For hospital readmissions from SNFs, MedPAC deemed 76 percent of readmissions as "potentially avoidable"–associated with $12 billion in Medicare expenditures.[83] Mor et al. analyzed 2006 Medicare claims and SNF assessment data (Minimum Data Set), and reported a 23.5 percent readmission rate from SNFs, associated with $4.3 billion in

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[79] Friedman, B., and Basu, J.: The rate and cost of hospital readmissions for preventable conditions. Med. Care Res. Rev. 61(2):225-240, 2004. doi:10.1177/1077558704263799

[80] Jencks, S.F., Williams, M.V., and Coleman, E.A.: Rehospitalizations among patients in the Medicare Fee-for-Service Program. N. Engl. J. Med. 360(14):1418-1428, 2009. doi:10.1016/j.jvs.2009.05.045

[81] MedPAC: Payment policy for inpatient readmissions, in Report to the Congress: Promoting Greater Efficiency in Medicare. Washington, D.C., pp. 103-120, 2007. Available from http://www.medpac.gov/documents/reports/Jun07_EntireReport.pdf

[82] ibid.

[83] ibid.

expenditures.[84] Fewer studies have investigated potentially preventable readmission rates from the remaining post-acute care settings.

We have addressed the high rates of hospital readmissions in the acute care setting, as well as in PAC. For example, we developed the following measure: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510), as well as similar measures for other PAC providers (NQF #2502 for IRFs and NQF #2512 for LTCHs).[85] These measures are endorsed by the NQF, and the NQF-endorsed SNF measure (NQF #2510) was adopted into the SNF VBP Program in the FY 2016 SNF final rule (80 FR 46411 through 46419). Note that these NQF-endorsed measures assess all-cause unplanned readmissions.

Several general methods and algorithms have been developed to assess potentially avoidable or preventable hospitalizations and readmissions for the Medicare population. These include the Agency for Healthcare Research and Quality's (AHRQ's) Prevention Quality Indicators, approaches developed by MedPAC, and proprietary approaches, such as the 3M™ algorithm for Potentially Preventable Readmissions.[86] [87] [88] Recent work led by Kramer et al. for MedPAC identified 13 conditions for which readmissions were deemed as potentially preventable among SNF and IRF populations.[89] [90] Although much of the existing literature

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[84] Mor, V., Intrator, O., Feng, Z., et al.: The revolving door of rehospitalization from skilled nursing facilities. Health Aff. 29(1):57-64, 2010. doi:10.1377/hlthaff.2009.0629

[85] National Quality Forum: All-Cause Admissions and Readmissions Measures. pp. 1-319, April 2015. Available from http://www.qualityforum.org/Publications/2015/04/All-Cause_Admissions_and_Readmissions_Measures_-_Final_Report.aspx

[86] Goldfield, N.I., McCullough, E.C., Hughes, J.S., et al.: Identifying potentially preventable readmissions. Health Care Finan. Rev. 30(1):75-91, 2008. Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195042/

[87] National Quality Forum: Prevention Quality Indicators Overview. 2008.

[88] MedPAC: Online Appendix C: Medicare Ambulatory Care Indicators for the Elderly. pp. 1-12, prepared for Chapter 4, 2011. Available from http://www.medpac.gov/documents/reports/Mar11_Ch04_APPENDIX.pdf?sfvrsn=0

[89] Kramer, A., Lin, M., Fish, R., et al.: Development of Inpatient Rehabilitation Facility Quality Measures: Potentially Avoidable Readmissions, Community Discharge, and Functional Improvement. pp. 1-42, 2015. Available from http://www.medpac.gov/documents/contractor-reports/development-of-inpatient-rehabilitation-facility-quality-measures-potentially-avoidable-readmissions-community-discharge-and-functional-improvement.pdf?sfvrsn=0

[90] Kramer, A., Lin, M., Fish, R., et al.: Development of Potentially Avoidable Readmission and Functional Outcome SNF Quality Measures. pp. 1-75, 2014. Available from http://www.medpac.gov/documents/contractor-reports/mar14_snfqualitymeasures_contractor.pdf?sfvrsn=0

addresses hospital readmissions more broadly and potentially avoidable hospitalizations for specific settings like long-term care, these findings are relevant to the development of potentially preventable readmission measures for PAC.[91] [92] [93]

Potentially Preventable Readmission Measure Definition*:* We conducted a comprehensive environmental scan, analyzed claims data, and obtained input from a TEP to develop a definition and list of conditions for which hospital readmissions are potentially preventable. The Ambulatory Care Sensitive Conditions and Prevention Quality Indicators, developed by AHRQ, served as the starting point in this work. For patients in the 30-day post-PAC discharge period, a potentially preventable readmission (PRR) refers to a readmission for which the probability of occurrence could be minimized with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care. Our list of PPR conditions is categorized by 3 clinical rationale groupings:

- Inadequate management of chronic conditions;
- Inadequate management of infections; and
- Inadequate management of other unplanned events.

Additional details regarding the definition for potentially preventable readmissions are available in the document titled, Proposed Measure Specifications for Measures Proposed in the FY 2017 SNF QRP NPRM, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

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[91] Allaudeen, N., Vidyarthi, A., Maselli, J., et al.: Redefining readmission risk factors for general medicine patients. J. Hosp. Med. 6(2):54-60, 2011. doi:10.1002/jhm.805

[92] Gao, J., Moran, E., Li, Y.-F., et al.: Predicting potentially avoidable hospitalizations. Med. Care 52(2):164-171, 2014. doi:10.1097/MLR.0000000000000041

[93] Walsh, E.G., Wiener, J.M., Haber, S., et al.: Potentially avoidable hospitalizations of dually eligible Medicare and Medicaid beneficiaries from nursing facility and home-and community-based services waiver programs. J. Am. Geriatr. Soc. 60(5):821-829, 2012. doi:10.1111/j.1532-5415.2012.03920.x

This proposed measure focuses on readmissions that are potentially preventable and also unplanned. Similar to the SNF 30-Day All-Cause Readmission Measure (NQF #2510), this proposed measure uses the current version of the CMS Planned Readmission Algorithm as the main component for identifying planned readmissions. A complete description of the CMS Planned Readmission Algorithm, which includes lists of planned diagnoses and procedures, can be found on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html. In addition to the CMS Planned Readmission Algorithm, this proposed measure incorporates procedures that are considered planned in post-acute care settings, as identified in consultation with TEPs. Full details on the planned readmissions criteria used, including the CMS Planned Readmission Algorithm and additional procedures considered planned for post-acute care, can be found in the document titled, Proposed Measure Specifications for Measures Proposed in the FY 2017 SNF QRP NPRM at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

The proposed measure, Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program, assesses potentially preventable readmission rates while accounting for patient demographics, principal diagnosis in the prior hospital stay, comorbidities, and other patient factors. While estimating the predictive power of patient characteristics, the model also estimates a facility-specific effect, common to patients treated in each facility. This proposed measure is calculated for each SNF based on the ratio of the predicted number of risk-adjusted, unplanned, potentially preventable hospital readmissions that occur within 30 days after a SNF discharge, including the estimated facility effect, to the estimated predicted number of risk-adjusted, unplanned inpatient hospital readmissions for the same patients treated at the average SNF. A ratio above 1.0 indicates a

higher than expected readmission rate (worse) while a ratio below 1.0 indicates a lower than expected readmission rate (better). This ratio is referred to as the standardized risk ratio (SRR). The SRR is then multiplied by the overall national raw rate of potentially preventable readmissions for all SNF stays. The resulting rate is the risk-standardized readmission rate (RSRR) of potentially preventable readmissions. The full methodology of this proposed measure is detailed in the document titled, Proposed Measure Specifications for Measures Proposed in the FY 2017 SNF QRP NPRM at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

An eligible SNF stay is followed until: (1) the 30-day post-discharge period ends; or (2) the patient is readmitted to an acute care hospital (IPPS or CAH) or LTCH. If the readmission is unplanned and potentially preventable, it is counted as a readmission in the measure calculation. If the readmission is planned, the readmission is not counted in the measure rate. This measure is risk adjusted. The risk adjustment modeling estimates the effects of patient characteristics, comorbidities, and select health care variables on the probability of readmission. More specifically, the risk-adjustment model for SNFs accounts for demographic characteristics (age, sex, original reason for Medicare entitlement), principal diagnosis during the prior proximal hospital stay, body system specific surgical indicators, comorbidities, length of stay during the patient's prior proximal hospital stay, intensive care unit (ICU) utilization, end-stage renal disease status, and number of acute care hospitalizations in the preceding 365 days.

The proposed measure is calculated using 1 calendar year of FFS claims data, to ensure the statistical reliability of this measure for facilities. In addition, we are proposing a minimum of 25 eligible stays for public reporting of the proposed measure. For technical information about this proposed measure including information about the measure calculation, risk adjustment, and exclusions, refer to the document titled, Proposed Measure Specifications for Measures Proposed

in the FY 2017 SNF QRP NPRM at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

A TEP convened by our measure development contractor provided recommendations on the technical specifications of this proposed measure, including the development of an approach to define potentially preventable hospital readmission for PAC. Details from the TEP meetings, including TEP members' ratings of conditions proposed as being potentially preventable, are available in the TEP Summary Report available on the CMS Web site at 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. We also solicited stakeholder feedback on the development of this measure through a public comment period held from November 2 through December 1, 2015. Comments on the measure varied, with some commenters supportive of the proposed measure, while others either were not in favor of the measure, or suggested potential modifications to the measure specifications, such as including standardized function data. A summary of the public comments is also available on the CMS Web site at 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.

The MAP encouraged continued development of the proposed measure. Specifically, the MAP stressed the need to promote shared accountability and ensure effective care transitions. More information about the MAP's recommendations for this measure is available at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx. At the time, the risk-adjustment model was still under development. Following completion of that development work, we were able to test for measure validity and reliability as identified in the measure specifications document

provided above. Testing results are within range for similar outcome measures finalized in public reporting and value-based purchasing programs, including the SNFRM (NQF #2510) adopted into the SNF VBP Program in the FY 2016 SNF final rule (80 FR 46411 through 46419).

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed measures focused on potentially preventable hospital readmissions. We are unaware of any other measures for this IMPACT Act domain that have been endorsed or adopted by other consensus organizations. Therefore, we are proposing the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP, under the Secretary's authority to specify non-NQF-endorsed measures under section 1899B(e)(2)(B) of the Act, for the SNF QRP for the FY 2018 payment determination and subsequent years given the evidence previously discussed above.

We plan to submit the proposed measure to the NQF for consideration of endorsement. If this proposed measure is finalized, we intend to provide initial confidential feedback to SNFs, prior to public reporting of this proposed measure, based on 1 calendar year of claims data from discharges in CY 2016. We intend to publicly report this proposed measure using claims data from CY 2017.

We are inviting public comment on our proposal to adopt the measure, Potentially Preventable 30-Day Post-Discharge Readmission Measure for the SNF QRP.

7. Skilled Nursing Facility Quality Measure Proposed for the FY 2020 Payment Determination and Subsequent Years

In addition to the measures we are retaining as described in section V.B.5. of this proposed rule under our policy described in section V.B.3. of this proposed rule and the new quality measures proposed in section V.B.6. of this proposed rule for the FY 2018 payment determinations and subsequent years, we are also proposing one new quality measure to meet the

requirements of the IMPACT Act for the FY 2020 payment determination and subsequent years. The proposed measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, addresses the IMPACT Act quality domain of Medication Reconciliation.

a. Quality Measure Addressing the IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program

Sections 1899B (a)(2)(E)(i)(III) and 1899B(c)(1)(C) of the Act require the Secretary to specify a quality measure to address the domain of medication reconciliation by October 1, 2018 for IRFs, LTCHs and SNFs; and by January 1, 2017 for HHAs. We are proposing to adopt the quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PPAC SNF QRP, for the SNF QRP as a resident-assessment based, cross-setting quality measure to meet the IMPACT Act requirements with data collection beginning October 1, 2018 for the FY 2020 payment determinations and subsequent years.

This proposed measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. Specifically, the proposed quality measure reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that stay. For this proposed quality measure, a drug regimen review is defined as the review of all medications or drugs the patient is taking to identify any potential clinically significant medication issues. This proposed quality measure utilizes both the processes of medication reconciliation and a drug regimen review, in the event an actual or potential medication issue occurred. The proposed measure informs whether the PAC facility identified and addressed each clinically significant medication issue and if the facility responded or addressed the medication issue in a timely manner. Of note, drug regimen review in PAC settings is generally considered

to include medication reconciliation and review of the patient's drug regimen to identify potential clinically significant medication issues.[94] This measure is applied uniformly across the PAC settings.

Medication reconciliation is a process of reviewing an individual's complete and current medication list. Medication reconciliation is a recognized process for reducing the occurrence of medication discrepancies that may lead to Adverse Drug Events (ADEs).[95] Medication discrepancies occur when there is conflicting information documented in the medical records. The World Health Organization regards medication reconciliation as a standard operating protocol necessary to reduce the potential for ADEs that cause harm to patients. Medication reconciliation is an important patient safety process that addresses medication accuracy during transitions in resident care and in identifying preventable ADEs.[96] The Joint Commission added medication reconciliation to its list of National Patient Safety Goals (2005), suggesting that medication reconciliation is an integral component of medication safety.[97] The Society of Hospital Medicine published a statement in agreement of the Joint Commission's emphasis and value of medication reconciliation as a patient safety goal.[98] There is universal agreement that medication reconciliation directly addresses resident safety issues that can result from medication miscommunication and unavailable or incorrect information. [99, 10097,101]

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[94] Ibid.
[95] Ibid.
[96] Leotsakos A., et al. Standardization in patient safety: the WHO High 5s project. Int J Qual Health Care. 2014:26(2):109-116.
[97] The Joint Commission. 2016 Long Term Care: National Patient Safety Goals Medicare/Medicaid Certification-based Option. (NPSG.03.06.01).
[98] Greenwald, J. L., Halasyamani, L., Greene, J., LaCivita, C., et al. (2010). Making inpatient medication reconciliation patient centered, clinically relevant and implementable: a consensus statement on key principles and necessary first steps. Journal of Hospital Medicine, 5(8), 477-485.
[99]Leotsakos A., et al. Standardization in patient safety: the WHO High 5s project. Int J Qual Health Care. 2014:26(2):109-116.

The performance of timely medication reconciliation is valuable to the process of drug regimen review. Preventing and responding to ADEs is of critical importance as ADEs account for significant increases in health services utilization and costs[102,103,104] including subsequent emergency room visits and re-hospitalizations.[105] Annual health care costs in the United States are estimated at $3.5 billion, resulting in 7,000 deaths annually.[106]

Medication errors include the duplication of medications, delivery of an incorrect drug, inappropriate drug omissions, or errors in the dosage, route, frequency, and duration of medications. Medication errors are one of the most common types of medical error and can occur at any point in the process of ordering and delivering a medication. Medication errors have the potential to result in an ADE. [107,108,109,110,111,112] Inappropriately prescribed medications are also considered a major healthcare concern in the United States for the elderly population, with costs

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[100] The Joint Commission. 2016 Long Term Care: National Patient Safety Goals Medicare/Medicaid Certification-based Option. (NPSG.03.06.01)..

[101] IHI. Medication Reconciliation to Prevent Adverse Drug Events [Internet]. Cambridge, MA: Institute for Healthcare Improvement; [cited 2016 Jan 11]. Available from: http://www.ihi.org/topics/adesmedicationreconciliation/Pages/default.aspx

[102] Institute of Medicine. Preventing Medication Errors. Washington DC: National Academies Press; 2006.

[103] Jha AK, Kuperman GJ, Rittenberg E, et al. Identifying hospital admissions due to adverse drug events using a computer-based monitor. Pharmacoepidemiol Drug Saf. 2001;10(2):113-119.

[104] Hohl CM, Nosyk B, Kuramoto L, et al. Outcomes of emergency department patients presenting with adverse drug events. Ann Emerg Med. 2011;58:270–279.

[105] Kohn LT, Corrigan JM, Donaldson MS. To Err Is Human: Building a Safer Health System Washington, DC: National Academies Press; 1999.

[106] Greenwald, J. L., Halasyamani, L., Greene, J., LaCivita, C., et al. (2010). Making inpatient medication reconciliation patient centered, clinically relevant and implementable: a consensus statement on key principles and necessary first steps. Journal of Hospital Medicine, 5(8), 477-485.

[107] Institute of Medicine. To err is human: building a safer health system. Washington, DC: National Academies Press; 2000.

[108] Lesar TS, Briceland L, Stein DS. Factors related to errors in medication prescribing. JAMA. 1997:277(4): 312-317.

[109] Bond CA, Raehl CL, & Franke T. Clinical pharmacy services, hospital pharmacy staffing, and medication errors in United States hospitals. Pharmacotherapy. 2002:22(2): 134-147.

[110] Bates DW, Cullen DJ, Laird N, Petersen LA, Small SD, et al. Incidence of adverse drug events and potential adverse drug events. Implications for prevention. JAMA. 1995:274(1): 29-34.

[111] Barker KN, Flynn EA, Pepper GA, Bates DW, & Mikeal RL. Medication errors observed in 36 health care facilities. JAMA. 2002: 162(16):1897-1903.

[112] Bates DW, Boyle DL, Vander Vliet MB, Schneider J, & Leape L. Relationship between medication errors and adverse drug events. J Gen Intern Med. 1995:10(4): 199-205.

of roughly $7.2 billion annually.[113]

There is strong evidence that medication discrepancies occur during transfers from acute care facilities to post-acute care facilities. Discrepancies occur when there is conflicting information documented in the medical records. Almost one-third of medication discrepancies have the potential to cause patient harm.[114] Medication discrepancies upon admission to SNFs have been reported as occurring at a rate of over 21 percent. It has been found that at least one medication discrepancy occurred in over 71 percent of all the SNF admissions.[115] An estimated fifty percent of patients experienced a clinically important medication error after hospital discharge in an analysis of two tertiary care academic hospitals.[116]

Medication reconciliation has been identified as an area for improvement during transfer from the acute care facility to the receiving post-acute care facility. Post-acute care facilities report gaps in medication information between the acute care hospital and the receiving post-acute care setting when performing medication reconciliation.[117,118] Hospital discharge has been identified as a particularly high risk point in time, with evidence that medication reconciliation identifies high levels of discrepancy.[119,120,121,122,123,124] Also, there is evidence that medication

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[113] Fu, Alex Z., et al. "Potentially inappropriate medication use and healthcare expenditures in the US community-dwelling elderly." Medical care 45.5 (2007): 472-476.
[114] Wong, Jacqueline D., et al. "Medication reconciliation at hospital discharge: evaluating discrepancies." Annals of Pharmacotherapy 42.10 (2008): 1373-1379.
[115] Tjia, J., Bonner, A., Briesacher, B. A., McGee, S., Terrill, E., & Miller, K. (2009). Medication discrepancies upon hospital to skilled nursing facility transitions. Journal of general internal medicine, 24(5), 630-635.
[116] Kripalani S, Roumie CL, Dalal AK, et al. Effect of a pharmacist intervention on clinically important medication errors after hospital discharge: A randomized controlled trial. Ann Intern Med. 2012:157(1):1-10.
[117] Gandara, Esteban, et al. "Communication and information deficits in patients discharged to rehabilitation facilities: an evaluation of five acute care hospitals." Journal of Hospital Medicine 4.8 (2009): E28-E33.
[118] Gandara, Esteban, et al. "Deficits in discharge documentation in patients transferred to rehabilitation facilities on anticoagulation: results of a system wide evaluation." Joint Commission Journal on Quality and Patient Safety 34.8 (2008): 460-463.
[119] Coleman EA, Smith JD, Raha D, Min SJ. Post hospital medication discrepancies: prevalence and contributing factors. Arch Intern Med. 2005 165(16):1842–1847.
[120] Wong JD, Bajcar JM, Wong GG, et al. Medication reconciliation at hospital discharge: evaluating discrepancies. Ann Pharmacother. 2008 42(10):1373–1379.

reconciliation discrepancies occur throughout the patient stay.[125,126] For older patients who may have multiple comorbid conditions and thus multiple medications, transitions between acute and post-acute care settings can be further complicated,[127] and medication reconciliation and patient knowledge (medication literacy) can be inadequate post-discharge.[128] The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues - PAC SNF QRP, provides an important component of care coordination for PAC settings and would affect a large proportion of the Medicare population who transfer from hospitals into PAC services each year. For example, in 2013, 1.7 million Medicare FFS beneficiaries had SNF stays, 338,000 beneficiaries had IRF stays, and 122,000 beneficiaries had LTCH stays.[129]

A TEP convened by our measure development contractor provided input on the technical specifications of this proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, including components of reliability, validity and the feasibility of implementing the measure across PAC settings. The TEP supported the measure's implementation across PAC settings and was supportive of our plans to standardize this measure for cross-setting development. A summary of the TEP proceedings is available on the PAC

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[121] Hawes EM, Maxwell WD, White SF, Mangun J, Lin FC. Impact of an outpatient pharmacist intervention on medication discrepancies and health care resource utilization in post hospitalization care transitions. *Journal of Primary Care & Community Health*. 2014; 5(1):14-18.
[122] Foust JB, Naylor MD, Bixby MB, Ratcliffe SJ. Medication problems occurring at hospital discharge among older adults with heart failure. *Research in Gerontological Nursing*. 2012, 5(1): 25-33.
[123] Pherson EC, Shermock KM, Efird LE, et al. Development and implementation of a post discharge home-based medication management service. *Am J Health Syst Pharm*. 2014; 71(18): 1576-1583.
[124] Pronovosta P, Weasta B, Scwarza M, et al. Medication reconciliation: a practical tool to reduce the risk of medication errors. J Crit Care. 2003; 18(4): 201-205.
[125] Bates DW, Cullen DJ, Laird N, Petersen LA, Small SD, et al. Incidence of adverse drug events and potential adverse drug events. Implications for prevention. JAMA. 1995:274(1): 29-34.
[126] Himmel, W., M. Tabache, and M. M. Kochen. "What happens to long-term medication when general practice patients are referred to hospital?."European journal of clinical pharmacology 50.4 (1996): 253-257.
[127] Chhabra, P. T., et al. (2012). "Medication reconciliation during the transition to and from LTC settings: a systematic review." Res Social Adm Pharm **8**(1): 60-75.
[128] Kripalani S, Roumie CL, Dalal AK, et al. Effect of a pharmacist intervention on clinically important medication errors after hospital discharge: A randomized controlled trial. Ann Intern Med. 2012:157(1):1-10.
[129] *March 2015 Report to the Congress: Medicare Payment Policy.* Medicare Payment Advisory Commission; 2015.

Quality Initiatives Downloads and Video Web site at 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.

We solicited stakeholder feedback on the development of this measure by means of a public comment period held from September 18 through October 6, 2015. Through public comments submitted by several stakeholders and organizations, we received support for implementation of this proposed measure. The public comment summary report for the proposed measure is available on the CMS Public Comment Web site at 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.

The NQF-convened MAP met on December 14 and 15, 2015 and provided input on the use of this proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP. The MAP encouraged continued development of the proposed quality measure to meet the mandate added by the IMPACT Act. The MAP agreed with the measure gaps identified by CMS including medication reconciliation, and stressed that medication reconciliation be present as an ongoing process. More information about the MAPs recommendations for this measure is available at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

Since the MAP's review and recommendation of continued development, we have continued to refine this proposed measure in compliance with the MAP's recommendations. The proposed measure is both consistent with the information submitted to the MAP and support its scientific acceptability for use in quality reporting programs. Therefore, we are proposing this measure for implementation in the SNF QRP as required by the IMPACT Act.

We reviewed the NQF's endorsed measures and identified one NQF-endorsed cross-

setting quality measure related to medication reconciliation, which applies to the SNF, LTCH, IRF, and HHA settings of care: Care for Older Adults (COA) (NQF #0553). The quality measure, Care for Older Adults (COA) (NQF #0553) assesses the percentage of adults 66 years and older who had a medication review. The Care for Older Adults (COA) (NQF #0553) measure requires at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record. This is in contrast to the proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, which reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and that timely follow-up with a physician occurred each time one or more potential clinically significant medication issues were identified throughout that stay.

After careful review of both quality measures, we have decided to propose the quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP for the following reasons:

- The IMPACT Act requires the implementation of quality measures, using patient assessment data that are standardized and interoperable across PAC settings. The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP, employs three standardized resident-assessment data elements for each of the four PAC settings so that data are standardized, interoperable, and comparable; whereas, the Care for Older Adults (COA), (NQF #0553) quality measure does not contain data elements that are standardized across all four PAC settings.

- The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, requires the identification of potential clinically significant medication issues at the beginning, during and at the end of the resident's stay to capture data on each resident's complete PAC stay; whereas, the Care for Older Adults (COA), (NQF #0553)

quality measure only requires annual documentation in the form of a medication list in the medical record of the target population.

- The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP, includes identification of the potential clinically significant medication issues and communication with the physician (or physician designee), as well as resolution of the issue(s) within a rapid timeframe (by midnight of the next calendar day); whereas, the Care for Older Adults (COA), (NQF #0553) quality measure does not include any follow-up or timeframe in which the follow-up would need to occur.

- The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP, does not have age exclusions; whereas, the Care for Older Adults (COA), (NQF #0553) quality measure limits the measure's population to patients aged 66 and older.

- The proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP, will be reported to SNFs quarterly to facilitate internal quality monitoring and quality improvement in areas such as resident safety, care coordination and resident satisfaction; whereas, the Care for Older Adults (COA), (NQF #0553) quality measure would not enable quarterly quality updates, and thus data comparisons within and across PAC providers would be difficult due to the limited data and scope of the data collected.

Therefore, based on the evidence discussed above, we are proposing to adopt the quality measure entitled, Drug Regimen Review Conducted with Follow-Up for Identified Issues - PAC SNF QRP, for the SNF QRP for FY 2020 payment determination and subsequent years. We plan to submit the quality measure to the NQF for consideration for endorsement.

The calculation of the proposed quality measure would be based on the data collection of three standardized items to be included in the MDS. The collection of data by means of the standardized items would be obtained at admission and discharge. For more information about

the data submission required for this proposed measure, please see section V.B.9. of this proposed rule.

The standardized items used to calculate this proposed quality measure do not duplicate existing items currently used for data collection within the MDS. The proposed measure denominator is the number of resident stays with a discharge or expired assessment during the reporting period. The proposed measure numerator is the number of stays in the denominator where the medical record contains documentation of a drug regimen review conducted at: (1) admission; and (2) discharge with a look back through the entire resident stay, with all potential clinically significant medication issues identified during the course of care and followed-up with a physician or physician designee by midnight of the next calendar day. This measure is not risk adjusted. For technical information about this proposed measure including information about the measure calculation and discussion pertaining to the standardized items used to calculate this measure, refer to the document titled, Proposed Measure Specifications for Measures Proposed in the FY 2017 SNF QRP NPRM available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

Data for the proposed quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP, would be collected using the MDS with submission through the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

We invite public comment on our proposal to adopt the quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC SNF QRP, for the SNF QRP.

8. SNF QRP Quality Measures and Measure Concepts under Consideration for Future Years

We are inviting comment on the importance, relevance, appropriateness, and applicability for each of the quality measures in Table 13 for future years in the SNF QRP. We are

developing a measure related to the IMPACT Act domain, accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions. We are considering the possibility of adding quality measures that rely on the patient's perspective; that is, measures that include patient-reported experience of care and health status data. For this purpose, we are considering a measure focused on pain and four measures focused on function that rely on the collection of patient-reported data. Finally, we are considering a measure related to health and well-being, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine, and a measure related to patient safety, Percent of SNF Residents Who Newly Received an Antipsychotic Medication.

TABLE 13: SNF QRP QUALITY MEASURES UNDER CONSIDERATION FOR FUTURE YEARS

IMPACT Act Domain	***Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions***
IMPACT Act Measure	• Transfer of health information and care preferences when an individual transitions
NQS Priority	**Patient- and Caregiver-Centered Care**
Measures	• Percent of Residents Who Self-Report Moderate to Severe Pain • Application of the Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) • Application of the Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) • Application of the Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) • Application of the Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
NQS Priority	**Health and Well-Being**
Measure	• Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
NQS Priority	**Patient Safety**
Measure	• Percent of SNF Residents Who Newly Received an Antipsychotic Medication

9. Form, Manner, and Timing of Quality Data Submission

a. Participation/Timing for New SNFs

In the FY 2016 SNF PPS final rule (80 FR 46455), we established the requirements associated with the timing of data submission, beginning with the submission of data required for the FY 2018 payment determination, for new SNFs. We finalized that a new SNF would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. For example, for FY 2018 payment determinations, if a SNF received its CCN on August 28, 2016, and 30 days are added (August 28 + 30 days = September 27), the SNF would be required to submit data for residents who are admitted beginning on October 1, 2016. We are not proposing any new policies related to the participation and timing for new SNFs.

b. Finalized Data Collection Timelines and Requirements for the FY 2018 Payment Determination and Subsequent Years

In the FY 2016 SNF PPS final rule (80 FR 46457) for the FY 2018 payment determination, we finalized that SNFs submit data on the three finalized quality measures for residents who are admitted to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016, using the data submission method and schedule that we proposed in this section. We also finalized that we would collect that single quarter of data for FY 2018 to remain consistent with the usual October release schedule for the MDS, to give SNFs a sufficient amount of time to update their systems so that they can comply with the new data reporting requirements, and to give CMS a sufficient amount of time to determine compliance for the FY 2018 program. The proposed use of one quarter of data for the initial year of quality reporting is consistent with the approach we used to implement a number of other

QRPs, including the LTCH, IRF, and Hospice QRPs.

We also finalized that, following the close of the reporting quarter, October 1, 2016, through December 31, 2016, for the FY 2018 payment determination, SNFs would have an additional 5.5 months to correct and/or submit their quality data and we finalized that the final deadline for submitting data for the FY 2018 payment determination would be May 15, 2017. (80 FR 46457). The statement that SNFs would have an additional 5.5 months was incorrect in that the time between the close of the quarter on December 31, 2016 and May 15, 2017 is 4.5 months, not 5.5 months. Therefore, we propose that SNFs will have 4.5 months, from January 1, 2017 through May 15, 2017, following the data submission period of October 1, 2016 through December 31, 2016, in which to complete their data submissions and make corrections to their data where necessary.

TABLE 14: Finalized Measures, Data Collection Source, Data Collection Period and Data Submission Deadlines Affecting the FY 2018 Payment Determination

Quality Measure	Data Collection Source	Data Collection Period	Data Submission Deadline for FY 2018 Payment Determination
NQF # 0678: Percent of Patients or Residents with Pressure Ulcers that are New or Worsened	MDS	10/01/16 – 12/31/16	May 15, 2017
NQF # 0674: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	MDS	10/01/16 – 12/31/16	May 15, 2017
NQF # 2631: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	MDS	10/01/16 – 12/31/16	May 15, 2017

c. Data Collection Timelines and Requirements for the FY 2019 Payment Determinations and Subsequent Years

In the FY 2016 SNF PPS final rule (80 FR 46457), we finalized that, for the FY 2019 payment determination, we would collect data from the 2nd through 4th quarters of FY 2017 (that is, data for residents who are admitted from January 1st and discharged up to and including September 30th) to determine whether a SNF has met its quality reporting requirements for that

FY. In the FY 2016 SNF PPS final rule we also finalized that beginning with the FY 2020 payment determination, we would move to a full year of fiscal year (FY) data collection. We intended to propose the FY 2019 payment determination quality reporting data submission deadlines in future rulemaking.

In the FY 2016 SNF PPS final rule (80 FR 46457), we also finalized that we would collect FY 2018 data in a manner that would remain consistent with the usual October release schedule for the MDS. However, to align with the data reporting cycles in other quality reporting programs, in contrast to fiscal year data collection that we finalized last year, we are now proposing to move to calendar year (CY) reporting following the initial reporting of data from October 1, 2016, through December 31, 2016, as finalized in the FY 2016 SNF PPS final rule (80 FR 46457), for the FY 2018 payment determination.

More specifically, we are proposing to follow a CY schedule for measure and data submission requirements that includes quarterly deadlines following each quarter of data submission, beginning with data reporting for the FY 2019 payment determinations. Each quarterly deadline will occur approximately 4.5 months after the end of a given calendar quarter as outlined below in Table 15. This timeframe will give SNFs enough time to submit corrections to the assessment data, as discussed below. Thus, if finalized, the FY 2019 payment determination would be based on 12 calendar months of data reporting beginning on January 1, 2017, and ending on December 31, 2017 (that is, data from January 1, 2017, up to and including December 31, 2017.) This approach would enable CMS to move to a full 12 months of data reporting immediately following the first 3 months of reporting (October 1, 2016 through December 31, 2016 for the FY 2018 payment determination) rather than an interim year which uses only 9 months of data, and a subsequent 12 months of FY data reporting following the initial reporting for the FY 2018 payment determination.

We invite public comments on our proposal to adopt calendar year data collection time

frames, following the initial 3-month reporting period from October 1, 2016, to December 31, 2016, for all measures finalized for adoption into the SNF QRP.

Our proposal to implement, for the FY 2019 payment determination and all subsequent years for assessment-based data submitted via the MDS, calendar year, quarterly data collection periods followed by data submission deadlines is consistent with the approach taken by the LTCH QRP and the IRF QRP, which are based on CY data and for which each data collection quarterly period is followed by a 4.5 month time frame that allows for the continued submission and correction of data until a deadline has been reached for that quarter of data. At that point, the data submitted becomes a frozen "snapshot" of data for both public reporting purposes and for the purposes of determining compliance in meeting the data reporting thresholds.

TABLE 15: Proposed Data Collection Period and Data Submission Deadlines Affecting the FY 2019 Payment Determination and Subsequent Years

Quality Measure	Data Collection Source	Proposed Data Collection/ submission Quarterly Reporting Period*	Proposed Quarterly Review and Correction Periods and Data Submission Quarterly Deadlines for FY 2019 Payment Determination**
NQF # 0678: Percent of Patients or Residents with Pressure Ulcers that are New or Worsened NQF # 0674: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) NQF #2631: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	MDS	CY 17 Q1 1/1/2017-3/31/2017 CY 17 Q2 4/1/2017-6/30/17 CY 17 Q3 7/1/2017-9/30/2017 CY 17 Q4 10/1/2017-12/31/2017	CY 2017 Q1 Deadline: August 15, 2017 CY 2017 Q2 Deadline: November 15, 2017 CY 2017 Q3 Deadline: February 15, 2018 CY 2017 Q4 Deadline May 15, 2018

* Data collection/submission will follow a similar quarterly reporting period schedule for subsequent CYs.
** Data review and correction periods and data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

Further, we propose that beginning with FY 2019 payment determination, assessment-based measures finalized for adoption into the SNF QRP will follow a CY schedule of data reporting and quarterly review and correction periods and data submission deadlines as provided

in Table 16 for all subsequent payment determination years unless otherwise specified:

TABLE 16: Proposed Data Collection Period and Data Submission Deadlines Affecting the FY 19 Payment Determination and Subsequent Years

Proposed CY Data Collection Quarter	**Proposed Data Collection/submission Quarterly Reporting Period**	**Proposed Quarterly Review and Correction Periods and Data Submission Deadlines for Payment Determination**
Quarter 1	January 1- March 31	April 1- **August 15**
Quarter 2	April 1-June 30	July 1-**November 15**
Quarter 3	July 1- September 30	October 1- **February 15**
Quarter 4	October 1- December 31	January 1- **May 15**

We invite public comment on the proposed data collection period and data submission deadlines affecting the FY 2019 payment determination and subsequent years and on our use of CY reporting with quarterly deadlines following a period of approximately 4.5 months of time to enable the correction of such data.

d. Proposed Timeline and Data Submission Mechanisms for Claims-Based Measures Proposed for the FY 2018 Payment Determination and Subsequent Years

The Medicare Spending per Beneficiary- PAC SNF QRP, Discharge to Community- PAC SNF QRP, and Potentially Preventable Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP measures, which we have proposed in this proposed rule, are Medicare FFS claims-based measures. Because claims-based measures can be calculated based on data that are already reported to the Medicare program for payment purposes, no additional information collection will be required from SNFs. As previously discussed in V.B.6., for the Medicare Spending per Beneficiary-PAC SNF QRP Measure, the Discharge to Community-PAC SNF QRP measure and the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP, we propose to use 1 year of claims data beginning with CY 2016 claims data to inform confidential feedback reports for SNFs, and CY 2017 claims data for public reporting.

We invite public comments on this proposal.

e. Proposed Timeline and Data Submission Mechanisms for the FY 2020 Payment Determination and Subsequent Years for New SNF QRP Assessment-Based Quality Measure

As discussed in section V.B.7. of this proposed rule, for the proposed measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues - PAC SNF QRP, affecting FY 2020 payment determination and subsequent years, we are proposing that SNFs would submit data by completing data elements to be included in the MDS and then submitting the MDS to CMS through the Quality Improvement and Evaluation System (QIES), Assessment Submission and Processing System (ASAP) system beginning October 1, 2018. For more information on SNF QRP reporting through the QIES ASAP system, refer to the "Related Links" section at the bottom of: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage.

We invite public comments on our proposed SNF QRP data collection requirements for the proposed measure affecting the FY 2020 payment determination and subsequent years.

For the FY 2020 payment determination, we propose that SNFs submit data on the proposed assessment-based quality measure for residents who are admitted to the SNF on and after October 1, 2018, and discharged from SNF Part A covered stays (that is, both residents discharged from Part A covered stays and physically discharged) up to and including December 31, 2018, using the data submission schedule that we propose in this section.

We propose to collect a single quarter of data for the FY 2020 payment determination to remain consistent with the usual October release schedule for the MDS, to give SNFs a sufficient amount of time to update their systems so that they can comply with the new data reporting requirements, and to give CMS a sufficient amount of time to determine compliance for the FY 2020 program. The proposed use of one quarter of data for the initial year of assessment data reporting in the SNF QRP is consistent with the approach we used previously for the SNF QRP

and in other QRPs, including the LTCH, IRF, and Hospice QRPs in which we have finalized the use of fewer than 12 months of data.

We also propose that following the close of the reporting quarter, October 1, 2018, through December 31, 2018, for the FY 2020 payment determination, SNFs would have an additional 4.5 months to correct and/or submit their quality data and that the final deadline for submitting data for the FY 2020 payment determination would be May 15, 2019. We further propose that for the FY 2021 payment determination and subsequent years, we will collect data using the CY reporting cycle as previously proposed in section V.B.9.c of this proposed rule.

TABLE 17: Proposed New SNF QRP Assessment-Based Quality Measures- Data Collection Period and Data Submission Deadlines Affecting the FY 2020 Payment Determination

Quality Measure	Data Collection Source	Proposed Data Collection/Submission Reporting Period	Proposed Data Submission Deadline for FY 2020 Payment Determination
Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP	MDS	10/01/18 – 12/31/18	May 15, 2019

We invite public comment on the proposed new SNF QRP assessment-based quality measure data collection period and data submission deadline affecting the FY 2020 payment determination.

For this measure, we also propose to follow a CY schedule for measure and data submission requirements that includes quarterly deadlines following each quarter of data submission, beginning with data reporting for the FY 2021 payment determinations. As previously discussed, each quarterly deadline will occur approximately 4.5 months after the end of a given calendar quarter as outlined in Table 18. Thus, if finalized, the FY 2021 payment determination would be based on 12 calendar months of data reporting beginning January 1, 2019, and ending December 31, 2019. Table 18 provides the data submission and collection method, data collection period and data submission timelines for the assessment-based quality

measure affecting the FY 2021 payment determination and subsequent years.

TABLE 18: New SNF QRP Assessment-Based Quality Measure Data Collection Period and Data Submission Deadline Affecting FY 2021 Payment Determination and Subsequent Years

Quality Measure	Data Collection Source	Proposed Data Collection/ submission Quarterly Reporting Period*	Proposed Data Submission Quarterly Deadlines for FY 2021 Payment Determination**
Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP	MDS	CY 19 Q1 1/1/2019-3/31/2019 CY 19 Q2 4/1/2019-6/30/19 CY 19 Q3 7/1/2019-9/30/2019 CY 19 Q4 10/1/2019-12/31/2019	CY 2019 Q1 Deadline: August 15, 2019 CY 2019 Q2 Deadline: November 15, 2019 CY 2019 Q3 Deadline: February 15, 2020 CY 2019 Q4 Deadline May 15, 2020

* Data collection/submission will follow a similar quarterly reporting period schedule for subsequent CYs.
** Data review and correction periods and data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

We invite public comment on the SNF QRP assessment-based quality measure data collection period and data submission deadline affecting the FY 2021 payment determination and subsequent years for the new assessment-based measure.

10. SNF QRP Data Completion Thresholds for the FY 2018 Payment Determination and Subsequent Years

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46458) for our finalized policies regarding data completion thresholds for the FY 2018 payment determination and subsequent years. We finalized that, beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the proposed quality measures on at least 80 percent of the MDS assessments that they submit. We also finalized that, for the FY 2018 SNF QRP, any SNF that does not meet the proposed requirement that 80 percent of all MDS assessments submitted contain 100 percent of all data items necessary to calculate the SNF QRP measures would be subject to a reduction of 2 percentage points to its FY 2018 market basket

percentage. We finalized that a SNF has reported all of the data necessary to calculate the measures if the data actually can be used for purposes of calculating the quality measures, as opposed to, for example, the use of a dash [-], to indicate that the SNF was unable to perform a pressure ulcer assessment. We wish to clarify that the provision we finalized will affect FY 2018 payment determinations and subsequent years and is dependent upon the successful achievement of the completion threshold of the data used to calculate the measures we finalize. At this time, we are not proposing any changes to these policies.

11. SNF QRP Data Validation Requirements for the FY 2018 Payment Determination and Subsequent Years

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46458 through 46459) for a summary of our approach to the development of data validation process for the SNF QRP. At this time, we are continuing to explore data validation methodology that will limit the amount of burden and cost to SNFs, while allowing us to establish estimations of the accuracy of SNF QRP data. Hence, we are not proposing any further details pertaining to the data validation process for the SNF QRP, but we plan to do so in future rulemaking cycles.

12. SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent Years

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46459 through 46460) for our finalized policies regarding submission exception and extension requirements for the FY 2018 payment determination and subsequent years. At this time, we are not proposing any changes to these policies.

13. SNF QRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years

We refer the reader to the FY 2016 SNF PPS final rule (80 FR 46460 through 46461) for a summary of our finalized reconsideration and appeals procedures for the SNF QRP for FY 2018

payment determination and subsequent years. At this time, we are not proposing any changes to these procedures.

14. Public Display of Quality Measure Data for the SNF QRP & Procedures for the Opportunity to Review and Correct Data and Information

Section 1899B(g) of the Act requires the Secretary to establish procedures for public reporting of SNFs' performance, including the performance of individual SNFs, on quality measures specified under paragraph (c)(1) and resource use and other measures specified under paragraph (d)(1) of the Act (collectively, IMPACT Act measures) beginning not later than 2 years after the applicable specified application date under section 1899B(a)(2)(E) of the Act. Under section 1899B(g)(2) of the Act, the procedures must ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act, which refers to public display and review requirements in the Hospital Inpatient Quality Reporting Program (HIQR), that each SNF has the opportunity to review and submit corrections to its data and information that are to be made public prior to the information being made public. In future rulemaking, we intend to propose a policy to publicly display performance information for individual SNFs on IMPACT Act measures, as required under the Act.

In this proposed rule, we are proposing procedures that would allow individual SNFs to review and correct their data and information on IMPACT Act measures that are to be made public before those measure data are made public.

For assessment-based measures, we propose a process by which we would provide each SNF with a confidential feedback report that would allow the SNF to review its performance on such measures and, during a review and correction period, to review and correct the data the SNF submitted to CMS via the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for each such measure. In addition, during the review and correction period, the SNF would be able to request correction of any

errors in the assessment-based measure rate calculations.

We propose that these confidential feedback reports would be available to each SNF using the Certification and Survey Provider Enhanced Reporting (CASPER) System. We refer to these reports as the SNF Quality Measure (QM) Reports. We propose to provide monthly updates to the data contained in these reports that pertain to assessment-based data, as the data become available. We propose to provide the reports so that providers would be able to view their data and information at both the facility- and resident-level for quality measures. The CASPER facility-level QM Reports may contain information such as the numerator, denominator, facility rate, and national rate. The CASPER patient-level QM Reports may contain individual patient information which will provide information related to which patients were included in the quality measures to identify any potential errors. In addition, we would make other reports available in the CASPER System, such as MDS data submission reports and provider validation reports, which would disclose SNFs' data submission status, providing details on all items submitted for a selected assessment and the status of records submitted. Additional information regarding the content and availability of these confidential feedback reports would be provided on an ongoing basis at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html.

As previously proposed in section V.B.9.b, SNFs would have approximately 4.5 months after the reporting quarter to correct any errors that appear on the CASPER-generated QM reports pertaining to their assessment-based data used to calculate the assessment-based measures. During the time of data submission for a given quarterly reporting period and up until the quarterly submission deadline, SNFs could review and perform corrections to errors in the assessment data used to calculate the measures and could request correction of measure calculations. However, once the quarterly submission deadline occurs, the data is "frozen" and

calculated for public reporting and providers can no longer submit any corrections. We would encourage SNFs to submit timely assessment data during a given quarterly reporting period and review their data and information early during the review and correction period so that they can identify errors and resubmit data before the data submission deadline.

As noted in this section, the data would be populated into the confidential feedback reports and we intend to update the reports monthly with all data that have been submitted and are available. We believe that a proposed data submission and review period consisting of the reporting quarter plus approximately 4.5 months, is sufficient time for SNFs to submit, review and, where necessary, correct their data and information. These proposed time frames and deadlines for review and correction of assessment-based measures and data satisfy the statutory requirement that SNFs be provided the opportunity to review and correct their data and information that is to be made public and are consistent with the informal process hospitals follow in the HIQR Program.

We propose that, in addition to the data collection/submission quarterly reporting periods that are followed by data review and correction periods and submission deadlines, we afford SNFs a 30-day preview period prior to public display during which SNFs may preview the performance information on their measures that will be made public. We propose to provide a preview report also using the CASPER System with which SNFs are familiar. The CASPER preview reports would inform providers of their performance on each measure which will be publicly reported. The CASPER preview reports for the reporting quarter will be available after the 4.5-month review and correction period and its data submission deadline, and are refreshed on a quarterly basis for those measures publicly reported quarterly, and annually for those measures publicly reported annually. We propose to give SNFs 30 days to review this information, beginning from the date on which they can access the preview report. Corrections to the underlying data would not be permitted during this time; however, SNFs may contest

incorrect measure calculations during the 30-day preview period. We propose that if CMS determines that the measure, as it is displayed in the preview report, contains a calculation error, CMS could suppress the data on the public reporting Web site, recalculate the measure and publish it at the time of the next scheduled public display date. This process would be consistent with that followed in the HIQR Program. If finalized, we intend to utilize a subregulatory mechanism, such as our SNF QRP Web site, to explain the process for how and when providers may ask for a correction to their measure calculations.

We invite public comment on these proposals.

In addition to assessment-based measures, we have also proposed claims-based measures for the SNF QRP. As noted in this section, section 1899B(g)(2) of the Act requires prepublication provider review and correction procedures that are consistent with those followed in the HIQR Program. For claims-based measures used in the HIQR Program, we provide hospitals 30 days to preview their claims-based measures and data in a preview report containing aggregate hospital-level data. We propose to adopt a similar process for the SNF QRP.

Prior to the public display of our claims-based measures, in alignment with the HIQR, HAC and HVBP Programs, we propose to make available through the CASPER system a confidential preview report that will contain information pertaining to claims-based measure rate calculations, for example, facility and national rates. Such data and information would be for feedback purposes only and could not be corrected. This information would be accompanied by additional confidential information based on the most recent administrative data available at the time we extract the claims data for purposes of calculating the rates. Because the claims-based measures are calculated on an annual basis, these confidential CASPER QM reports for claims-based measures will be refreshed annually. SNFs would have 30 days from the date the preview report is made available in which to review this information. The 30-day preview period is the only time when SNFs would be able to see claims-based measures before they are publicly

displayed. SNFs will not be able to make corrections to underlying claims data during this preview period, nor will they be able to add new claims to the data extract. However, SNFs may request that we correct our measure calculation if the SNF believes it is incorrect during the 30 day preview period. We propose that if we agree that the measure, as it is displayed in the preview report, contains a calculation error, we would suppress the data on the public reporting website, recalculate the measure, and publish it at the time of the next scheduled public display date. This process would be consistent with that followed in the HIQR Program. If finalized, we intend to utilize a subregulatory mechanism, such as our SNF QRP website, to explain the process for how and when providers may contest their measure calculations.

The proposed claims-based measures—Medicare Spending per Beneficiary- PAC SNF QRP Measure; Discharge to Community- PAC SNF QRP and Potentially Preventable 30 Day Post-Discharge Readmission Measure for SNF QRP—use Medicare administrative data from hospitalizations for Medicare FFS beneficiaries. Public reporting of data will be based on one CY of data. We propose to create data extracts using claims data for these claims based measures, at least 90 days after the last discharge date in the applicable period (12 calendar months preceding), which we will use for the calculations. For example, if the last discharge date in the applicable period for a measure is December 31, 2017, for data collection January 1, 2017, through December 31, 2017, we would create the data extract on approximately March 31, 2018, at the earliest, and use that data to calculate the claims-based measures for that applicable period. Since SNFs would not be able to submit corrections to the underlying claims snapshot nor add claims (for those measures that use SNF claims) to this data set at the conclusion of the at least 90-day period following the last date of discharge used in the applicable period, at that time we would consider SNF claims data to be complete for purposes of calculating the claims-based measures.

We propose that beginning with data that will be publicly displayed in 2018, claims-

based measures will be calculated using claims data with at least a 90 day run off period after the last discharge date in the applicable period, at which time we would create a data extract or snapshot of the available claims data to use for the measure calculations. This timeframe allows us to balance the need to provide timely program information to SNFs with the need to calculate the claims-based measures using as complete a data set as possible. As noted, under this proposed procedure, during the 30-day preview period, SNFs would not be able to submit corrections to the underlying claims data or add new claims to the data extract. This is for two reasons. First, for certain measures, the claims data used to calculate the measure is derived not from the SNF's claims, but from the claims of another provider. For example, the proposed measure Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP uses claims data submitted by the hospital to which the patient was readmitted. The claims are not those of the SNF, and therefore, the SNF could not make corrections to them. Second, even where the claims used to calculate the measures are those of the SNF, it would not be not possible to correct the data after it is extracted for the measures calculation. This is because it is necessary to take a static "snapshot" of the claims to perform the necessary measure calculations.

We seek to have as complete a data set as possible. We recognize that the proposed at least 90-day "run-out" period when we would take the data extract to calculate the claims-based measures is less than the Medicare program's current timely claims filing policy under which providers have up to one year from the date of discharge to submit claims. We considered a number of factors in determining that the proposed at least 90-day run-out period is appropriate to calculate the claims-based measures. After the data extract is created, it takes several months to incorporate other data needed for the calculations (particularly in the case of risk-adjusted or episode-based measures). We then need to generate and check the calculations. Because several months lead time is necessary after acquiring the data to generate the claims-based calculations, if we were to delay our data extraction point to 12 months after the last date of the last discharge

in the applicable period, we would not be able to deliver the calculations to SNFs sooner than 18 to 24 months after the last discharge. We believe this would create an unacceptably long delay, both for SNFs and for us to deliver timely calculations to SNFs for quality improvement.

We invite public comment on these proposals.

15. Mechanism for Providing Feedback Reports to SNFs

Section 1899B(f) of the Act requires the Secretary to provide confidential feedback reports to post-acute care providers on their performance for the measures specified under paragraphs (c)(1) and (d)(1), beginning 1 year after the specified application date that applies to such measures and PAC providers. As discussed earlier, the reports we propose to provide to SNFs to review their data and information would be confidential feedback reports that would enable SNFs to review their performance on the measures required under the SNF QRP. We propose that these confidential feedback reports would be available to each SNF using the CASPER System. Data contained within these CASPER reports would be updated, as previously described, on a monthly basis as the data become available except for claims-based measures which can only be previewed on an annual basis.

We intend to provide detailed procedures to SNFs on how to obtain their confidential feedback CASPER reports on the SNF QRP website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html. We propose to use the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system to provide quality measure reports in a manner consistent with how providers obtain such reports to date. The QIES ASAP system is a confidential and secure system with access granted to providers, or their designees.

We seek public comment on this proposal to satisfy the requirement to provide confidential feedback reports to SNFs.

C. SNF Payment Models Research

As discussed in the FY 2015 SNF PPS proposed rule (79 FR 25786, May 6, 2014), we contracted with Acumen, LLC to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. Since that time, in an effort to establish a comprehensive approach to Medicare Part A SNF payment reform, we subsequently expanded the scope of the SNF Therapy Payment Research project to examine potential improvements and refinements to the overall SNF PPS payment system. In this proposed rule, we are taking the opportunity to update the public on the current state of the expanded SNF PMR project.

As has been stated previously, in September 2013, we completed the first phase of the SNF PMR, which included a literature review, stakeholder outreach, supplementary analyses, and a comprehensive review of options for a viable alternative to the current therapy payment model. CMS produced a report outlining the most promising and viable options that we plan to pursue in the second phase of the project. The report is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

During the second, and current, phase of the SNF PMR, which began in September 2013, our team has focused on developing the options outlined in the aforementioned report and has performed more comprehensive data analyses to begin outlining a new SNF payment model which could serve as a potential replacement for the current SNF PPS. To utilize the expertise of the stakeholder community in identifying the most viable alternative to the current SNF payment model, Acumen has hosted two TEPs. These TEPs brought together experts from across the SNF and post-acute care continuums to examine Acumen's research around a given topic and provide their comments and direction on where Acumen's research should continue.

The first TEP, which occurred in February 2015, was focused on the therapy component of SNF PPS. The objectives of this TEP were to discuss potential criteria for evaluating therapy payment approaches, review and discuss the key features of SNF therapy payment approaches,

and solicit recommendations for the further exploration and development of SNF therapy payment approaches. The presentation given by Acumen during this TEP, as well as a report which provides a summary of the discussion and recommendations from the TEP panelists, is available https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

The second TEP, which occurred in November 2015, was focused on the nursing component of the SNF PPS. This TEP included discussion of both the adequacy of nursing payments, as well as discussion of non-therapy ancillaries (NTAs), such as drugs. The overall objectives of this TEP were to review and discuss implications of research on the nursing component of SNF payments, evaluate alternative approaches to payment for SNF nursing and NTA services, and solicit recommendations for the further exploration and development of SNF nursing payment approaches. The presentation given by Acumen during this TEP, as well as a report which provides a summary of the discussion and recommendations from the TEP panelists, is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

We expect that Acumen will host a third TEP which will bring together the recommendations from stakeholders on the individual SNF payment elements, as well as the extensive analytic work conducted by Acumen, to outline what could serve as a potential revised SNF PPS payment model. As we have done with the two previous TEPs, we expect to post the presentation given by Acumen during this TEP, as well as a report which will provide a summary of the discussion and recommendations from the TEP panelists, after the TEP is completed.

As before, comments may be included as part of comments on this proposed rule. We are also soliciting comments outside the rulemaking process and these comments should be sent via email to SNFTherapyPayments@cms.hhs.gov. Information regarding the SNF PMR is available

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

VI. Collection of Information Requirements

Section V.B.6. of this preamble proposes the following three claims based measures for the FY 2018 payment determination and subsequent years: (1) Medicare Spending per Beneficiary-PAC SNF QRP; (2) Discharge to Community-PAC SNF QRP; and (3) Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP. These three measures are Medicare claims-based measures; because claims-based measures can be calculated based on data that are already reported to the Medicare program for payment purposes, we believe there will be no additional burden.

For the FY 2020 payment determination and subsequent years, in section V.B.6. we are also proposing one measure: Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC SNF QRP. Additionally, we propose that data for this measure will be collected and reported using the MDS (version effective October 1, 2018). While the reporting of data on quality measures is an information collection, we believe that the burden associated with modifications to the MDS discussed in this proposed rule fall under the PRA exceptions provided in section 1899B(m) of the Act because they are required to achieve the standardization of patient assessment data. Section 1899B(m) of the Act also provides that the PRA does not apply to section 1899B and the sections referenced in section 1899B(a)(2)(B) of the Act that require modification to achieve the standardization of patient assessment data. The requirement and burden will, however, be submitted to OMB for review and approval when the modifications to the MDS or other applicable PAC assessment instruments have achieved standardization and are no longer exempt from the burden submission requirements under section 1899B(m) of the Act.

We estimate the additional elements for the four newly proposed measures will take 7.5

minutes of nursing/clinical staff time to report data on admission and 2.5 minutes of nursing/clinical staff time to report data on discharge, for a total of 10 minutes. We estimate that the additional MDS-RAI items we are proposing will be completed by Registered Nurses (RN) for approximately 75 percent of the time required and Pharmacists for approximately 25 percent of the time required. Individual providers determine the staffing resources necessary. We estimate 2,101,370 discharges from 16,484 SNFs annually, with an additional burden of 10 minutes. This would equate to 350,228 total hours or 21.25 hours per SNF. We believe this work will be completed by RNs (75 percent) and Pharmacists (25 percent). We obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates (http://www.bls.gov/oes/current/oes_nat.htm), to account for overhead and fringe benefits, we have doubled the mean hourly wage. Per the National Occupational Employment and Wage Estimates, the mean hourly wage for a RN (BLS occupation code: 29-1141) is $33.55. However, to account for overhead and fringe benefits, we have double the mean hourly wage, making it $67.10 for an RN. The mean hourly wage for a pharmacist (BLS occupation code: 29-1051) is $56.96. To account for overhead and fringe benefits, we have double the mean hourly wage, making it $113.92 for a pharmacist. Given these wages and time estimates, the total cost related to the four newly proposed measures is estimated at $1,674.34 per SNF annually, or $27,599,743.81 for all SNFs annually. While we are setting out burden, the requirements and associated estimates will not be submitted to OMB for approval under Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.) since the burden estimates are either claims-based or associated with the exemption under section 1899B(m) of the IMPACT Act of 2014. We are setting out the burden as a courtesy to advise interested parties of the proposed actions' time and costs.

As described in further detail in section V.A.2.b. of this proposed rule, we are proposing to specify the SNFPPR measure for the SNF VBP Program. Like the SNFRM (NQF #2510),

which was adopted for the SNF VBP Program in the FY 2016 SNF PPS final rule (80 FR 46419), the proposed SNFPPR measure is also claims-based. Because claims-based measures are calculated based on claims that are already submitted to the Medicare program for payment purposes, there is no additional burden associated with data collection or submission for these measures. Thus there is no additional reporting burden associated with the SNFPPR measure.

If you wish to comment on any of the aforementioned claims, please submit your comments as specified under the DATES and ADDRESSES captions of this proposed rule.

VII. 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.

VIII. Economic Analyses

A. Regulatory Impact Analysis

1. 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), and the Congressional Review Act (5 U.S.C. 804(2)).

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.

2. Statement of Need

This proposed rule would update the FY 2016 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.

3. Overall Impacts

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2016 (80 FR 46390). Based on the above, we estimate that the aggregate impact would be an increase of $800 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment. The impact analysis of this proposed rule represents the projected effects of the changes in the SNF PPS from FY 2016 to FY 2017. Although the best data available are utilized, there is no attempt to predict behavioral responses to these changes, or to make adjustments for future changes in such variables as days or case-mix.

Certain 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 certain events

that may occur within the assessed impact time period. Some examples of possible events may include newly-legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of previously-enacted legislation, or new statutory provisions. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is such that the changes may interact and, thus, the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we would update the FY 2016 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 2017. As discussed previously, for FY 2012 and each subsequent FY, as required by section 1888(e)(5)(B) of the Act, as amended by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by the MFP adjustment. The special AIDS add-on established by section 511 of the MMA remains in effect until such date as the Secretary certifies that there is an appropriate adjustment in the case mix. We have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are fewer than 4,800 beneficiaries who qualify for the add-on payment for residents with AIDS. The impact to Medicare is included in the total column of Table 19. In updating the SNF PPS rates for FY 2017, 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 2017. Accordingly, the analysis that follows only describes the impact of this single year. In accordance with the requirements of the Act, we will publish a notice or rule for each subsequent FY that will provide for an update to the SNF PPS payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2017 SNF PPS payment impacts appear in Table 19. Using the most recently available data, in this case FY 2015, we apply the current FY 2016 wage index and labor-related share value to the number of payment days to simulate FY 2016 payments. Then, using the same FY 2015 data, we apply the proposed FY 2017 wage index and labor-related share value to simulate FY 2017 payments. We tabulate the resulting payments according to the classifications in Table 19 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2016 payments to the simulated FY 2017 payments to determine the overall impact. The breakdown of the various categories of data in the table 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 zero percent; however, there are distributional effects of the change.

- The fourth column shows the effect of all of the changes on the FY 2017 payments. The update of 2.1 percent (consisting of the market basket increase of 2.6 percentage points, reduced by the 0.5 percentage point MFP adjustment) 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 2.1 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 19, 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 Outlying region would experience a 2.3 percent increase in FY 2017 total payments.

TABLE 19: Projected Impact to the SNF PPS for FY 2017

	Number of Facilities FY 2017	Update Wage Data	Total Change
Group			
Total	15,427	0.0%	2.1%
Urban	10,935	0.0%	2.1%
Rural	4,492	0.0%	2.1%
Hospital based urban	524	0.0%	2.1%
Freestanding urban	10,411	0.0%	2.1%
Hospital based rural	606	0.0%	2.1%
Freestanding rural	3,886	0.0%	2.1%
Urban by region			
New England	797	0.0%	2.1%
Middle Atlantic	1,481	0.0%	2.1%
South Atlantic	1,861	0.0%	2.1%
East North Central	2,092	0.0%	2.1%
East South Central	547	0.0%	2.1%
West North Central	905	0.0%	2.1%
West South Central	1,321	0.0%	2.1%
Mountain	507	0.0%	2.1%
Pacific	1,419	-0.1%	2.0%
Outlying	5	0.2%	2.3%
Rural by region			
New England	139	0.0%	2.1%
Middle Atlantic	221	0.0%	2.1%
South Atlantic	505	0.1%	2.2%
East North Central	933	0.0%	2.1%
East South Central	529	0.1%	2.2%
West North Central	1,087	0.0%	2.1%
West South Central	743	0.1%	2.2%
Mountain	231	0.0%	2.1%
Pacific	104	0.0%	2.1%
Ownership			
Government	1,022	0.0%	2.1%
Profit	10,773	0.0%	2.1%
Non-profit	3,632	0.0%	2.1%

Note: The Total column includes the 2.6 percent market basket increase, reduced by the 0.5 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

5. Alternatives Considered

As described in this section, we estimate that the aggregate impact for FY 2017 under the SNF PPS would be an increase of $800 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment.

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 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 the payment methodology as discussed previously.

6. 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 Table 20, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 20 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 15,421 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 20: Accounting Statement: Classification of Estimated Expenditures, from the

2016 SNF PPS Fiscal Year to the 2017 SNF PPS Fiscal Year

Category	Transfers
Annualized Monetized Transfers	$800 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

* The net increase of $800 million in transfer payments is a result of the MFP adjusted market basket increase of $800 million.

7. Conclusion

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2016 (80 FR 46390). Based on the above, we estimate the overall estimated payments for SNFs in FY 2017 are projected to increase by $800 million, or 2.1 percent, compared with those in FY 2016. We estimate that in FY 2017 under RUG-IV, SNFs in urban and rural areas would experience, on average, a 2.1 and 2.1 percent increase, respectively, in estimated payments compared with FY 2016. Providers in the urban Outlying region would experience the largest estimated increase in payments of approximately 2.3 percent. Providers in the urban Pacific region would experience the smallest estimated increase in payments of 2.0 percent.

8. Effects of the Proposed Requirements for the SNF VBP and SNF QRP Program

The proposed requirements set forth for the SNF VBP and SNF QRP Program in this proposed rule would not impact SNFs in FY 2017; therefore, we are not including a regulatory impact analysis for the SNF VBP and SNF QRP Program in this proposed rule.

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, we estimate approximately 91 percent of SNFs are considered small businesses 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 25 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 2016 (80 FR 46390). Based on the above, we estimate that the aggregate impact would be an increase of $800 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment. While it is projected in Table 19 that most 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 2017 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. According to MedPAC, Medicare covers approximately 12 percent of total patient days in freestanding facilities and 21 percent of facility revenue (Report to the Congress: Medicare Payment Policy, March 2016, available at http://medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf). 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 19. As indicated in Table 19, the effect on facilities is projected to be an aggregate

positive impact of 2.1 percent. 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.

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 2016 (80 FR 46476)), 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 19, the effect on facilities is projected to be an aggregate positive impact of 2.1 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.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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 2016, that threshold is approximately $146 million. This proposed rule does not include any mandate on state, local, or tribal governments in the aggregate, or by the private sector, of $146 million.

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.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

Dated: April 6, 2016

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Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Dated: April 14, 2016

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Sylvia M. Burwell,

Secretary,

Department of Health and Human Services.

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