

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 411, 413, 424, and 488

[CMS-1679-P]

RIN 0938-AS96

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal To Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020

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) 2018. It also proposes to revise and rebase the market basket index by updating the base year from 2010 to 2014, and by adding a new cost category for Installation, Maintenance, and Repair Services. The rule also includes proposed revisions to the SNF Quality Reporting Program (QRP), including measure and standardized patient assessment data proposals and proposals related to public display. In addition, it includes proposals for the Skilled Nursing Facility Value-Based Purchasing Program that will affect Medicare payment to SNFs beginning in FY 2019 and clarification on the requirements regarding the composition of professionals for the survey team. The proposed rule also seeks to clarify the regulatory requirements for team composition for surveys conducted for investigating a complaint and to align regulatory provisions for investigation of complaints with the statutory requirements. The proposed rule also includes one proposal related to the performance period for the National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Reporting Measure included in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2017.

ADDRESSES: In commenting, please refer to file code CMS-1679-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-AS96, 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-1679-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-1679-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 SW., 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.

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

James Poyer, (410) 786-2261 and Stephanie Frilling, (410) 786-4507, for information related to the skilled nursing facility value-based purchasing program.

Delia Houseal, (410) 786-2724, for information related to the end-stage renal disease quality incentive program.

Rebecca Ward, (410) 786-1732 and Caecilia Blondiaux, (410) 786-2190, for survey type definitions.

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 Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site 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 Web site

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no

longer published in the **Federal Register**. Instead, these tables are available exclusively through the Internet on the CMS Web site. 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/SNFPSP/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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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
 ALJ Administrative Law Judge
 ARD Assessment reference date

BBA Balanced Budget Act of 1997, Public Law 105-33
 BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106-113
 BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554
 CAH Critical access hospital
 CARE Continuity Assessment Record and Evaluation
 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
 DTI Deep tissue injuries
 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
 ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification
 IGI IHS (Information Handling Services) Global Insight, Inc.
 IMPACT Improving Medicare Post-Acute Care Transformation Act of 2014, Public Law 113-185
 IPPS Inpatient prospective payment system
 IRF Inpatient Rehabilitation Facility
 IRF-PAI Inpatient Rehabilitation Facility Patient Assessment Instrument
 LTC Long-term care
 LTCH Long-term care hospital
 MACRA Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10
 MAP Measures Application Partnership
 MDS Minimum data set
 MFP Multifactor productivity
 MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173
 MSA Metropolitan statistical area
 NF Nursing facility
 NQF National Quality Forum
 OASIS Outcome and Assessment Information Set
 OBRA 87 Omnibus Budget Reconciliation Act of 1987, Public Law 100-203
 OMB Office of Management and Budget
 PAC Post-acute care
 PAMA Protecting Access to Medicare Act of 2014, Public Law 113-93
 PPS Prospective Payment System
 PQRS Physician Quality Reporting System
 QIES Quality Improvement and 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, Public Law 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
 SNF Skilled nursing facility
 SNF PMR Skilled Nursing Facility Payment Models Research
 SNF QRP Skilled Nursing Facility Quality Reporting Program
 SNF VBP Skilled Nursing Facility Value-Based Purchasing Program
 SNFPPR Skilled Nursing Facility Potentially Preventable Readmission Measure
 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, Public Law 104-4
 VBP Value-based purchasing

I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for FY 2018 as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It would also respond to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register**, before the August 1 that precedes the start of each fiscal year (FY), certain specified information relating to the payment update (see section II.C. of this proposed rule). This proposed rule also includes proposals that would update the requirements for the Skilled Nursing Facility Quality Reporting Program (SNF QRP), additional proposals for the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), and clarification of requirements related to survey team composition and investigation of complaints under §§ 488.30, 488.301, 488.314, and 488.308. The proposed rule also includes one proposal related to the performance period for the National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Reporting Measure included in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). Finally, in this proposed rule we will be soliciting comments regarding potential changes to the recently finalized Requirements for Long-Term Care Facilities that would result in a burden reduction if modified or eliminated, as well as potential CMMI models or other

demonstration projects that would reduce cost and increase quality of care for SNF, or more generally Post-Acute Care patients.

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 2017 (81 FR 51970), which reflects the SNF market basket update, as required by section 1888(e)(5)(B)(iii) of the Act for FY 2018. Additionally, in section V.A. of this proposed rule, we propose to revise and rebase the market basket index for FY 2018 and subsequent FYs by updating the base year from 2010 to 2014, and by adding a new cost category for Installation, Maintenance, and Repair Services. We are also proposing additional polices, measures and data reporting requirements for the Skilled Nursing Facility Quality Reporting Program (SNF QRP) and requirements for the SNF VBP Program, including an exchange function to translate SNF performance scores calculated using the program's scoring methodology into value-based incentive payments.

We also propose to clarify the regulatory requirements for team composition for surveys conducted for the purposes of investigating a complaint and on-site monitoring of compliance, and to align the regulatory provisions for special surveys and investigation of complaints with the statute. The proposed changes clarify that the requirement for an interdisciplinary team that must include registered nurse is applicable to surveys conducted under sections 1819(g)(2) and 1919(g)(2) of the Act, and not to those surveys conducted to investigate complaints or to monitor compliance on-site under sections 1819(g)(4) and 1919(g)(4) of the Act. Revising the regulatory language under §§ 488.30, 488.301, 488.308, and 488.314 to correspond to the statutory requirements found in sections 1819(g) and 1919(g) of the Act will add clarity to these requirements by making them more explicit. We also propose to revise the performance period for the National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Reporting Measure included in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP).

C. Summary of Cost and Benefits

Provision description	Total transfers
Proposed FY 2018 SNF PPS payment rate update.	The overall economic impact of this proposed rule would be an estimated increase of \$390 million in aggregate payments to SNFs during FY 2018.
Proposed FY 2018 Cost to Updating the Quality Reporting Program.	The overall cost for SNFs to submit data for the Quality Reporting Program for the provisions in this proposed rule is \$60 million.

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 physicians' services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf.

Section 215(a) of Protecting Access to Medicare Act of 2014 (Pub. L. 113–93, enacted on April 1, 2014) (PAMA) added section 1888(g) to the Act requiring the Secretary to specify an all-cause all-condition hospital readmission measure and 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 Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185, enacted October 6, 2014) (IMPACT Act) added section 1899B to the Act that, among other things, requires SNFs to report standardized assessment data including such data on quality measures in specified quality measure domains, as well as data on resource use and other 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 2017 (81 FR 51970, August 5, 2016).

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

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

Along with other proposed revisions discussed later in this preamble, this proposed rule would provide the

required annual updates to the per diem payment rates for SNFs for FY 2018.

III. SNF PPS Rate Setting Methodology and FY 2018 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. In the SNF PPS final rule for FY 2014 (78 FR 47939 through 47946), we revised and rebased the market basket index, which

included updating the base year from FY 2004 to FY 2010. For FY 2018, as discussed in section V.A. of this proposed rule, we are proposing to rebase and revise the SNF market basket, updating the base year from FY 2010 to 2014.

The SNF market basket index is used to compute the market basket percentage change that is used to update the SNF federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage update is adjusted by a forecast error correction, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule. For FY 2018, the growth rate of the proposed 2014-based SNF market basket is estimated to be 2.7 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2017 forecast with historical data through fourth quarter 2016.

However, we note that section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114–10, enacted on April 16, 2015) (MACRA) amended section 1888(e) of the Act to add section 1888(e)(5)(B)(iii) of the Act. Section 1888(e)(5)(B)(iii) of the Act establishes a special rule for FY 2018 that requires the market basket percentage, after the application of the productivity adjustment, to be 1.0 percent. In accordance with section 1888(e)(5)(B)(iii) of the Act, we will use a market basket percentage of 1.0 percent to update the federal rates set forth in this proposed rule. In section III.B.5. of this proposed rule, we discuss the specific application of the MACRA-specified market basket adjustment to the forthcoming annual update of the SNF PPS payment rates. In addition, in section V.B.1. of this proposed rule, we discuss the 2 percent reduction applied to the market basket update for those SNFs that fail to submit measures data as required by section 1888(e)(6)(A) of the Act.

2. Use of the SNF Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of the previous FY to the midpoint of the current FY. Absent the addition of section 1888(e)(5)(B)(iii) of the Act, added by section 411(a) of MACRA, we would have used the percentage change in the SNF market basket index to compute the update factor for FY 2018. Based on the

proposed revision and rebasing of the SNF market basket discussed in section V.A. of this proposed rule, this factor would be based on the IGI first quarter 2017 forecast (with historical data through the fourth quarter 2016) of the FY 2018 percentage increase in the proposed 2014-based SNF market basket index reflecting routine, ancillary, and capital-related expenses. As discussed in sections III.B.3. and III.B.4. of this proposed rule, this market basket percentage change would be reduced by the applicable forecast error correction (as described in § 413.337(d)(2)) and by the MFP adjustment as required by section 1888(e)(5)(B)(ii) of the Act. As noted previously, section 1888(e)(5)(B)(iii) of the Act, added by section 411(a) of the MACRA, requires us to use a 1.0 percent market basket percentage instead of the estimated 2.7 percent market basket percentage, adjusted as described below, to adjust the SNF PPS federal rates for FY 2018. Additionally, as discussed in section II.B. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full federal rates that started with cost reporting periods beginning in July 1998 has expired.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003 final rule (68 FR 46057 through 46059), § 413.337(d)(2) provides for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will reflect both

upward and downward adjustments, as appropriate.

For FY 2016 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.3 percentage points, while the actual increase for FY

2016 was 2.3 percentage points, resulting in the actual increase being the same as the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point

threshold, the FY 2018 market basket percentage change of 2.7 percent would not have been adjusted to account for the forecast error correction. Table 1 shows the forecasted and actual market basket amounts for FY 2016.

TABLE 1—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2016

Index	Forecasted FY 2016 increase *	Actual FY 2016 increase **	FY 2016 difference
SNF	2.3	2.3	0.0

* Published in **Federal Register**; based on second quarter 2015 IGI forecast (2010-based index).

** Based on the first quarter 2017 IGI forecast, with historical data through the fourth quarter 2016 (2010-based index).

4. Multifactor Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (Affordable Care Act) requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the multifactor productivity (MFP) adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the MFP adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost-reporting period, or other annual period). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS Web site 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 Web site at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html>.

a. Incorporating the MFP Adjustment Into the Market Basket Update

Per section 1888(e)(5)(A) of the Act, the Secretary shall establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding fiscal year.

If not for the enactment of section 411(a) of the MACRA, the FY 2018 update would include a calculation of the MFP adjustment as the 10-year moving average of changes in MFP for the period ending September 30, 2018, which is estimated to be 0.4 percent. Also, if not for the enactment of section 411(a) of the MACRA, 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 2018 for the SNF PPS would be based on IGI’s first quarter 2017 forecast of the SNF market basket update, which is estimated to be 2.7 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 would then be reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2018) of 0.4 percent, which would be calculated as described above and based on IGI’s first quarter 2017 forecast. Absent the enactment of section 411(a) of MACRA, the resulting MFP-adjusted SNF market basket update would have been equal to 2.3 percent, or 2.7 percent less 0.4 percentage point. However, as discussed above, section 1888(e)(5)(B)(iii) of the Act, added by section 411(a) of the MACRA, requires us to apply a 1.0 percent positive market basket adjustment in determining the FY 2018 SNF payment rates set forth in this proposed rule, without regard to the market basket update as adjusted by the MFP adjustment described above.

5. Market Basket Update Factor for FY 2018

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 2018 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, 2016, through September 30, 2017 to the average market basket level for the period of October 1, 2017, through September 30, 2018. This process yields a percentage change in the proposed 2014-based SNF market basket of 2.7 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust the market basket percentage change by the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference

between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the difference between the forecasted FY 2016 SNF market basket percentage change and the actual FY 2016 SNF market basket percentage change (FY 2016 is the most recently available FY for which there is historical data) did not exceed the 0.5 percentage point threshold, the FY 2018 market basket percentage change of 2.7 percent would not be adjusted by the forecast error correction.

If not for the enactment of section 411(a) of the MACRA, the SNF market basket for FY 2018 would be determined in accordance with section 1888(e)(5)(B)(ii) of the Act, which requires us to reduce the market basket

percentage change by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2018) of 0.4 percent, as described in section III.B.4. of this proposed rule. Thus, absent the enactment of MACRA, the resulting net SNF market basket update would equal 2.3 percent, or 2.7 percent less the 0.4 percentage point MFP adjustment. We note that our policy has been that, if more recent data becomes available (for example, a more recent estimate of the SNF market basket and/or MFP adjustment), we would use such data, if appropriate, to determine the SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the SNF PPS final rule.

Historically, we have used the SNF market basket, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices from one year to the next. However, section 1888(e)(5)(B)(iii) of the Act, as added by section 411(a) of the MACRA, requires us to use a market basket percentage of 1.0 percent, after application of the MFP to adjust the federal rates for FY 2018. Under section 1888(e)(5)(B)(iii) of the Act, the market basket percentage increase used to determine the federal rates set forth in this proposed rule will be 1.0 percent for FY 2018. Tables 2 and 3 reflect the updated components of the unadjusted federal rates for FY 2018, prior to adjustment for case-mix.

TABLE 2—FY 2018 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing— case-mix	Therapy— case-mix	Therapy— non-case-mix	Non-case-mix
Per Diem Amount	\$177.16	\$133.44	\$17.58	\$90.42

TABLE 3—FY 2018 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing— case-mix	Therapy— case-mix	Therapy— non-case-mix	Non-case-mix
Per Diem Amount	\$169.24	\$153.87	\$18.78	\$92.09

In addition, we note that section 1888(e)(6)(A)(i) of the Act provides that, beginning in FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year involved, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018) (for additional information on the SNF QRP, including the statutory authority and the selected measures, we refer readers to section V.B of this proposed rule). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket index percentage change being less than 0.0 for a fiscal year, and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative

manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act shall apply only for the fiscal year involved, and the Secretary shall not take into account such reduction in computing the payment amount for a subsequent fiscal year.

Accordingly, we propose that beginning with FY 2018, for SNFs that do not satisfy the reporting requirements for the FY 2018 SNF QRP, we would apply a penalty of a 2.0 percentage point reduction to the SNF market basket percentage change for that fiscal year, after application of any applicable forecast error adjustment as specified in § 413.337(d)(2), MFP adjustment as specified in § 413.337(d)(3), and the 1 percent SNF market basket percentage change for FY 2018 required by section 1888(e)(5)(B)(iii) of the Act. We note that in FY 2018, the application of this penalty to those SNFs that do not meet the requirements for the FY 2018 SNF QRP would produce a market basket index percentage change for that FY that is less than zero (specifically, a net update of negative 1.0 percentage point), and would also result in FY 2018 payment rates that are less than such payment rates for the preceding FY. We also propose to amend the regulations at

§ 413.337 by adding a new paragraph (d)(4) that would implement this statutory 2 percent reduction. We invite comments on these proposals.

C. Case-Mix Adjustment

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

to create case-mix indexes (CMIs). The original RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the SNF PPS proposed rule for FY 2010 (74 FR 22208), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting Resource Utilization Groups, Version 4 (RUG–IV) case-mix classification system reflected the data collected in 2006–2007 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 Web site at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>.

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

For the limited number of SNF residents that qualify for this add-on, there is a significant increase in payments. For example, using FY 2015

data (which still used ICD–9–CM coding), we identified fewer than 5085 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 2018, an urban facility with a resident with AIDS in RUG–IV group “HC2” would have a case-mix adjusted per diem payment of \$442.50 (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 \$1,008.90.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2018 payment rates set forth in this proposed rule reflect the use of the RUG–IV case-mix classification system from October 1, 2017, through September 30, 2018. We list the proposed case-mix adjusted RUG–IV payment rates for FY 2018, 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	\$473.02	\$249.53	.....	\$90.42	\$812.97
RUL	2.57	1.87	455.30	249.53	.....	90.42	795.25
RVX	2.61	1.28	462.39	170.80	.....	90.42	723.61
RVL	2.19	1.28	387.98	170.80	.....	90.42	649.20
RHX	2.55	0.85	451.76	113.42	.....	90.42	655.60
RHL	2.15	0.85	380.89	113.42	.....	90.42	584.73
RMX	2.47	0.55	437.59	73.39	.....	90.42	601.40
RML	2.19	0.55	387.98	73.39	.....	90.42	551.79
RLX	2.26	0.28	400.38	37.36	.....	90.42	528.16
RUC	1.56	1.87	276.37	249.53	.....	90.42	616.32
RUB	1.56	1.87	276.37	249.53	.....	90.42	616.32
RUA	0.99	1.87	175.39	249.53	.....	90.42	515.34
RVC	1.51	1.28	267.51	170.80	.....	90.42	528.73
RVB	1.11	1.28	196.65	170.80	.....	90.42	457.87
RVA	1.10	1.28	194.88	170.80	.....	90.42	456.10

TABLE 4—RUG-IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—Continued
[Urban]

RUG-IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RHC	1.45	0.85	256.88	113.42	.....	90.42	460.72
RHB	1.19	0.85	210.82	113.42	.....	90.42	414.66
RHA	0.91	0.85	161.22	113.42	.....	90.42	365.06
RMC	1.36	0.55	240.94	73.39	.....	90.42	404.75
RMB	1.22	0.55	216.14	73.39	.....	90.42	379.95
RMA	0.84	0.55	148.81	73.39	.....	90.42	312.62
RLB	1.50	0.28	265.74	37.36	.....	90.42	393.52
RLA	0.71	0.28	125.78	37.36	.....	90.42	253.56
ES3	3.58	.....	634.23	.....	\$17.58	90.42	742.23
ES2	2.67	.....	473.02	.....	17.58	90.42	581.02
ES1	2.32	.....	411.01	.....	17.58	90.42	519.01
HE2	2.22	.....	393.30	.....	17.58	90.42	501.30
HE1	1.74	.....	308.26	.....	17.58	90.42	416.26
HD2	2.04	.....	361.41	.....	17.58	90.42	469.41
HD1	1.60	.....	283.46	.....	17.58	90.42	391.46
HC2	1.89	.....	334.83	.....	17.58	90.42	442.83
HC1	1.48	.....	262.20	.....	17.58	90.42	370.20
HB2	1.86	.....	329.52	.....	17.58	90.42	437.52
HB1	1.46	.....	258.65	.....	17.58	90.42	366.65
LE2	1.96	.....	347.23	.....	17.58	90.42	455.23
LE1	1.54	.....	272.83	.....	17.58	90.42	380.83
LD2	1.86	.....	329.52	.....	17.58	90.42	437.52
LD1	1.46	.....	258.65	.....	17.58	90.42	366.65
LC2	1.56	.....	276.37	.....	17.58	90.42	384.37
LC1	1.22	.....	216.14	.....	17.58	90.42	324.14
LB2	1.45	.....	256.88	.....	17.58	90.42	364.88
LB1	1.14	.....	201.96	.....	17.58	90.42	309.96
CE2	1.68	.....	297.63	.....	17.58	90.42	405.63
CE1	1.50	.....	265.74	.....	17.58	90.42	373.74
CD2	1.56	.....	276.37	.....	17.58	90.42	384.37
CD1	1.38	.....	244.48	.....	17.58	90.42	352.48
CC2	1.29	.....	228.54	.....	17.58	90.42	336.54
CC1	1.15	.....	203.73	.....	17.58	90.42	311.73
CB2	1.15	.....	203.73	.....	17.58	90.42	311.73
CB1	1.02	.....	180.70	.....	17.58	90.42	288.70
CA2	0.88	.....	155.90	.....	17.58	90.42	263.90
CA1	0.78	.....	138.18	.....	17.58	90.42	246.18
BB2	0.97	.....	171.85	.....	17.58	90.42	279.85
BB1	0.90	.....	159.44	.....	17.58	90.42	267.44
BA2	0.70	.....	124.01	.....	17.58	90.42	232.01
BA1	0.64	.....	113.38	.....	17.58	90.42	221.38
PE2	1.50	.....	265.74	.....	17.58	90.42	373.74
PE1	1.40	.....	248.02	.....	17.58	90.42	356.02
PD2	1.38	.....	244.48	.....	17.58	90.42	352.48
PD1	1.28	.....	226.76	.....	17.58	90.42	334.76
PC2	1.10	.....	194.88	.....	17.58	90.42	302.88
PC1	1.02	.....	180.70	.....	17.58	90.42	288.70
PB2	0.84	.....	148.81	.....	17.58	90.42	256.81
PB1	0.78	.....	138.18	.....	17.58	90.42	246.18
PA2	0.59	.....	104.52	.....	17.58	90.42	212.52
PA1	0.54	.....	95.67	.....	17.58	90.42	203.67

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	\$451.87	\$287.74	.....	\$92.09	\$831.70
RUL	2.57	1.87	434.95	287.74	.....	92.09	814.78
RVX	2.61	1.28	441.72	196.95	.....	92.09	730.76
RVL	2.19	1.28	370.64	196.95	.....	92.09	659.68
RHX	2.55	0.85	431.56	130.79	.....	92.09	654.44
RHL	2.15	0.85	363.87	130.79	.....	92.09	586.75
RMX	2.47	0.55	418.02	84.63	.....	92.09	594.74
RML	2.19	0.55	370.64	84.63	.....	92.09	547.36
RLX	2.26	0.28	382.48	43.08	.....	92.09	517.65

TABLE 5—RUG-IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—Continued
[Rural]

RUG-IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUC	1.56	1.87	264.01	287.74		92.09	643.84
RUB	1.56	1.87	264.01	287.74		92.09	643.84
RUA	0.99	1.87	167.55	287.74		92.09	547.38
RVC	1.51	1.28	255.55	196.95		92.09	544.59
RVB	1.11	1.28	187.86	196.95		92.09	476.90
RVA	1.10	1.28	186.16	196.95		92.09	475.20
RHC	1.45	0.85	245.40	130.79		92.09	468.28
RHB	1.19	0.85	201.40	130.79		92.09	424.28
RHA	0.91	0.85	154.01	130.79		92.09	376.89
RMC	1.36	0.55	230.17	84.63		92.09	406.89
RMB	1.22	0.55	206.47	84.63		92.09	383.19
RMA	0.84	0.55	142.16	84.63		92.09	318.88
RLB	1.50	0.28	253.86	43.08		92.09	389.03
RLA	0.71	0.28	120.16	43.08		92.09	255.33
ES3	3.58		605.88		\$18.78	92.09	716.75
ES2	2.67		451.87		18.78	92.09	562.74
ES1	2.32		392.64		18.78	92.09	503.51
HE2	2.22		375.71		18.78	92.09	486.58
HE1	1.74		294.48		18.78	92.09	405.35
HD2	2.04		345.25		18.78	92.09	456.12
HD1	1.60		270.78		18.78	92.09	381.65
HC2	1.89		319.86		18.78	92.09	430.73
HC1	1.48		250.48		18.78	92.09	361.35
HB2	1.86		314.79		18.78	92.09	425.66
HB1	1.46		247.09		18.78	92.09	357.96
LE2	1.96		331.71		18.78	92.09	442.58
LE1	1.54		260.63		18.78	92.09	371.50
LD2	1.86		314.79		18.78	92.09	425.66
LD1	1.46		247.09		18.78	92.09	357.96
LC2	1.56		264.01		18.78	92.09	374.88
LC1	1.22		206.47		18.78	92.09	317.34
LB2	1.45		245.40		18.78	92.09	356.27
LB1	1.14		192.93		18.78	92.09	303.80
CE2	1.68		284.32		18.78	92.09	395.19
CE1	1.50		253.86		18.78	92.09	364.73
CD2	1.56		264.01		18.78	92.09	374.88
CD1	1.38		233.55		18.78	92.09	344.42
CC2	1.29		218.32		18.78	92.09	329.19
CC1	1.15		194.63		18.78	92.09	305.50
CB2	1.15		194.63		18.78	92.09	305.50
CB1	1.02		172.62		18.78	92.09	283.49
CA2	0.88		148.93		18.78	92.09	259.80
CA1	0.78		132.01		18.78	92.09	242.88
BB2	0.97		164.16		18.78	92.09	275.03
BB1	0.90		152.32		18.78	92.09	263.19
BA2	0.70		118.47		18.78	92.09	229.34
BA1	0.64		108.31		18.78	92.09	219.18
PE2	1.50		253.86		18.78	92.09	364.73
PE1	1.40		236.94		18.78	92.09	347.81
PD2	1.38		233.55		18.78	92.09	344.42
PD1	1.28		216.63		18.78	92.09	327.50
PC2	1.10		186.16		18.78	92.09	297.03
PC1	1.02		172.62		18.78	92.09	283.49
PB2	0.84		142.16		18.78	92.09	253.03
PB1	0.78		132.01		18.78	92.09	242.88
PA2	0.59		99.85		18.78	92.09	210.72
PA1	0.54		91.39		18.78	92.09	202.26

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 2018, 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 2018, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2013 and before October 1, 2014 (FY 2014 cost report data).

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

In addition, we propose to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2018 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 2018, 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 2018, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. The proposed wage index applicable to FY 2018 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>.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas.

In adopting the CBSA geographic designations, we provided for a 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.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010 in the **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015,

OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), we again wish to clarify that this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index. As noted above, the proposed wage index applicable to FY 2018 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; Professional fees: Labor-related; Administrative and Facilities Support Services; All other—Labor-Related Services; and a proportion of Capital-Related expenses. Effective beginning FY 2018, as discussed in section V.A. of this proposed rule, we are proposing to revise the labor-related share to reflect the relative importance of the proposed 2014-based SNF market basket cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional fees: Labor-related; Administrative and Facilities Support services; Installation, Maintenance, and Repair services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking

into account historical and projected price changes between the base year and FY 2018. 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 2018 than the base year weights from the SNF market basket. The proposed methodology for calculating the labor-related portion for FY 2018 is discussed in section V.A. of

this proposed rule and the proposed labor-related share is provided in Table 15.

Tables 6 and 7 show the proposed RUG-IV case-mix adjusted federal rates for FY 2018 by labor-related and non-labor-related components.

TABLE 6—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	812.97	\$575.58	\$237.39
RUL	795.25	563.04	232.21
RVX	723.61	512.32	211.29
RVL	649.20	459.63	189.57
RHX	655.60	464.16	191.44
RHL	584.73	413.99	170.74
RMX	601.40	425.79	175.61
RML	551.79	390.67	161.12
RLX	528.16	373.94	154.22
RUC	616.32	436.35	179.97
RUB	616.32	436.35	179.97
RUA	515.34	364.86	150.48
RVC	528.73	374.34	154.39
RVB	457.87	324.17	133.70
RVA	456.10	322.92	133.18
RHC	460.72	326.19	134.53
RHB	414.66	293.58	121.08
RHA	365.06	258.46	106.60
RMC	404.75	286.56	118.19
RMB	379.95	269.00	110.95
RMA	312.62	221.33	91.29
RLB	393.52	278.61	114.91
RLA	253.56	179.52	74.04
ES3	742.23	525.50	216.73
ES2	581.02	411.36	169.66
ES1	519.01	367.46	151.55
HE2	501.30	354.92	146.38
HE1	416.26	294.71	121.55
HD2	469.41	332.34	137.07
HD1	391.46	277.15	114.31
HC2	442.83	313.52	129.31
HC1	370.20	262.10	108.10
HB2	437.52	309.76	127.76
HB1	366.65	259.59	107.06
LE2	455.23	322.30	132.93
LE1	380.83	269.63	111.20
LD2	437.52	309.76	127.76
LD1	366.65	259.59	107.06
LC2	384.37	272.13	112.24
LC1	324.14	229.49	94.65
LB2	364.88	258.34	106.54
LB1	309.96	219.45	90.51
CE2	405.63	287.19	118.44
CE1	373.74	264.61	109.13
CD2	384.37	272.13	112.24
CD1	352.48	249.56	102.92
CC2	336.54	238.27	98.27
CC1	311.73	220.70	91.03
CB2	311.73	220.70	91.03
CB1	288.70	204.40	84.30
CA2	263.90	186.84	77.06
CA1	246.18	174.30	71.88
BB2	279.85	198.13	81.72
BB1	267.44	189.35	78.09
BA2	232.01	164.26	67.75
BA1	221.38	156.74	64.64
PE2	373.74	264.61	109.13
PE1	356.02	252.06	103.96
PD2	352.48	249.56	102.92
PD1	334.76	237.01	97.75
PC2	302.88	214.44	88.44
PC1	288.70	204.40	84.30
PB2	256.81	181.82	74.99

TABLE 6—RUG-IV CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG-IV category	Total rate	Labor portion	Non-labor portion
PB1	246.18	174.30	71.88
PA2	212.52	150.46	62.06
PA1	203.67	144.20	59.47

TABLE 7—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	831.70	\$588.84	\$242.86
RUL	814.78	576.86	237.92
RVX	730.76	517.38	213.38
RVL	659.68	467.05	192.63
RHX	654.44	463.34	191.10
RHL	586.75	415.42	171.33
RMX	594.74	421.08	173.66
RML	547.36	387.53	159.83
RLX	517.65	366.50	151.15
RUC	643.84	455.84	188.00
RUB	643.84	455.84	188.00
RUA	547.38	387.55	159.83
RVC	544.59	385.57	159.02
RVB	476.90	337.65	139.25
RVA	475.20	336.44	138.76
RHC	468.28	331.54	136.74
RHB	424.28	300.39	123.89
RHA	376.89	266.84	110.05
RMC	406.89	288.08	118.81
RMB	383.19	271.30	111.89
RMA	318.88	225.77	93.11
RLB	389.03	275.43	113.60
RLA	255.33	180.77	74.56
ES3	716.75	507.46	209.29
ES2	562.74	398.42	164.32
ES1	503.51	356.49	147.02
HE2	486.58	344.50	142.08
HE1	405.35	286.99	118.36
HD2	456.12	322.93	133.19
HD1	381.65	270.21	111.44
HC2	430.73	304.96	125.77
HC1	361.35	255.84	105.51
HB2	425.66	301.37	124.29
HB1	357.96	253.44	104.52
LE2	442.58	313.35	129.23
LE1	371.50	263.02	108.48
LD2	425.66	301.37	124.29
LD1	357.96	253.44	104.52
LC2	374.88	265.42	109.46
LC1	317.34	224.68	92.66
LB2	356.27	252.24	104.03
LB1	303.80	215.09	88.71
CE2	395.19	279.79	115.40
CE1	364.73	258.23	106.50
CD2	374.88	265.42	109.46
CD1	344.42	243.85	100.57
CC2	329.19	233.07	96.12
CC1	305.50	216.29	89.21
CB2	305.50	216.29	89.21
CB1	283.49	200.71	82.78
CA2	259.80	183.94	75.86
CA1	242.88	171.96	70.92
BB2	275.03	194.72	80.31
BB1	263.19	186.34	76.85
BA2	229.34	162.37	66.97
BA1	219.18	155.18	64.00
PE2	364.73	258.23	106.50
PE1	347.81	246.25	101.56
PD2	344.42	243.85	100.57
PD1	327.50	231.87	95.63

TABLE 7—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–IV category	Total rate	Labor portion	Non-labor portion
PC2	297.03	210.30	86.73
PC1	283.49	200.71	82.78
PB2	253.03	179.15	73.88
PB1	242.88	171.96	70.92
PA2	210.72	149.19	61.53
PA1	202.26	143.20	59.06

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 2018 (federal rates effective October 1, 2017), 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 2017 to the weighted average wage adjustment factor for FY 2018. For this calculation, we would use the same FY 2016 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 2018 would be 1.0003.

E. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ, Table 8 shows the adjustments made to

the federal per diem rates to compute the provider’s actual per diem PPS payment for FY 2018. We derive the Labor and Non-labor columns from Table 6. The wage index used in this example is based on the proposed wage index, which may be found in Table A available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html>. As illustrated in Table 8, SNF XYZ’s total PPS payment for FY 2018 would equal \$47,647.74.

TABLE 8—ADJUSTED RATE COMPUTATION EXAMPLE SNF XYZ: LOCATED IN FREDERICK, MD (URBAN CBSA 43524) WAGE INDEX: 0.9886

[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	\$512.32	0.9886	\$506.48	\$211.29	\$717.77	\$717.77	14	\$10,048.78
ES2	411.36	0.9886	406.67	169.66	576.33	576.33	30	17,289.90
RHA	258.46	0.9886	255.51	106.60	362.11	362.11	16	5,793.76
CC2*	238.27	0.9886	235.55	98.27	333.82	761.11	10	7,611.10
BA2	164.26	0.9886	162.39	67.75	230.14	230.14	30	6,904.20
.....	.....	.....	.....	.....	.....	.....	100	47,647.74

* Reflects a 128 percent adjustment from section 511 of the MMA.

¹ Available on the CMS Web site 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 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, for FY 2018, 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.

In connection with the administrative level of care presumption, we now propose to amend the existing regulations text at § 413.345 by removing the parenthetical phrase “(including the designation of those specific Resource Utilization Groups under the resident classification system that represent the required SNF level of care, as provided in § 409.30 of this chapter)” that currently appears in the second sentence of § 413.345. The proposed deletion of the current reference to publishing such material annually in the **Federal Register**, along with the specific reference to “Resource Utilization Groups,” would serve to

conform the text of these regulations more closely to that of the corresponding statutory language at section 1888(e)(4)(H)(ii) of the Act, which refers in more general terms to the applicable “case mix classification system.” Moreover, we note that the recurring announcements in the **Federal Register** of the administrative presumption’s designated groups as part of each annual update of the SNF PPS rates has in actual practice proven to be largely a formality, resulting in exactly the same designated groups repetitively being promulgated routinely year after year. Accordingly, we now propose instead to disseminate this standard description of the administrative presumption’s designated groups exclusively through the SNF PPS Web site, and to announce such designations in rulemaking only in the event that we are actually proposing to make changes in them.

Along with this proposed revision, we also propose to make appropriate conforming revisions in other portions of the regulations text. Specifically, we propose to remove from the introductory text of § 409.30, the parenthetical phrase “(in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter)” for the same reasons we propose to remove the parenthetical phrase from § 413.345 as discussed in this proposed rule. In addition, we propose to replace the phrase to “one of the Resource Utilization Groups that is designated” in § 409.30 introductory text with the phrase “one of the case-mix classifiers CMS designates” to conform more closely with the statutory language in section 1888(e)(4)(G) and (H) of the Act, which refers in more general terms to the “resident classification system” or “case mix classification system,” and to clarify that “CMS” makes these designations. We additionally propose to revise § 409.30 to reflect more clearly our longstanding policy that the assignment of a designated case-mix classifier would serve to trigger the administrative presumption only when that assignment is itself correct. As we noted in the FY 2000 SNF PPS final rule (64 FR 41667, July 30, 1999), “. . . 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.” We also propose to make similar conforming revisions in the “resident classification system” definition that currently appears in

§ 413.333 to replace “Resource Utilization Groups” with “resident classification system”, as well as in the material in § 424.20(a)(1)(ii) on SNF level of care certifications to replace the phrase “one of the Resource Utilization Groups designated” with “one of the case-mix classifiers that CMS designates,” in both cases to conform more closely with the statutory language in section 1888(e)(4)(G) and (H) of the Act, as discussed in this proposed rule, which refers in more general terms to the “resident classification system” or “case mix classification system,” and to clarify in § 424.20(a)(1)(ii) that “CMS” designates these case-mix classifiers. Finally, regarding the § 424.20, we also propose to revise paragraph (e)(2)(ii)(B)(2) by updating its existing cross-reference to the provision at § 483.40(e) on delegating physician tasks in SNFs, which was recently redesignated as new § 483.30(e) under the revised long-term care facility requirements for participation (81 FR 68861, October 4, 2016).

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 (MAC) for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. 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 Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf. In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted on November 29, 1999) (BBRA) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual high-cost, low

probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.gov/transmittals/downloads/ab001860.pdf.

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate additional, individual services for exclusion within each of the specified service categories. In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA do not designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: They must fall within one of the four service categories specified in the BBRA; and they also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA

Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791). In this proposed rule, we specifically invite public comments identifying HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2017). 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.

In addition, we note that one category of services which consolidated billing excludes under the regulations at § 411.15(p)(3) consists of certain exceptionally intensive types of outpatient hospital services. As we explained in the FY 2000 SNF PPS final rule, this exclusion applies to “. . . those types of outpatient hospital

services that *we specifically identify* as being beyond the scope of SNF care plans generally” (64 FR 41676, July 30, 1999, emphasis added). To further clarify this longstanding policy noted above that the outpatient hospital exclusion applies solely to those services that we specifically designate for this purpose, we are proposing to revise § 411.15(p)(3)(iii) to state this more explicitly. In addition, we note that recent revisions in the long-term care facility requirements for participation (81 FR 68858, October 4, 2016) have moved the comprehensive care plan regulations from their previous location at § 483.20(k) to a new, redesignated § 483.21(b); accordingly, we also propose to make a conforming revision in the existing cross-reference to that provision that appears in the regulations text at § 411.15(p)(3)(iii).

C. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN-SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html>.

V. Other Issues

A. Revising and Rebased the SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires the Secretary to establish a market basket index that reflects the 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 in section III.B of this proposed rule, to update the SNF PPS per diem rates and to determine the labor-related share on an annual basis.

The SNF market basket is a fixed-weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured.

The index itself is constructed in three steps. First, a base period is selected (in this proposed rule, the base period is 2014) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories with the proportion of total costs that each category represents being calculated. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

Effective for cost reporting periods beginning on or after July 1, 1998, we revised and rebased our 1977 routine costs input price index and adopted a total expenses SNF input price index using FY 1992 as the base year. In the FY 2002 SNF PPS final rule (66 FR 39582), we rebased and revised the market basket to a base year of FY 1997. In the FY 2008 SNF PPS final rule (72 FR 43425), we rebased and revised the market basket to a base year of FY 2004. In the FY 2014 SNF PPS final rule (78 FR 47939), we last revised and rebased the SNF market basket, which included updating the base year from FY 2004 to FY 2010. For FY 2018, we are proposing to rebase the market basket to reflect 2014 Medicare-allowable total cost data (routine, ancillary, and capital-related) from freestanding SNFs and to revise applicable cost categories and price proxies used to determine the market basket. We propose to maintain our policy of using data from freestanding SNFs, which represent 93 percent of the total SNFs shown in Table 25. We believe using freestanding MCR data, as opposed to the hospital-based SNF MCR data, for the proposed cost weight calculation is most appropriate because of the complexity of hospital-based data and the representativeness of the freestanding data. Hospital-based SNF expenses, are embedded in the hospital cost report. Any attempt to incorporate data from hospital-based facilities requires more complex calculations and assumptions regarding the ancillary costs related to the hospital-based SNF unit. We believe the use of freestanding SNF cost report data is technically appropriate for reflecting the cost structures of SNFs serving Medicare beneficiaries.

We are proposing to use 2014 as the base year. We believe that the 2014 Medicare cost reports represent the most recent, complete set of Medicare cost report (MCR) data available to develop cost weights for SNFs at the time of rulemaking. The 2014 Medicare cost reports are for cost reporting periods beginning on and after October 1, 2013 and before October 1, 2014. While these dates appear to reflect fiscal year data, we note that a Medicare cost report that begins in this timeframe is generally classified as a “2014 cost report.” For example, we found that of the available 2014 Medicare cost reports for SNFs, approximately 7 percent had an October 1, 2013 begin date, approximately 70 percent of the reports had a January 1, 2014 begin date, and approximately 12 percent had a July 1, 2014 begin date. For this reason, and for the reasons explained below, we are defining the

base year of the market basket as “2014-based” instead of “FY 2014-based”.

Specifically, we are proposing to develop cost category weights for the 2014-based SNF market basket in two stages. First, we are proposing to derive eight major expenditures or cost weights from the 2014 MCR data (CMS Form 2540–10) for freestanding SNFs: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; Capital-related; and a residual “All Other”. With the exception of the Home Office Contract Labor cost weight, these are the same cost categories calculated using the 2010 MCR data for the FY 2010-based SNF market basket. We provide a detailed discussion of our proposal to use the 2014 MCR data to determine the Home Office Contract Labor cost weight in section IV.A.1.a of this preamble. The residual “All Other” category would reflect all remaining costs that are not captured in the other seven cost categories. Second, we are proposing to divide the residual “All Other” cost category into subcategories, using U.S. Department of Commerce Bureau of Economic Analysis’ (BEA) 2007 Benchmark Input-Output (I–O) “use table before redefinitions, purchaser’s value” for the Nursing and Community Care Facilities industry (NAICS 623A00) aged forward to 2014 using price changes. Furthermore, we are proposing to continue to use the same overall methodology as was used for the FY 2010-based SNF market basket to develop the capital related cost weights of the 2014-based SNF market basket. We note that we are no longer referring to the market basket as a “FY based” market basket and instead refer to the proposed market basket as simply “2014-based.” We are proposing this change in naming convention for the market basket because the base year cost weight data for the proposed market basket does not reflect strictly fiscal year data. For example, the proposed 2014-based SNF market basket uses Medicare cost report data and other government data that reflects fiscal year 2014, calendar year 2014, and state fiscal year 2014 expenses to determine the base year cost weights. Given that it is based on a mix of classifications of 2014 data, we are proposing to refer to the market basket simply as “2014-based” as opposed to a “FY 2014-based” or “CY 2014-based”.

1. Development of Cost Categories and Weights

a. Use of Medicare Cost Report Data To Develop Major Cost Weights

In order to create a market basket that is representative of freestanding SNF providers serving Medicare patients and to help ensure accurate major cost weights (which is the percent of total Medicare allowable costs, as defined below), we propose to apply edits to remove reporting errors and outliers. Specifically, the SNF Medicare Cost Reports used to calculate the market basket cost weights excluded any providers that reported costs less than or equal to zero for the following categories: Total facility costs; total operating costs; Medicare general inpatient routine service costs; and Medicare PPS payments. The final sample used included roughly 96 percent of those providers who submitted a Medicare cost report for 2014.

Additionally, for each of the major cost weights (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance, Home Office Contract Labor, and Capital-related Expenses) the data are trimmed to remove outliers (a standard statistical process) by: (1) Requiring that major expenses (such as Wages and Salaries costs) and total Medicare-allowable costs are greater than zero; and (2) excluding the top and bottom five percent of the major cost weight (for example, Wages and Salaries costs as a percent of total Medicare-allowable costs). This trimming process is done for each cost weight individually and, therefore, providers excluded from one cost weight calculation are not automatically excluded from other cost weight calculations. These are the same types of edits utilized for the FY 2010-based SNF market basket, as well as other PPS market baskets (including but not limited to IPPS market basket and HHA market basket). We believe this trimming process improves the accuracy of the data used to compute the major cost weights by removing possible data misreporting.

Finally, the final weights of the proposed 2014-based SNF market basket are based on weighted means. For example, the final Wages and Salaries cost weight after trimming is equal to the sum of total Medicare-allowable wages and salaries divided by the sum of total Medicare-allowable costs. This methodology is consistent with the methodology used to calculate the FY 2010-based SNF market basket cost

weights and other PPS market basket cost weights.

As stated above, the major cost weights of the proposed 2014-based SNF market basket are derived from 2014 MCR data that is reported on CMS Form 2540–10, effective for freestanding SNFs with a cost reporting period beginning on or after December 1, 2010. The major cost weights for the FY 2010-based SNF market basket were derived from the 2010 MCR data that is reported on CMS Form 2540–96. CMS Form 2540–96 was effective for freestanding SNFs with cost reporting periods beginning on and after October 1, 1997. The OMB control number for both Form 2549–10 and Form 2540–96 is 0938–0463.

For all of the cost weights, we use Medicare allowable-total costs as the denominator (that is, Wages and Salaries cost weight = Wages and Salaries costs divided by Medicare-allowable total costs). Medicare-allowable total costs were equal to total costs (after overhead allocation) from Worksheet B part 1, column 18, for lines 30, 40 through 49, 51, 52, and 71 plus Medicaid drug costs as defined below. We included estimated Medicaid drug costs in the pharmacy cost weight, as well as the denominator for total Medicare-allowable costs. This is the same methodology used for the FY 2010-based SNF market basket and the FY 2004-based SNF market basket. The inclusion of Medicaid drug costs was finalized in the FY 2008 SNF PPS final rule (72 FR 43425 through 43430), and for the same reasons set forth in that final rule, we are proposing to continue to use this methodology in the proposed 2014-based SNF market basket.

We are proposing that for the 2014-based SNF market basket we obtain costs for one additional major cost category from the Medicare cost reports that was not used in the FY 2010-based SNF market basket—Home Office Contract Labor Costs. We describe the detailed methodology for obtaining costs for each of these eight cost categories below. The methodology used is similar to the methodology used in the FY 2010-based SNF market basket, as described in the FY 2014 SNF PPS final rule (78 FR 47940 through 47942).

(1) *Wages and Salaries*: To derive Wages and Salaries costs for the Medicare-allowable cost centers, we are proposing first to calculate total unadjusted wages and salaries costs as reported on Worksheet S–3, part II, column 3, line 1. We are then proposing to remove the wages and salaries attributable to non-Medicare-allowable cost centers (that is, excluded areas), as well as a portion of overhead wages and

salaries attributable to these excluded areas. Excluded area wages and salaries are equal to wages and salaries as reported on Worksheet S–3, part II, column 3, lines 3, 4, and 7 through 11 plus nursing facility and non-reimbursable salaries from Worksheet A, column 1, lines 31, 32, 50, and 60 through 63.

Overhead wages and salaries are attributable to the entire SNF facility; therefore, we are proposing to include only the proportion attributable to the Medicare-allowable cost centers. We are proposing to estimate the proportion of overhead wages and salaries that is attributable to the non-Medicare-allowable cost centers (that is, excluded areas) by multiplying the ratio of excluded area wages and salaries (as defined above) to total wages and salaries as reported on Worksheet S–3, part II, column 3, line 1 by total overhead wages and salaries as reported on Worksheet S3, Part III, column 3, line 14. We used a similar methodology to derive wages and salaries costs in the FY 2010-based SNF market basket.

(2) *Employee Benefits*: Medicare-allowable employee benefits are equal to total benefits as reported on Worksheet S–3, part II, column 3, lines 17 through 19 minus non-Medicare-allowable (that is, excluded area) employee benefits and minus a portion of overhead benefits attributable to these excluded areas. Non-Medicare-allowable employee benefits are derived by multiplying total excluded wages and salaries (as defined above in the ‘Wages and Salaries’ section) times the ratio of total benefit costs as reported on Worksheet S–3, part II, column 3, lines 17 through 19 to total wages and salary costs as reported on Worksheet S3, part II, column 3, line 1. Likewise, the portion of overhead benefits attributable to the excluded areas is derived by multiplying overhead wages and salaries attributable to the excluded areas (as defined in the ‘Wages and Salaries’ section) times the ratio of total benefit costs to total wages and salary costs (as defined above). We used a similar methodology in the FY 2010-based SNF market basket.

(3) *Contract Labor*: We are proposing to derive Medicare-allowable contract labor costs from Worksheet S–3, part II, column 3, line 17, which reflects costs for contracted direct patient care services, that is, nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services.

(4) *Pharmaceuticals*: We are proposing to calculate pharmaceuticals costs using the non-salary costs from the Pharmacy cost center (Worksheet B, part

I, column 0, line 11 less Worksheet A, column 1, line 11) and the Drugs Charged to Patients' cost center (Worksheet B, part I, column 0, line 49 less Worksheet A, column 1, line 49). Since these drug costs were attributable to the entire SNF and not limited to Medicare-allowable services, we adjusted the drug costs by the ratio of Medicare-allowable pharmacy total costs (Worksheet B, part I, column 11, for lines 30, 40 through 49, 51, 52, and 71) to total pharmacy costs from Worksheet B, part I, column 11, line 11. Worksheet B, part I allocates the general service cost centers, which are often referred to as "overhead costs" (in which pharmacy costs are included) to the Medicare-allowable and non-Medicare-allowable cost centers.

Second, similar to the FY 2010-based SNF market basket, we propose to continue to adjust the drug expenses reported on the MCR to include an estimate of total Medicaid drug costs, which are not represented in the Medicare-allowable drug cost weight. Similar to the FY 2010-based SNF market basket, we are estimating Medicaid drug costs based on data representing dual-eligible Medicaid beneficiaries. Medicaid drug costs are

estimated by multiplying Medicaid dual-eligible drug costs per day times the number of Medicaid days as reported in the Medicare-allowable skilled nursing cost center (Worksheet S3, part I, column 5, line 1) in the SNF MCR. Medicaid dual-eligible drug costs per day (where the day represents an unduplicated drug supply day) were estimated using a sample of 2014 Part D claims for those dual-eligible beneficiaries who had a Medicare SNF stay during the year. Medicaid dual-eligible beneficiaries would receive their drugs through the Medicare Part D benefit, which would work directly with the pharmacy and, therefore, these costs would not be represented in the Medicare SNF MCRs. A random twenty percent sample of Medicare Part D claims data yielded a Medicaid drug cost per day of \$19.62. We note that the FY 2010-based SNF market basket also relied on data from the Part D claims, which yielded a dual-eligible Medicaid drug cost per day of \$17.39 for 2010.

(5) *Professional Liability Insurance:* We are proposing to calculate the professional liability insurance costs from Worksheet S-2 of the MCRs as the sum of premiums; paid losses; and self-

insurance (Worksheet S-2, column 1 through 3, line 41).

(6) *Capital-Related:* We are proposing to derive the Medicare-allowable capital-related costs from Worksheet B, part II, column 18 for lines 30, 40 through 49, 51, 52, and 71.

(7) *Home Office Contract Labor Costs:* We are proposing to calculate Medicare-allowable home office contract labor costs by multiplying total home office contract labor costs (as reported on Worksheet S3, part 2, column 3, line 16) times the ratio of Medicare-allowable operating costs (Medicare-allowable total costs less Medicare-allowable capital costs) to total operating costs (equal to Worksheet B, part I, column 18, line 100 less Worksheet B, part I, column 0, line 1 and 2).

(8) *All Other (residual):* The "All Other" cost weight is a residual, calculated by subtracting the major cost weights (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance, Home Office Contract Labor, and Capital-Related) from 100.

Table 9 shows the major cost categories and their respective cost weights as derived from the Medicare cost reports for this proposed rule.

TABLE 9—MAJOR COST CATEGORIES AS DERIVED FROM THE MEDICARE COST REPORTS

Major cost categories	Proposed 2014-based	FY 2010-based
Wages and Salaries	44.3	46.1
Employee Benefits	9.3	10.5
Contract Labor	6.8	5.5
Pharmaceuticals	7.3	7.9
Professional Liability Insurance	1.1	1.1
Home Office Contract Labor*	0.7	n/a
Capital-related	7.9	7.4
All other (residual)	22.6	21.5

* Home office contract labor costs were included in the residual "All Other" cost weight of the FY 2010-based SNF market basket.

The Wages and Salaries and Employee Benefits cost weights as calculated directly from the Medicare cost reports decreased by 1.8 and 1.2 percentage points, respectively, while the Contract Labor cost weight increased 1.3 percentage points between the FY 2010-based SNF market basket and 2014-based SNF market basket. The decrease in the Wages and Salaries occurred among most cost centers and in aggregate for the General Service (overhead) and Inpatient Routine Service cost centers, which together account for about 80 percent of total facility costs.

As we did for the FY 2010-based SNF market basket (78 FR 26452), we are proposing to allocate contract labor costs to the Wages and Salaries and Employee Benefits cost weights based on their relative proportions under the assumption that contract labor costs are comprised of both wages and salaries and employee benefits. The contract labor allocation proportion for wages and salaries is equal to the Wages and Salaries cost weight as a percent of the sum of the Wages and Salaries cost weight and the Employee Benefits cost weight. Using the 2014 Medicare cost report data, this percentage is 83

percent; therefore, we are proposing to allocate approximately 83 percent of the Contract Labor cost weight to the Wages and Salaries cost weight and 17 percent to the Employee Benefits cost weight. For the FY 2010-based SNF market basket, the wages and salaries to employee benefit ratio was 81/19 percent.

Table 10 shows the Wages and Salaries and Employee Benefits cost weights after contract labor allocation for the FY 2010-based SNF market basket and the proposed 2014-based SNF market basket.

TABLE 10—WAGES AND SALARIES AND EMPLOYEE BENEFITS COST WEIGHTS AFTER CONTRACT LABOR ALLOCATION

Major cost categories	Proposed 2014-based market basket	FY 2010-based market basket
Wages and Salaries	50.0	50.6
Employee Benefits	10.5	11.5

b. Derivation of the Detailed Operating Cost Weights

To further divide the “All Other” residual cost weight estimated from the 2014 Medicare cost report data into more detailed cost categories, we are proposing to use the 2007 Benchmark I–O “Use Tables/Before Redefinitions/Purchaser Value” for Nursing and Community Care Facilities industry (NAICS 623A00), published by the Census Bureau’s Bureau of Economic Analysis (BEA). These data are publicly available at the following Web site: <http://www.bea.gov/industry/io/annual.htm>. The BEA Benchmark I–O data are generally scheduled for publication every 5 years with the most recent data available for 2007. The 2007 Benchmark I–O data are derived from the 2007 Economic Census and are the building blocks for BEA’s economic accounts. Therefore, they represent the most comprehensive and complete set of data on the economic processes or mechanisms by which output is produced and distributed.¹ BEA also produces Annual I–O estimates. However, while based on a similar methodology, these estimates reflect less comprehensive and less detailed data sources and are subject to revision when benchmark data become available. Instead of using the less detailed Annual I–O data, we are proposing to inflate the 2007 Benchmark I–O data aged forward to 2014 by applying the annual price changes from the respective price proxies to the appropriate market basket cost categories that are obtained from the 2007 Benchmark I–O data. We repeated this practice for each year. We then calculated the cost shares that each cost category represents of the 2007 data inflated to 2014. These resulting 2014 cost shares were applied to the “All Other” residual cost weight to obtain the detailed cost weights for the proposed 2014-based SNF market basket. For example, the cost for Food: Direct Purchases represents 13.7 percent of the sum of the “All Other” 2007 Benchmark I–O Expenditures inflated to 2014. Therefore, the Food: Direct Purchases cost weight represents 3.1

percent of the proposed 2014-based SNF market basket’s “All Other” cost category (0.137×22.6 percent = 3.1 percent). For the FY 2010-based SNF market basket (78 FR 26456), we used the same methodology utilizing the 2002 Benchmark I–O data (aged to FY 2010).

Using this methodology, we are proposing to derive 21 detailed SNF market basket operating cost category weights from the proposed 2014-based SNF market basket “All Other” residual cost weight (22.6 percent). These categories are: (1) Fuel: Oil and Gas; (2) Electricity; (3) Water and Sewerage; (4) Food: Direct Purchases; (5) Food: Contract Services; (6) Chemicals; (7) Medical Instruments and Supplies; (8) Rubber and Plastics; (9) Paper and Printing Products; (10) Apparel; (11) Machinery and Equipment; (12) Miscellaneous Products; (13) Professional Fees: Labor-Related; (14) Administrative and Facilities Support Services; (15) Installation, Maintenance, and Repair Services; (16) All Other: Labor-Related Services; (17) Professional Fees: Nonlabor-Related; (18) Financial Services; (19) Telephone Services; (20) Postage; and (21) All Other: Nonlabor-Related Services.

We note that the machinery and equipment expenses are for equipment that is paid for in a given year and not depreciated over the asset’s useful life. Depreciation expenses for movable equipment are reflected in the capital component of the proposed 2014-based SNF market basket (described in section IV.A.1.c. of this proposed rule).

We would also note that for ease of reference we are renaming the Nonmedical Professional Fees: Labor-Related and Nonmedical Professional Fees: Nonlabor-related cost categories (as labeled in the FY 2010-based SNF market basket) to be Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related in the proposed 2014-based SNF market basket. These cost categories still represent the same nonmedical professional fees that were included in the FY 2010-based SNF market basket, which we describe in section IV.A.4. of this proposed rule.

For the proposed 2014-based SNF market basket, we also are proposing to include a separate cost category for

Installation, Maintenance, and Repair Services in order to proxy these costs by a price index that better reflects the price changes of labor associated with maintenance-related services. Previously these costs were included in the All Other: Labor-Related Services category of the FY 2010-based SNF market basket.

c. Derivation of the Detailed Capital Cost Weights

Similar to the FY 2010-based SNF market basket, we further divided the Capital-related cost weight into: Depreciation, Interest, Lease and Other Capital-related cost weights.

We calculated the depreciation cost weight (that is, depreciation costs excluding leasing costs) using depreciation costs from Worksheet S–2, column 1, lines 20 and 21. Since the depreciation costs reflect the entire SNF facility (Medicare and non-Medicare-allowable units), we used total facility capital costs as the denominator. This methodology assumes that the depreciation of an asset is the same regardless of whether the asset was used for Medicare or non-Medicare patients. This methodology yielded depreciation as a percent of capital costs of 27.3 percent for 2014. We then apply this percentage to the proposed 2014-based SNF market basket Medicare-allowable Capital-related cost weight of 7.9 percent, yielding a Medicare-allowable depreciation cost weight (excluding leasing expenses, which is described in more detail below) of 2.2 percent. To further disaggregate the Medicare-allowable depreciation cost weight into fixed and moveable depreciation, we are proposing to use the 2014 SNF MCR data for end-of-the-year capital asset balances as reported on Worksheet A7. The 2014 SNF MCR data showed a fixed/moveable split of 83/17. The FY 2010-based SNF market basket, which utilized the same data from the FY 2010 MCRs, had a fixed/moveable split of 85/15.

We also derived the interest expense share of capital-related expenses from 2014 SNF MCR data, specifically from Worksheet A, column 2, line 81. Similar to the depreciation cost weight, we calculated the interest cost weight using total facility capital costs. This

¹ http://www.bea.gov/papers/pdf/IOmanual_092906.pdf.

methodology yielded interest as a percent of capital costs of 27.4 percent for 2014. We then apply this percentage to the proposed 2014-based SNF market basket Medicare-allowable Capital-related cost weight of 7.9 percent, yielding a Medicare-allowable interest cost weight (excluding leasing expenses) of 2.2 percent. As done with the last rebasing (78 FR 26454), we are proposing to determine the split of interest expense between for-profit and not-for-profit facilities based on the distribution of long-term debt outstanding by type of SNF (for-profit or not-for-profit/government) from the 2014 SNF MCR data. We estimated the split between for-profit and not-for-profit interest expense to be 27/73 percent compared to the FY 2010-based SNF market basket with 41/59 percent.

Because the detailed data were not available in the MCRs, we used the most recent 2014 Census Bureau Service Annual Survey (SAS) data to derive the capital-related expenses attributable to leasing and other capital-related

expenses. The FY 2010-based SNF market basket used the 2010 SAS data. Based on the 2014 SAS data, we determined that leasing expenses are 63 percent of total leasing and capital-related expenses costs. In the FY 2010-based SNF market basket, leasing costs represent 62 percent of total leasing and capital-related expenses costs. We then apply this percentage to the proposed 2014-based SNF market basket residual Medicare-allowable capital costs of 3.6 percent derived from subtracting the Medicare-allowable depreciation cost weight and Medicare-allowable interest cost weight from the 2014-based SNF market basket of total Medicare-allowable capital cost weight (7.9 percent – 2.2 percent – 2.2 percent = 3.6 percent). This produces the proposed 2014-based SNF Medicare-allowable leasing cost weight of 2.3 percent and all-other capital-related cost weight of 1.3 percent.

Lease expenses are not broken out as a separate cost category in the SNF market basket, but are distributed

among the cost categories of depreciation, interest, and other capital-related expenses, reflecting the assumption that the underlying cost structure and price movement of leasing expenses is similar to capital costs in general. As was done with past SNF market baskets and other PPS market baskets, we assumed 10 percent of lease expenses are overhead and assigned them to the other capital-related expenses cost category. This is based on the assumption that leasing expenses include not only depreciation, interest, and other capital-related costs but also additional costs paid to the lessor. We distributed the remaining lease expenses to the three cost categories based on the proportion of depreciation, interest, and other capital-related expenses to total capital costs, excluding lease expenses.

Table 11 shows the capital-related expense distribution (including expenses from leases) in the proposed 2014-based SNF market basket and the FY 2010-based SNF market basket.

TABLE 11—COMPARISON OF THE CAPITAL-RELATED EXPENSE DISTRIBUTION OF THE 2014-BASED SNF MARKET BASKET AND THE FY 2010-BASED SNF MARKET BASKET

Cost category	Proposed 2014-based SNF market basket	FY 2010-based SNF market basket
Capital-related Expenses	7.9	7.4
Total Depreciation	2.9	3.2
Total Interest	3.0	2.1
Other Capital-related Expenses	2.0	2.1

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal and therefore, the detail capital cost weights may not add to the total capital-related expenses cost weight due to rounding.

Table 12 presents the proposed 2014-based SNF market basket and the FY 2010-based SNF market basket.

TABLE 12—PROPOSED 2014-BASED SNF MARKET BASKET AND FY 2010-BASED SNF MARKET BASKET

Cost category	Proposed 2014-based SNF market basket	FY 2010-based SNF market basket
Total	100.0	100.0
Compensation	60.4	62.1
Wages and Salaries ¹	50.0	50.6
Employee Benefits ¹	10.5	11.5
Utilities	2.6	2.2
Electricity	1.2	1.4
Fuel: Oil and Gas	1.3	0.7
Water and Sewerage	0.2	0.1
Professional Liability Insurance	1.1	1.1
All Other	27.9	27.2
Other Products	14.3	16.1
Pharmaceuticals	7.3	7.9
Food: Direct Purchase	3.1	3.7
Food: Contract Purchase	0.7	1.2
Chemicals	0.2	0.2
Medical Instruments and Supplies	0.6	0.8
Rubber and Plastics	0.8	1.0

TABLE 12—PROPOSED 2014-BASED SNF MARKET BASKET AND FY 2010-BASED SNF MARKET BASKET—Continued

Cost category	Proposed 2014-based SNF market basket	FY 2010-based SNF market basket
Paper and Printing Products	0.8	0.8
Apparel	0.3	0.2
Machinery and Equipment	0.3	0.2
Miscellaneous Products	0.3	0.3
All Other Services	13.6	11.0
Labor-Related Services	7.4	6.2
Professional Fees: Labor-related	3.8	3.4
Installation, Maintenance, and Repair Services	0.6	n/a
Administrative and Facilities Support	0.5	0.5
All Other: Labor-Related Services	2.5	2.3
Non Labor-Related Services	6.2	4.8
Professional Fees: Nonlabor-Related	1.8	2.0
Financial Services	2.0	0.9
Telephone Services	0.5	0.6
Postage	0.2	0.2
All Other: Nonlabor-Related Services	1.8	1.1
Capital-Related Expenses	7.9	7.4
Total Depreciation	2.9	3.2
Building and Fixed Equipment	2.5	2.7
Movable Equipment	0.4	0.5
Total Interest	3.0	2.1
For-Profit SNFs	0.8	0.9
Government and Nonprofit SNFs	2.1	1.2
Other Capital-Related Expenses	2.0	2.1

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal and therefore, the detailed cost weights may not add to the aggregate cost weights or to 100.0 due to rounding.

¹ Contract labor is distributed to wages and salaries and employee benefits based on the share of total compensation that each category represents.

2. Price Proxies Used To Measure Operating Cost Category Growth

After developing the 30 cost weights for the proposed 2014-based SNF market basket, we selected the most appropriate wage and price proxies currently available to represent the rate of change for each expenditure category. With four exceptions (three for the capital-related expenses cost categories and one for Professional Liability Insurance (PLI)), we base the wage and price proxies on Bureau of Labor Statistics (BLS) data, and group them into one of the following BLS categories:

- *Employment Cost Indexes:* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. ECIs are superior to Average Hourly Earnings (AHE) as price proxies for input price indexes because they are not affected by shifts in occupation or industry mix, and because they measure pure price change and are available by both occupational group and by industry. The industry ECIs are based on the 2004 North American Classification System (NAICS).

- *Producer Price Indexes:* Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are used when the purchases of goods or services are made at the wholesale level.

- *Consumer Price Indexes:* Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by consumers. CPIs are only used when the purchases are similar to those of retail consumers rather than purchases at the wholesale level, or if no appropriate PPI were available.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because only a sample was surveyed rather than the entire population.) Timeliness implies that the proxy is published regularly, preferably at least once a quarter. The market baskets are updated quarterly, and therefore, it is important for the underlying price proxies to be up-to-

date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, whenever possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently, because we believe that this is an optimal way to stay abreast of the most current data available. Availability means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs that we have selected to propose in this regulation meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

Table 12 lists all price proxies for the proposed 2014-based SNF market basket. Below is a detailed explanation of the price proxies used for each operating cost category.

- *Wages and Salaries:* We are proposing to use the ECI for Wages and Salaries for Private Industry Workers in Nursing Care Facilities (NAICS 6231; BLS series code CIU20262310000001) to measure price growth of this category. NAICS 623 includes facilities that provide a mix of health and social services, with many of the health services being largely some level of nursing services. Within NAICS 623 is NAICS 6231, which includes nursing care facilities primarily engaged in providing inpatient nursing and rehabilitative services. These facilities, which are most comparable to Medicare-certified SNFs, provide skilled nursing and continuous personal care services for an extended period of time, and, therefore, have a permanent core staff of registered or licensed practical nurses. This is the same index used in the FY 2010-based SNF market basket.

- *Employee Benefits:* We are proposing to use the ECI for Benefits for Nursing Care Facilities (NAICS 6231) to measure price growth of this category. The ECI for Benefits for Nursing Care Facilities is calculated using BLS's total compensation (BLS series ID CIU20162310000001) for nursing care facilities series and the relative importance of wages and salaries within total compensation. We believe this constructed ECI series is technically appropriate for the reason stated above in the Wages and Salaries price proxy section. This is the same index used in the FY 2010-based SNF market basket.

- *Electricity:* We are proposing to use the PPI Commodity for Commercial Electric Power (BLS series code WPU0542) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- *Fuel: Oil and Gas:* We are proposing to change the proxy used for the Fuel: Oil and Gas cost category. The FY 2010-based SNF market basket uses the PPI Commodity for Commercial Natural Gas (BLS series code WPU0552) to proxy these expenses. For the proposed 2014-based SNF market basket, we are proposing to use a blend of the PPI Industry for Petroleum Refineries (BLS series code PCU32411–32411) and the

PPI Commodity for Natural Gas (BLS series code WPU0531). Our analysis of the Bureau of Economic Analysis' 2007 Benchmark I–O data for Nursing and Community Care Facilities shows that petroleum refineries expenses accounts for approximately 65 percent and natural gas accounts for approximately 35 percent of the fuel: Oil and gas expenses. Therefore, we are proposing a blended proxy of 65 percent of the PPI Industry for Petroleum Refineries (BLS series code PCU32411–32411) and 35 percent of the PPI Commodity for Natural Gas (BLS series code WPU0531). We believe that these two price proxies are the most technically appropriate indices available to measure the price growth of the Fuel: Oil and Gas category in the proposed 2014-based SNF market basket.

- *Water and Sewerage:* We are proposing to use the CPI All Urban for Water and Sewerage Maintenance (BLS series code CUUR0000SEHG01) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- *Professional Liability Insurance:* We are proposing to use the CMS Hospital Professional Liability Insurance Index to measure price growth of this category. We were unable to find a reliable data source that collects SNF-specific PLI data. Therefore, we are proposing to use the CMS Hospital Professional Liability Index, which tracks price changes for commercial insurance premiums for a fixed level of coverage, holding non-price factors constant (such as a change in the level of coverage). This is the same index used in the FY 2010-based SNF market basket. We believe this is an appropriate proxy to measure the price growth associated of SNF professional liability insurance as it captures the price inflation associated with other medical institutions that serve Medicare patients.

- *Pharmaceuticals:* We are proposing to use the PPI Commodity for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- *Food: Wholesale Purchases:* We are proposing to use the PPI Commodity for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- *Food: Retail Purchase:* We are proposing to use the CPI All Urban for Food Away From Home (All Urban Consumers) (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- *Chemicals:* For measuring price change in the Chemicals cost category, we are proposing to use a blended PPI composed of the Industry PPIs for Other Basic Organic Chemical Manufacturing (NAICS 325190) (BLS series code PCU32519–32519), Soap and Cleaning Compound Manufacturing (NAICS 325610) (BLS series code PCU32561–32561), and Other Miscellaneous Chemical Product Manufacturing (NAICS 3259A0) (BLS series code PCU325998325998).

Using the 2007 Benchmark I–O data, we found that these three NAICS industries accounted for approximately 96 percent of SNF chemical expenses. The remaining four percent of SNF chemical expenses are for three other incidental NAICS chemicals industries such as Paint and Coating Manufacturing. We are proposing to create a blended index based on those three NAICS chemical expenses listed above that account for 96 percent of SNF chemical expenses. We are proposing to create this blend based on each NAICS' expenses as a share of their sum. These expenses as a share of their sum are listed in Table 13.

The FY 2010-based SNF market basket also used a blended chemical proxy that was based on 2002 Benchmark I–O data. We believe our proposed chemical blended index for the 2014-based SNF market basket is technically appropriate as it reflects more recent data on SNFs purchasing patterns. Table 13 provides the weights for the proposed 2014-based blended chemical index and the FY 2010-based blended chemical index.

TABLE 13—PROPOSED CHEMICAL BLENDED INDEX WEIGHTS

NAICS	Industry description	2014-based index (percent)	2010-based index (percent)
325190	Other basic organic chemical manufacturing	22	7
25510	Paint and coating manufacturing	n/a	12
325610	Soap and cleaning compound manufacturing	37	49
3259A0	Other miscellaneous chemical product manufacturing	41	32

TABLE 13—PROPOSED CHEMICAL BLENDED INDEX WEIGHTS—Continued

NAICS	Industry description	2014-based index (percent)	2010-based index (percent)
	Total	100	100

- Medical Instruments and Supplies:** We are proposing to use a blend for the Medical Instruments and Supplies cost category. The 2007 Benchmark I–O data shows an approximate 60/40 split between ‘Medical and Surgical Appliances and Supplies’ and ‘Surgical and Medical Instruments’. Therefore, we are proposing a blend composed of 60 percent of the PPI Commodity for Medical and Surgical Appliances and Supplies (BLS series code WPU1563) and 40 percent of the PPI Commodity for Surgical and Medical Instruments (BLS series code WPU1562).

The FY 2010-based SNF market basket used the single, higher level PPI Commodity for Medical, Surgical, and Personal Aid Devices (BLS series code WPU156). We believe that the proposed price proxy better reflects the mix of expenses for this cost category as obtained from the 2007 Benchmark I–O data.

- Rubber and Plastics:** We are proposing to use the PPI Commodity for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Paper and Printing Products:** We are proposing to use the PPI Commodity for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Apparel:** We are proposing to use the PPI Commodity for Apparel (BLS series code WPU0381) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Machinery and Equipment:** We are proposing to use the PPI Commodity for Machinery and Equipment (BLS series code WPU11) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Miscellaneous Products:** For measuring price change in the Miscellaneous Products cost category, we are proposing to use the PPI Commodity for Finished Goods less Food and Energy (BLS series code WPUFD4131). Both food and energy are already adequately represented in separate cost categories and should not

also be reflected in this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Professional Fees: Labor-Related:** We are proposing to use the ECI for Total Compensation for Private Industry Workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same index used in the FY 2010-based SNF market basket (which was called the Nonmedical Professional Fees: Labor-Related cost category).

- Administrative and Facilities Support Services:** We are proposing to use the ECI for Total Compensation for Private Industry Workers in Office and Administrative Support (BLS series code CIU2010000220000I) to measure the price growth of this category. This is the same index used in the FY 2010-based SNF market basket.

- Installation, Maintenance and Repair Services:** We are proposing to include a separate cost category for Installation, Maintenance, and Repair Services in order to proxy these costs by a price index that better reflects the price changes of labor associated with maintenance-related services. We are proposing to use the ECI for Total Compensation for All Civilian Workers in Installation, Maintenance, and Repair (BLS series code CIU1010000430000I) to measure the price growth of this new cost category. Previously these costs were included in the All Other: Labor-Related Services category and were proxied by the ECI for Total Compensation for Private Industry Workers in Service Occupations (BLS series code CIU2010000300000I).

- All Other: Labor-Related Services:** We are proposing to use the ECI for Total Compensation for Private Industry Workers in Service Occupations (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Professional Fees: NonLabor-Related:** We are proposing to use the ECI for Total Compensation for Private Industry Workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same index used in the FY 2010-based SNF market basket (which was called

the Nonmedical Professional Fees: Nonlabor-Related cost category).

- Financial Services:** We are proposing to use the ECI for Total Compensation for Private Industry Workers in Financial Activities (BLS series code CIU201520A000000I) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Telephone Services:** We are proposing to use the CPI All Urban for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- Postage:** We are proposing to use the CPI All Urban for Postage (BLS series code CUUR0000SEEC) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

- All Other: NonLabor-Related Services:** We are proposing to use the CPI All Urban for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. This is the same index used in the FY 2010-based SNF market basket.

3. Price Proxies Used To Measure Capital Cost Category Growth

We are proposing to apply the same price proxies as were used in the FY 2010-based SNF market basket, and below is a detailed explanation of the price proxies used for each capital cost category. We also are proposing to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. This vintage weighting method is the same method that was used for the FY 2010-based SNF market basket and is described below.

- Depreciation—Building and Fixed Equipment:** We are proposing to use the BEA Chained Price Index for Private Fixed Investment in Structures, Nonresidential, Hospitals and Special Care (BEA Table 5.4.4. Price Indexes for Private Fixed Investment in Structures by Type). This BEA index is intended to capture prices for construction of facilities such as hospitals, nursing homes, hospices, and rehabilitation centers.

- *Depreciation—Movable Equipment:* We are proposing to use the PPI Commodity for Machinery and Equipment (BLS series code WPU11). This price index reflects price inflation associated with a variety of machinery and equipment that would be utilized by SNFs including but not limited to medical equipment, communication equipment, and computers.

- *Nonprofit Interest:* We are proposing to use the average yield on Municipal Bonds (Bond Buyer 20-bond index).

- *For-Profit Interest:* We are proposing to use the average yield on Moody's AAA corporate bonds (Federal Reserve). We are proposing different proxies for the interest categories because we believe interest price pressures differ between nonprofit and for-profit facilities.

- *Other Capital:* Since this category includes fees for insurances, taxes, and other capital-related costs, we are proposing to use the CPI All Urban for Owners' Equivalent Rent of Primary Residence (BLS series code CUUR0000SEHC01), which would reflect the price growth of these costs.

We believe that these price proxies continue to be the most appropriate proxies for SNF capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability.

As stated above, we are proposing to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. To capture the long-term nature, the price proxies are vintage-weighted; and the vintage weights are calculated using a two-step process. First, we determine the expected useful life of capital and debt instruments held by SNFs. Second, we identify the proportion of expenditures within a cost category that is attributable to each individual year over the useful life of the relevant capital assets, or the vintage weights.

We rely on Bureau of Economic Analysis (BEA) fixed asset data to derive the useful lives of both fixed and movable capital, which is the same data source used to derive the useful lives for the FY 2010-based SNF market basket. The specifics of the data sources used are explained below.

a. Calculating Useful Lives for Moveable and Fixed Assets

Estimates of useful lives for movable and fixed assets for the proposed 2014-based SNF market basket are 10 and 23 years, respectively. These estimates are based on three data sources from the BEA: (1) Current-cost average age; (2) historical-cost average age; and (3)

industry-specific current cost net stocks of assets.

BEA current-cost and historical-cost average age data by asset type are not available by industry but are published at the aggregate level for all industries. The BEA does publish current-cost net capital stocks at the detailed asset level for specific industries. There are 61 detailed movable assets (including intellectual property) and there are 32 detailed fixed assets in the BEA estimates. Since we seek aggregate useful life estimates applicable to SNFs, we developed a methodology to approximate movable and fixed asset ages for nursing and residential care services (NAICS 623) using the published BEA data. For the proposed FY 2014 SNF market basket, we use the current-cost average age for each asset type from the BEA fixed assets Table 2.9 for all assets and weight them using current-cost net stock levels for each of these asset types in the nursing and residential care services industry, NAICS 6230. (For example, nonelectro medical equipment current-cost net stock (accounting for about 37 percent of total moveable equipment current-cost net stock in 2014) is multiplied by an average age of 4.7 years. Current-cost net stock levels are available for download from the BEA Web site at <http://www.bea.gov/national/FA2004/Details/Index.html>. We then aggregate the "weighted" current-cost net stock levels (average age multiplied by current-cost net stock) into moveable and fixed assets for NAICS 6230. We then adjust the average ages for moveable and fixed assets by the ratio of historical-cost average age (Table 2.10) to current-cost average age (Table 2.9).

This produces historical cost average age data for movable (equipment and intellectual property) and fixed (structures) assets specific to NAICS 6230 of 4.8 and 11.6 years, respectively. The average age reflects the average age of an asset at a given point in time, whereas we want to estimate a useful life of the asset, which would reflect the average over all periods an asset is used. To do this, we multiply each of the average age estimates by two to convert to average useful lives with the assumption that the average age is normally distributed (about half of the assets are below the average at a given point in time, and half above the average at a given point in time). This produces estimates of likely useful lives of 9.6 and 23.2 years for movable and fixed assets, which we round to 10 and 23 years, respectively. We are proposing an interest vintage weight time span of 21 years, obtained by weighting the

fixed and movable vintage weights (23 years and 10 years, respectively) by the fixed and movable split (87 percent and 13 percent, respectively). This is the same methodology used for the FY 2010-based SNF market basket which had useful lives of 22 years and 6 years for fixed and moveable assets, respectively. The impact of revising the useful life for moveable assets from 6 years to 10 years had little to no impact on the growth rate of the proposed 2014-based SNF market basket capital cost weight. Over the 2014 to 2026 time period, the impact on the growth rate of the capital cost weight was no larger than 0.01 percent in absolute terms.

b. Constructing Vintage Weights

Given the expected useful life of capital (fixed and moveable assets) and debt instruments, we must determine the proportion of capital expenditures attributable to each year of the expected useful life for each of the three asset types: Building and fixed equipment, moveable equipment, and interest. These proportions represent the vintage weights. We were not able to find a historical time series of capital expenditures by SNFs. Therefore, we approximated the capital expenditure patterns of SNFs over time, using alternative SNF data sources. For building and fixed equipment, we used the stock of beds in nursing homes from the National Nursing Home Survey (NNHS) conducted by the National Center for Health Statistics (NCHS) for 1962 through 1999. For 2000 through 2010, we extrapolated the 1999 bed data forward using a 5-year moving average of growth in the number of beds from the SNF MCR data. For 2011 to 2014, we propose to extrapolate the 2010 bed data forward using the average growth in the number of beds over the 2011 to 2014 time period. We then used the change in the stock of beds each year to approximate building and fixed equipment purchases for that year. This procedure assumes that bed growth reflects the growth in capital-related costs in SNFs for building and fixed equipment. We believe that this assumption is reasonable because the number of beds reflects the size of a SNF, and as a SNF adds beds, it also likely adds fixed capital.

As was done for the FY 2010-based SNF market basket (as well as prior market baskets), we are proposing to estimate moveable equipment purchases based on the ratio of ancillary costs to routine costs. The time series of the ratio of ancillary costs to routine costs for SNFs measures changes in intensity in SNF services, which are assumed to be associated with movable equipment

purchase patterns. The assumption here is that as ancillary costs increase compared to routine costs, the SNF caseload becomes more complex and would require more movable equipment. The lack of movable equipment purchase data for SNFs over time required us to use alternative SNF data sources. A more detailed discussion of this methodology was published in the FY 2008 SNF final rule (72 FR 43428). We believe the resulting two time series, determined from beds and the ratio of ancillary to routine costs, reflect real capital purchases of building and fixed equipment and movable equipment over time.

To obtain nominal purchases, which are used to determine the vintage weights for interest, we converted the two real capital purchase series from

1963 through 2014 determined above to nominal capital purchase series using their respective price proxies (the BEA Chained Price Index for Nonresidential Construction for Hospitals & Special Care Facilities and the PPI for Machinery and Equipment). We then combined the two nominal series into one nominal capital purchase series for 1963 through 2014. Nominal capital purchases are needed for interest vintage weights to capture the value of debt instruments.

Once we created these capital purchase time series for 1963 through 2014, we averaged different periods to obtain an average capital purchase pattern over time: (1) For building and fixed equipment, we averaged 30, 23-year periods; (2) for movable equipment, we averaged 43, 10-year periods; and (3)

for interest, we averaged 32, 21-year periods. We calculate the vintage weight for a given year by dividing the capital purchase amount in any given year by the total amount of purchases during the expected useful life of the equipment or debt instrument. To provide greater transparency, we posted on the CMS market basket Web site at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html>, an illustrative spreadsheet that contains an example of how the vintage-weighted price indexes are calculated.

The vintage weights for the proposed 2014-based SNF market basket and the FY 2010-based SNF market basket are presented in Table 14.

TABLE 14—PROPOSED 2014-BASED VINTAGE WEIGHTS AND FY 2010-BASED VINTAGE WEIGHTS

Year ¹	Building and fixed equipment		Movable equipment		Interest	
	Proposed 2014-based 23 years	FY 2010-based 25 years	Proposed 2014-based 10 years	FY 2010-based 6 years	Proposed 2014-based 21 years	FY 2010-based 22 years
1	.056	.061	.085	.165	.032	.030
2	.055	.059	.087	.160	.033	.030
3	.054	.053	.091	.167	.034	.032
4	.052	.050	.097	.167	.036	.033
5	.049	.046	.099	.169	.037	.035
6	.046	.043	.102	.171	.039	.037
7	.044	.041	.108		.041	.039
8	.043	.039	.109		.043	.040
9	.040	.036	.110		.044	.041
10	.038	.034	.112		.045	.043
11	.038	.034			.048	.045
12	.039	.034			.052	.047
13	.039	.033			.056	.048
14	.039	.032			.058	.048
15	.039	.031			.060	.050
16	.039	.031			.059	.052
17	.040	.032			.057	.055
18	.041	.034			.057	.058
19	.043	.035			.056	.060
20	.042	.036			.056	.060
21	.042	.038			.057	.058
22	.042	.039				.058
23	.042	.042				
24		.043				
25		.044				
26						
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: The vintage weights are calculated using thirteen decimals. For presentational purposes, we are displaying three decimals and therefore, the detail vintage weights may not add to 1.000 due to rounding.

¹ Year 1 represents the vintage weight applied to the farthest year while the vintage weight for year 23, for example, would apply to the most recent year.

Table 15 shows all the price proxies for the proposed 2014-based SNF market basket.

TABLE 15—PROPOSED PRICE PROXIES FOR THE PROPOSED 2014-BASED SNF MARKET BASKET

Cost category	Weight	Proposed price proxy
Total	100.0	

TABLE 15—PROPOSED PRICE PROXIES FOR THE PROPOSED 2014-BASED SNF MARKET BASKET—Continued

Cost category	Weight	Proposed price proxy
Compensation	60.4	
Wages and Salaries ¹	50.0	ECI for Wages and Salaries for Private Industry Workers in Nursing Care Facilities.
Employee Benefits ¹	10.5	ECI for Total Benefits for Private Industry Workers in Nursing Care Facilities.
Utilities	2.6	
Electricity	1.2	PPI Commodity for Commercial Electric Power.
Fuel: Oil and Gas	1.3	Blend of Fuel PPIs.
Water and Sewerage	0.2	CPI for Water and Sewerage Maintenance (All Urban Consumers).
Professional Liability Insurance	1.1	CMS Professional Liability Insurance Premium Index.
All Other	27.9	
Other Products	14.3	
Pharmaceuticals	7.3	PPI Commodity for Pharmaceuticals for Human Use, Prescription.
Food: Direct Purchase	3.1	PPI Commodity for Processed Foods and Feeds.
Food: Contract Purchase	0.7	CPI for Food Away From Home (All Urban Consumers).
Chemicals	0.2	Blend of Chemical PPIs.
Medical Instruments and Supplies	0.6	Blend of Medical Instruments and Supplies PPIs.
Rubber and Plastics	0.8	PPI Commodity for Rubber and Plastic Products.
Paper and Printing Products	0.8	PPI Commodity for Converted Paper and Paperboard Products.
Apparel	0.3	PPI Commodity for Apparel.
Machinery and Equipment	0.3	PPI Commodity for Machinery and Equipment.
Miscellaneous Products	0.3	PPI Commodity for Finished Goods Less Food and Energy.
All Other Services	13.6	
Labor-Related Services	7.4	
Professional Fees: Labor-related	3.8	ECI for Total Compensation for Private Industry Workers in Professional and Related.
Installation, Maintenance, and Repair Services	0.6	ECI for Total Compensation for All Civilian workers in Installation, Maintenance, and Repair.
Administrative and Facilities Support	0.5	ECI for Total Compensation for Private Industry Workers in Office and Administrative Support.
All Other: Labor-Related Services	2.5	ECI for Total Compensation for Private Industry Workers in Service Occupations.
Non Labor-Related Services	6.2	
Professional Fees: Nonlabor-related	1.8	ECI for Total Compensation for Private Industry Workers in Professional and Related.
Financial Services	2.0	ECI for Total Compensation for Private Industry Workers in Financial Activities.
Telephone Services	0.5	CPI for Telephone Services.
Postage	0.2	CPI for Postage.
All Other: Nonlabor-Related Services	1.8	CPI for All Items Less Food and Energy.
Capital-Related Expenses	7.9	
Total Depreciation	2.9	
Building and Fixed Equipment	2.5	BEA's Chained Price Index for Private Fixed Investment in Structures, Nonresidential, Hospitals and Special Care—vintage weighted 23 years.
Movable Equipment	0.4	PPI Commodity for Machinery and Equipment—vintage weighted 10 years.
Total Interest	3.0	
For-Profit SNFs	0.8	Moody's—Average yield on Aaa bonds, vintage weighted 21 years.
Government and Nonprofit SNFs	2.1	Moody's—Average yield on Domestic Municipal Bonds—vintage weighted 21 years.
Other Capital-Related Expenses	2.0	CPI for Owners' Equivalent Rent of Primary Residence.

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal and, therefore, the detailed cost weights may not add to the aggregate cost weights or to 100.0 due to rounding.

¹ Contract labor is distributed to wages and salaries and employee benefits based on the share of total compensation that each category represents.

4. Labor-Related Share

We define the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost

categories in the input price index. Effective for FY 2018, we are proposing to revise and update the labor-related share to reflect the relative importance of the proposed 2014-based SNF market basket cost categories that we believe are labor-intensive and vary with, or are influenced by, the local labor market.

For the proposed 2014-based SNF market basket these are: (1) Wages and Salaries (including allocated contract labor costs as described above); (2) Employee Benefits (including allocated contract labor costs as described above); (3) Professional fees: Labor-related; (4) Administrative and Facilities Support

Services; (5) Installation, Maintenance, and Repair services; (6) All Other: Labor-Related Services; and (7) a proportion of capital-related expenses. We propose to continue to include a proportion of capital-related expenses because a portion of these expenses are deemed to be labor-intensive and vary with, or are influenced by, the local labor market. For example, a proportion of construction costs for a medical building would be attributable to local construction workers' compensation expenses.

Consistent with previous SNF market basket revisions and rebasings, the All Other: Labor-related services cost category is mostly comprised of building maintenance and security services (including, but not limited to, landscaping services, janitorial services, waste management services, and investigation and security services). Because these services tend to be labor-intensive and are mostly performed at the SNF facility (and therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

The proposed inclusion of the Installation, Maintenance, and Repair Services cost category into the labor-related share remains consistent with the current labor-related share, since this cost category was previously included in the FY 2010-based SNF market basket All Other: Labor-related Services cost category. We proposed to establish a separate Installation, Maintenance, and Repair Services cost category so that we can use the ECI for Total Compensation for All Civilian Workers in Installation, Maintenance, and Repair to reflect the specific price changes associated with these services. We also use this cost category in the 2012-based IRF market basket (80 FR 47059), 2012-based IPF market basket (80 FR 46667), and 2013-based LTCH market basket (81 FR 57091).

As discussed in the FY 2014 SNF PPS proposed rule (78 FR 26462), in an effort to determine more accurately the share of nonmedical professional fees

(included in the proposed 2014-based SNF market basket Professional Fees cost categories) that should be included in the labor-related share, we surveyed SNFs regarding the proportion of those fees that are attributable to local firms and the proportion that are purchased from national firms. Based on these weighted results, we determined that SNFs purchase, on average, the following portions of contracted professional services inside their local labor market:

- 78 percent of legal services.
- 86 percent of accounting and auditing services.
- 89 percent of architectural, engineering services.
- 87 percent of management consulting services.

Together, these four categories represent 3.3 percentage points of the total costs for the proposed 2014-based SNF market basket. We applied the percentages from this special survey to their respective SNF market basket weights to separate them into labor-related and nonlabor-related costs. As a result, we are designating 2.8 of the 3.3 total to the labor-related share, with the remaining 0.5 categorized as nonlabor-related.

For the proposed 2014-based SNF market basket, we conducted a similar analysis of home office data. The Medicare cost report CMS Form 2540-10 requires a SNF to report information regarding their home office provider. Approximately 57 percent of SNFs reported some type of home office information on their Medicare cost report for 2014 (for example, city, state, zip code). Using the data reported on the Medicare cost report, we compared the location of the SNF with the location of the SNF's home office. For the FY 2010-based SNF market basket, we used the Medicare HOMER database to determine the location of the provider's home office as this information was not available on the Medicare cost report CMS Form 2540-96. For the proposed 2014-based SNF market basket, we are proposing to determine the proportion of home office

contract labor costs that should be allocated to the labor-related share based on the percent of total SNF home office contract labor costs as reported in Worksheet S-3, Part II attributable to those SNFs that had home offices located in their respective local labor markets—defined as being in the same Metropolitan Statistical Area (MSA). We determined a SNF's and home office's MSAs using their zip code information from the Medicare cost reports.

Using this methodology, we determined that 28 percent of SNFs' home office contract labor costs were for home offices located in their respective local labor markets. Therefore, we are proposing to allocate 28 percent of home office expenses to the labor-related share. The FY 2010-based SNF market basket allocated 32 percent of home office expenses to the labor-related share.

In the proposed 2014-based SNF market basket, home office expenses that were subject to allocation based on the home office allocation methodology represent 0.7 percent of the proposed 2014-based SNF market basket. Based on the home office results, we are apportioning 0.2 percentage point of the 0.7 percentage point figure into the labor-related share ($0.7 \times 0.28 = 0.193$, or 0.2) and designating the remaining 0.5 percentage point as nonlabor-related. In sum, based on the two allocations mentioned above, we apportioned 3.0 percentage points into the labor-related share. This amount is added to the portion of professional fees that we continue to identify as labor-related using the I-O data such as contracted advertising and marketing costs (0.8 percentage point of total operating costs) resulting in a Professional Fees: Labor-Related cost weight of 3.8 percent.

Table 16 compares the proposed 2014-based labor-related share and the FY 2010-based labor-related share based on the relative importance of IGI's first quarter 2017 forecast with historical data through the fourth quarter of 2016.

TABLE 16—FY 2018 AND FY 2017 SNF LABOR-RELATED SHARE

	Relative importance, labor-related, FY 2018 (2014-based index) 2017:Q1 forecast	Relative importance, labor-related, FY 2017 (FY 2010-based index) 2016:Q2 forecast
Wages and Salaries ¹	50.3	48.8
Employee Benefits ¹	10.3	11.3
Professional fees: Labor-related	3.7	3.5
Administrative and Facilities Support Services	0.5	0.5
Installation, Maintenance and Repair Services ²	0.6	n/a
All Other: Labor-related Services	2.5	2.3

TABLE 16—FY 2018 AND FY 2017 SNF LABOR-RELATED SHARE—Continued

	Relative importance, labor-related, FY 2018 (2014-based index) 2017:Q1 forecast	Relative importance, labor-related, FY 2017 (FY 2010-based index) 2016:Q2 forecast
Capital-related (.391)	2.9	2.7
Total	70.8	69.1

¹ The Wages and Salaries and Employee Benefits cost weight reflect contract labor costs as described above.

² Previously classified in the All Other: Labor-related services cost category in the FY 2010-based SNF market basket.

The FY 2018 SNF labor-related share (LRS) is 1.7 percentage points higher than the FY 2017 SNF LRS, which is based on the FY 2010-based SNF market basket relative importance. This implies an increase in the quantity of the labor-related services because rebasing the index contributed significantly to the increase. Also contributing to the higher labor-related share is a higher capital-related cost weight in the proposed 2014-based SNF market basket compared to the FY 2010-based SNF market basket. As stated above, we include a proportion of capital-related expenses in the labor-related share as we believe a portion of these expenses (such as construction labor costs) are

deemed to be labor-intensive and vary with, or are influenced by, the local labor market.

5. Proposed Market Basket Estimate for the FY 2018 SNF PPS Update

As discussed previously in this proposed rule, beginning with the FY 2018 SNF PPS update, we are proposing to adopt the 2014-based SNF market basket as the appropriate market basket of goods and services for the SNF PPS. Based on IGI's first quarter 2017 forecast with historical data through the fourth quarter of 2016, the most recent estimate of the proposed 2014-based SNF market basket for FY 2018 is 2.7 percent. IGI is a nationally recognized economic and

financial forecasting firm that contracts with CMS to forecast the components of CMS' market baskets.

Table 17 compares the proposed 2014-based SNF market basket and the FY 2010-based SNF market basket percent changes. For the historical period between FY 2013 and FY 2016, the average difference between the two market baskets is -0.3 percentage point. This is primarily the result of the lower pharmaceuticals cost category weight, increased Fuel: Oil and Gas cost category weight, and the change in the Fuels price proxy. For the forecasted period between FY 2017 and FY 2019, there is no difference in the average growth rate.

TABLE 17—PROPOSED 2014-BASED SNF MARKET BASKET AND FY 2010-BASED SNF MARKET BASKET, PERCENT CHANGES: 2013–2019

Fiscal year (FY)	Proposed 2014-based SNF market basket	FY 2010-based SNF market basket
Historical data:		
FY 2013	1.6	1.8
FY 2014	1.6	1.7
FY 2015	1.8	2.3
FY 2016	1.9	2.3
Average FY 2013–2016	1.7	2.0
Forecast:		
FY 2017	2.9	2.9
FY 2018	2.7	2.7
FY 2019	2.7	2.7
Average FY 2017–2019	2.8	2.8

Source: IHS Global Insight, Inc. 1st quarter 2017 forecast with historical data through 4th quarter 2016.

While we ordinarily would propose to use this 2014-based SNF market basket percentage to update the SNF PPS per diem rates for FY 2018, we note that section 411(a) of the MACRA amended section 1888(e) of the Act to add section 1888(e)(5)(B)(iii) of the Act. Section 1888(e)(5)(B)(iii) of the Act establishes a special rule for FY 2018 that requires the market basket percentage, after the application of the productivity adjustment, to be 1.0 percent. In accordance with section 1888(e)(5)(B)(iii) of the Act, we will use a market basket percentage of 1.0

percent to update the federal rates set forth in this proposed rule. Effective for FY 2019, we are proposing to use the proposed 2014-based SNF market basket to determine the market basket percentage update for the SNF PPS per diem rates. As stated in section V.A.4. in this preamble, we are proposing to use the proposed 2014-based SNF market basket to determine the labor-related share effective for FY 2018.

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

1. Background and Statutory Authority

Section 1888(e)(6)(A)(i) of the Act, as added by section 2(c)(4) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), requires that for fiscal years beginning with FY 2018, in the case of a SNF that does not submit data as applicable in accordance with sections 1888(e)(6)(B)(i)(II)–(III) of the Act for a fiscal year, the Secretary reduce the market basket percentage described in

section 1888(e)(5)(B)(i) of the Act for payment rates during that fiscal year by two percentage points. In section III.B of this proposed rule, we discuss proposed revisions in the market basket update regulations at § 413.337(d) that would implement this provision. In accordance with this statutory mandate, we have implemented a SNF Quality Reporting Program (QRP), which we believe promotes higher quality and more efficient health care for Medicare beneficiaries. 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 a full discussion of the statutory background and policy considerations that have shaped the SNF QRP.

Please note, the term “FY (year) SNF QRP” means the fiscal year for which the SNF QRP requirements applicable to that fiscal year must be met in order for a SNF to receive the full market basket percentage when calculating the payment rates applicable to it for that fiscal year.

The IMPACT Act (Pub. L. 113–185) amended Title XVIII of the Act, in part, by adding a new section 1899B, entitled “Standardized Post-Acute Care Assessment Data for Quality, Payment and Discharge Planning,” and by enacting new data reporting requirements for certain post-acute care (PAC) providers, including SNFs. Specifically, new sections 1899B(a)(1)(A)(ii) and (iii) of the Act require SNFs, inpatient rehabilitation facilities (IRFs), Long Term Care Hospitals (LTCHs) and home health agencies (HHAs), under each of their respective quality reporting program (which, for SNFs, is found at section 1888(e)(6) of the Act), to report data on quality measures specified under section 1899B(c)(1) of the Act for at least five domains, and data on resource use and other measures specified under section 1899B(d)(1) of the Act for at least three domains. Section 1899B(a)(1)(A)(i) of the Act further requires each of these PAC providers to report under their respective quality reporting program standardized patient assessment data in accordance with subsection (b) for at least the quality measures specified under subsection (c)(1) and that is for five specific categories: Functional status; cognitive function and mental status; special services, treatments, and interventions; medical conditions and co-morbidities; and impairments. All of the data that must be reported in accordance with section 1899B(a)(1)(A) of the Act must be standardized and interoperable so as

to allow for the exchange of the information among PAC providers and other providers and the use of such data in order to enable access to longitudinal information and to facilitate coordinated care. We refer readers to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429) for additional information on the IMPACT Act and its applicability to SNFs.

2. General Considerations Used for Selection of Quality 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 LTCH QRP, such as alignment with the CMS Quality Strategy,² which incorporates the three broad aims of the National Quality Strategy.³

As part of our consideration for measures for use in the SNF QRP, we review and evaluate measures that have been implemented in other programs and take into account measures that have been endorsed by NQF for provider settings other than the SNF setting. We have previously adopted measures that we referred to as “applications” of those measures. We have received questions pertaining to the term “application” and want to clarify that when a proposed or implemented measure is referred to as an, “application of” the measure it means that the measure will be used in the SNF setting, rather than the setting for which it was endorsed by the NQF. For example, in the FY 2016 SNF PPS final rule (80 FR 46440 through 46444) we adopted an Application of Percent of Residents Experiencing One or More Falls With Major Injury (Long Stay) (NQF #0674) which is endorsed for the nursing home setting but not the SNF setting. For such measures, we would then intend to seek NQF endorsement for the SNF setting, and the NQF endorses one or more of them, we will update the title of the measure to remove the reference to “application”.

a. Measuring and Accounting for Social Risk Factors in the SNF QRP

We consider related factors that may affect measures in the SNF QRP. We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social

support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. One of our core objectives is to improve beneficiary outcomes including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care. In addition, we seek to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible under our programs while ensuring that beneficiaries have adequate access to excellent care.

We have been reviewing reports prepared by HHS’ Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of measuring and accounting for social risk factors in CMS’ value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. On December 21, 2016, ASPE submitted a Report to Congress on a study it was required to conduct under section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The study analyzed the effects of certain social risk factors of Medicare beneficiaries on quality measures and measures of resource use used in one or more of nine Medicare value-based purchasing programs.⁴ The report also included considerations for strategies to account for social risk factors in these programs. In a January 10, 2017 report released by The National Academies of Sciences, Engineering, and Medicine, that body provided various potential methods for measuring and accounting for social risk factors, including stratified public reporting.⁵

As discussed in the FY 2017 SNF PPS final rule, the NQF has undertaken a 2-year trial period in which new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for selected social risk factors is appropriate for these measures. This trial entails temporarily allowing inclusion of social risk factors in the risk-adjustment

⁴ Office of the Assistant Secretary for Planning and Evaluation. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs. Available at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

⁵ National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press.

² <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>.

³ <http://www.aahr.gov/workingforquality/nqfs/nqs2011annlrpt.htm>.

approach for these measures. At the conclusion of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for quality measures.

As we continue to consider the analyses and recommendations from these reports and await the results of the NQF trial on risk adjustment for quality measures, we are continuing to work with stakeholders in this process. As we have previously communicated, we are concerned about holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. Keeping this concern in mind, while we sought input on this topic previously, we continue to seek public comment on whether we should account for social risk factors in measures in the SNF QRP, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include:

Confidential reporting to providers of measure rates stratified by social risk factors; public reporting of stratified measure rates; and potential risk adjustment of a particular measure as appropriate based on data and evidence.

In addition, we are also seeking public comment on which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to, dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence. We are seeking comments on which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk. We will take commenters' input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in the SNF QRP. We note that any such changes would be proposed through future notice and comment rulemaking.

We look forward to working with stakeholders as we consider the issue of accounting for social risk factors and reducing health disparities in CMS programs. Of note, implementing any of the above methods would be taken into consideration in the context of how this and other CMS programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of

data calculations, among others), so we also welcome comment on operational considerations. CMS is committed to ensuring that its beneficiaries have access to and receive excellent care, and that the quality of care furnished by providers and suppliers is assessed fairly in CMS programs.

3. Proposed Collection of Standardized Resident Assessment Data Under the SNF QRP

a. Proposed Definition of Standardized Resident Assessment Data

Section 1888(e)(6)(B)(i)(III) of the Act requires that for fiscal year 2019 and each subsequent year, SNFs report standardized patient assessment data required under section 1899B(b)(1) of the Act. For purposes of meeting this requirement, section 1888(e)(6)(B)(ii) of the Act requires a SNF to submit the standardized resident assessment data required under section 1819(b)(3) of the Act using the standard instrument designated by the state under section 1819(e)(5) of the Act.

For purposes of the SNF QRP, we refer to beneficiaries who receive services from SNFs as "residents," and we collect certain information about the SNF services they receive using the Resident Assessment Instrument Minimum Data Set (MDS).

Section 1899B(b)(1)(B) of the Act describes standardized patient assessment data as data required for at least the quality measures described in sections 1899B(c)(1) of the Act and that is for the following categories:

- Functional status, such as mobility and self-care at admission to a PAC provider and before discharge from a PAC provider;
- Cognitive function, such as ability to express ideas and to understand and mental status, such as depression and dementia;
- Special services, treatments and interventions such as the need for ventilator use, dialysis, chemotherapy, central line placement and total parenteral nutrition;
- Medical conditions and comorbidities such as diabetes, congestive heart failure and pressure ulcers;
- Impairments, such as incontinence and an impaired ability to hear, see or swallow; and
- Other categories deemed necessary and appropriate.

As required under section 1899B(b)(1)(A) of the Act, the standardized patient assessment data must be reported at least for SNF admissions and discharges, but the Secretary may require the data to be reported more frequently.

In this rule, we are proposing to define the standardized patient assessment data that SNFs must report to comply with section 1888(e)(6) of the Act, as well as the requirements for the reporting of these data. The collection of standardized patient assessment data is critical to our efforts to drive improvement in health care quality across the four post-acute care (PAC) settings to which the IMPACT Act applies. We intend to use these data for a number of purposes, including facilitating their exchange and longitudinal use among health care providers to enable high quality care and outcomes through care coordination, as well as for quality measure calculation, and identifying comorbidities that might increase the medical complexity of a particular admission.

SNFs are currently required to report resident assessment data through the MDS by responding to an identical set of assessment questions using an identical set of response options (we refer to each solitary question/response option as a data element and we refer to a group of questions/response options on a single topic as a data element), both of which incorporate an identical set of definitions and standards. The primary purpose of the identical questions and response options is to ensure that we collect a set of standardized data elements across SNFs which we can then use for a number of purposes, including SNF payment and measure calculation for the SNF QRP.

LTCHs, IRFs, and HHAs are also required to report patient assessment data through their applicable PAC assessment instruments, and they do so by responding to identical assessment questions developed for their respective settings using an identical set of response options (which incorporate an identical set of definitions and standards). Like the MDS, the questions and response options for each of these other PAC assessment instruments are standardized across the PAC provider type to which the PAC assessment instrument applies. However, the assessment questions and response options in the four PAC assessment instruments are not currently standardized with each other. As a result, questions and response options that appear on the MDS cannot be readily compared with questions and response options that appear, for example, on the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) the PAC assessment instrument used by IRFs. This is true even when the questions and response options are similar. This lack of

standardization across the four PAC provider types has limited our ability to compare one PAC provider type with another for purposes such as care coordination and quality improvement.

To achieve a level of standardization across SNFs, LTCHs, IRFs, and HHAs that enables us to make comparisons between them, we are proposing to define “standardized patient assessment data” as patient or resident assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply. Standardizing the questions and response options across the four PAC assessment instruments will also enable the data to be interoperable allowing it to be shared electronically, or otherwise, between PAC provider types. It will enable the data to be comparable for various purposes, including the development of cross-setting quality measures and to inform payment models that take into account patient characteristics rather than setting, as described in the IMPACT Act.

We are inviting public comment on this proposed definition.

b. General Considerations Used for the Selection of Proposed Standardized Resident Assessment Data

As part of our effort to identify appropriate standardized patient assessment data for purposes of collecting under the SNF QRP, we sought input from the general public, stakeholder community, and subject matter experts on items that would enable person-centered, high quality health care, as well as access to longitudinal information to facilitate coordinated care and improved beneficiary outcomes.

To identify optimal data elements for standardization, our data element contractor organized teams of researchers for each category, and each team worked with a group of advisors made up of clinicians and academic researchers with expertise in PAC. Information-gathering activities were used to identify data elements, as well as key themes related to the categories described in section 1899B(b)(1)(B) of the Act. In January and February 2016, our data element contractor also conducted provider focus groups for each of the four PAC provider types, and a focus group for consumers that included current or former PAC patients and residents, caregivers, ombudsmen, and patient advocacy group representatives. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Focus Group 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>.

Our data element contractor also assembled a 16-member TEP that met on April 7 and 8, 2016, and January 5 and 6, 2017, in Baltimore, Maryland, to provide expert input on data elements that are currently in each PAC assessment instrument, as well as data elements that could be standardized. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data TEP Summary Reports are 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>.

As part of the environmental scan, data elements currently in the four existing PAC assessment instruments were examined to see if any could be considered for proposal as standardized patient assessment data. Specifically, this evaluation included consideration of data elements in OASIS–C2 (effective January 2017); IRF–PAI, v1.4 (effective October 2016); LCDS, v3.00 (effective April 2016); and MDS 3.0, v1.14 (effective October 2016). Data elements in the standardized assessment instrument that we tested in the Post-Acute Care Payment Reform Demonstration (PAC PRD)—the Continuity Assessment Record and Evaluation (CARE) were also considered. A literature search was also conducted to determine whether additional data elements to propose as standardized patient assessment data could be identified.

We additionally held four Special Open Door Forums (SODFs) on October 27, 2015; May 12, 2016; September 15, 2016; and December 8, 2016, to present data elements we were considering and to solicit input. At each SODF, some stakeholders provided immediate input, and all were invited to submit additional comments via the CMS IMPACT Mailbox at PACQualityInitiative@cms.hhs.gov.

We also convened a meeting with federal agency subject matter experts (SMEs) on May 13, 2016. In addition, a public comment period was open from August 12, to September 12, 2016, to solicit comments on detailed candidate data element descriptions, data collection methods, and coding methods. The IMPACT Act Public Comment Summary Report containing

the public comments (summarized and verbatim) and our responses, 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>.

We specifically sought to identify standardized patient assessment data that we could feasibly incorporate into the LTCH, IRF, SNF, and HHA assessment instruments and that have the following attributes: (1) Being supported by current science; (2) testing well in terms of their reliability and validity, consistent with findings from the Post-Acute Care Payment Reform Demonstration (PAC PRD); (3) the potential to be shared (for example, through interoperable means) among PAC and other provider types to facilitate efficient care coordination and improved beneficiary outcomes; (4) the potential to inform the development of quality, resource use and other measures, as well as future payment methodologies that could more directly take into account individual beneficiary health characteristics; and (5) the ability to be used by practitioners to inform their clinical decision and care planning activities. We also applied the same considerations that we apply with quality measures, including the CMS Quality Strategy which is framed using the three broad aims of the National Quality Strategy.

4. Policy for Retaining SNF QRP Measures and Proposal To Apply That Policy to Standardized Patient Assessment Data

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 initially adopt a measure for the SNF QRP, 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 propose to apply this policy to the standardized patient assessment data that we adopt for the SNF QRP.

We are inviting public comment on our proposal.

5. Policy for Adopting Changes to SNF QRP Measures and Proposal To Apply That Policy to Standardized Patient Assessment Data

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 did not propose to make any changes to this

policy. We propose to apply this policy to the standardized patient assessment data that we adopt for the SNF QRP.

We are inviting public comment on our proposal.

6. Quality Measures Currently Adopted for the SNF QRP

The SNF QRP currently has seven adopted measures as outlined in Table 18.

TABLE 18—QUALITY MEASURES CURRENTLY ADOPTED FOR THE SNF QRP

Short name	Measure name & data source
Resident Assessment Instrument Minimum Data Set	
Pressure Ulcers	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
Application of Falls	Application of the NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/Care Plan	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues—Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program*
Claims-based	
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Facility (SNF) Quality Reporting Program (QRP)*
DTC	Discharge to Community—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)*
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program*

* Not currently NQF-endorsed for the SNF Setting.

7. SNF QRP Quality Measures Proposed Beginning With the FY 2020 SNF QRP

Beginning with the FY 2020 SNF QRP, in addition to the quality measures we are retaining under our policy described in section V.B.6. of this proposed rule, we are proposing to remove the current pressure ulcer measure entitled Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and to replace it with a modified version of the measure entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury and to adopt four function outcome measures on resident functional status. We are also proposing to characterize the data elements described below as standardized patient assessment data under section 1899B(b)(1)(B) of the Act that must be reported by SNFs under the SNF QRP through the MDS

The proposed measures are as follows:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).

- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).

- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

The measures are described in more detail below.

a. Proposal To Replace the Current Pressure Ulcer Quality Measure, Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), With a Modified Pressure Ulcer Measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

(1) Measure Background

In this proposed rule, we are proposing to remove the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) from the SNF QRP measure set and to replace it with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, beginning with the FY 2020 SNF QRP. The change in the measure name is to reduce confusion about the new modified measure. The modified version differs from the current version of the measure

because it includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator. The modified version of the measure would satisfy the IMPACT Act domain of skin integrity and changes in skin integrity.

We note that the technical specifications for the pressure ulcer measure were updated in August 2016 through a subregulatory process to ensure technical alignment of the SNF measure specifications with the LTCH, IRF, and HH specifications. The technical updates were added to ensure clarity in how the measure is calculated, and to avoid possible over counting of pressure ulcers in the numerator. In summary, we corrected the technical specifications to mitigate the risk of over counting new or worsened pressure ulcers and to reflect the actual unit of analysis as finalized in the rule, which is a stay (Medicare Part A stay) for SNF QRP, consistent with the IRF, and LTCH QRPs, rather than an episode (which could include multiple stays) as is used in the case of Nursing Home Compare. Thus, we updated the SNF measure specifications to reflect all resident stays, rather than the most-recent episode in a quarter, which is comprised of one or more stays in that measure calculation. Also to ensure alignment, we corrected our

specifications to ensure that healed wounds are not incorrectly captured in the measure. Further, we corrected the specifications to ensure the exclusion of residents who expire during their SNF stay. The SNF specifications can be reviewed on our Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

(2) Measure Importance

As described in the FY 2016 SNF PPS final rule (80 FR 46433), pressure ulcers are high-cost adverse events and are an important measure of quality. For information on the history and rationale for the relevance, importance, and applicability of having a pressure ulcer measure in the SNF QRP, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46433 through 46434).

We are proposing to adopt a modified version of the current pressure ulcer measure because unstageable pressure ulcers, including DTIs, are similar to Stage 2, Stage 3, and Stage 4 pressure ulcers in that they represent poor outcomes, are a serious medical condition that can result in death and disability, are debilitating and painful, and are often an avoidable outcome of medical care.^{6 7 8 9 10 11} Studies show that most pressure ulcers can be avoided and can also be healed in acute, post-acute, and long-term care settings with appropriate medical care.¹² Furthermore, some studies indicate that DTIs, if managed using appropriate care, can be resolved without deteriorating into a worsened pressure ulcer.^{13 14}

⁶ Casey, G. (2013). "Pressure ulcers reflect quality of nursing care." *Nurs N Z* 19(10): 20–24.

⁷ Gorzoni, M.L. and S.L. Pires (2011). "Deaths in nursing homes." *Rev Assoc Med Bras* 57(3): 327–331.

⁸ Thomas, J.M., et al. (2013). "Systematic review: Health-related characteristics of elderly hospitalized adults and nursing home residents associated with short-term mortality." *J Am Geriatr Soc* 61(6): 902–911.

⁹ White-Chu, E.F., et al. (2011). "Pressure ulcers in long-term care." *Clin Geriatr Med* 27(2): 241–258.

¹⁰ Bates-Jensen B.M. Quality indicators for prevention and management of pressure ulcers in vulnerable elders. *Ann Int Med*. 2001;135 (8 Part 2), 744–51.

¹¹ Bennet, G., Dealy, C. Posnett, J. (2004). The cost of pressure ulcers in the UK, *Age and Aging*, 33(3):230–235.

¹² Black, Joyce M., et al. "Pressure ulcers: Avoidable or unavoidable? Results of the national pressure ulcer advisory panel consensus conference." *Ostomy-Wound Management* 57.2 (2011): 24.

¹³ Sullivan, R. (2013). A Two-year Retrospective Review of Suspected Deep Tissue Injury Evolution in Adult Acute Care Patients. *Ostomy Wound*

While DTIs are a subset of unstageable pressure ulcers, we collect DTI data elements separately and analyze them both separately and with other unstageable pressure ulcer item categories in our analysis below. We note that DTIs are categorized as a type of unstageable pressure ulcer on the MDS and other post-acute care item sets.

While there are few studies that provide information regarding the incidence of unstageable pressure ulcers in PAC settings, an analysis conducted by a contractor suggests the incidence of unstageable pressure ulcers varies according to the type of unstageable pressure ulcer and setting. This analysis examined the national incidence of new unstageable pressure ulcers in SNFs at discharge compared with admission using SNF discharges from January through December 2015. The contractor found a national incidence of 0.40 percent of new unstageable pressure ulcers due to slough and/or eschar, 0.02 percent of new unstageable pressure ulcers due to non-removable dressing/device, and 0.57 percent of new DTIs. In addition, an international study spanning the time period 2006 to 2009, provides some evidence to suggest that the proportion of pressure ulcers identified as DTI has increased over time. The study found DTIs increased by three fold, to nine percent of all observed ulcers in 2009, and that DTIs were more prevalent than either Stage 3 or 4 ulcers. During the same time period, the proportion of Stage 1 and 2 ulcers decreased, and the proportion of Stage 3 and 4 ulcers remained constant.¹⁵

The inclusion of unstageable pressure ulcers, including DTIs, in the numerator of this measure is expected to increase measure scores and variability in measure scores, thereby improving the ability to discriminate among poor- and high-performing SNFs. In the currently implemented pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), analysis using data from Quarter 4 2015

Management 59(9) <http://www.o-wm.com/article/two-year-retrospective-review-suspected-deep-tissue-injury-evolution-adult-acute-care-patient>

¹⁴ Posthauer, M.E., Zulkowski, K. (2005). Special to OWM: The NPUAP Dual Mission Conference: Reaching Consensus on Staging and Deep Tissue Injury. *Ostomy Wound Management* 51(4) <http://www.o-wm.com/content/the-npuap-dual-mission-conference-reaching-consensus-staging-and-deep-tissue-injury>

¹⁵ VanGilder, C., MacFarlane, G.D., Harrison, P., Lachenbruch, C., Meyer, S. (2010). The Demographics of Suspected Deep Tissue Injury in the United States: An Analysis of the International Pressure Ulcer Prevalence Survey 2006–2009. *Advances in Skin & Wound Care*. 23(6): 254–261.

through Quarter 3 2016 reveals that (the SNF mean score is 1.75 percent; the 25th and 75th percentiles are 0.0 percent and 2.53 percent, respectively; and 29.11 percent of facilities have perfect scores. In the proposed measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, during the same timeframe, the SNF mean score is 2.58 percent; the 25th and 75th percentiles are 0.65 percent and 3.70 percent, respectively; and 20.32 percent of facilities have perfect scores.

(3) Stakeholder Feedback

Our measure development contractor sought input from subject matter experts, including Technical Expert Panels (TEPs), over the course of several years on various skin integrity topics and specifically those associated with the inclusion of unstageable pressure ulcers, including DTIs. Most recently, on July 18, 2016, a TEP convened by our measure development contractor provided input on the technical specifications of this proposed quality measure, including the feasibility of implementing the proposed measure's updates related to the inclusion of unstageable ulcers, including DTIs, across PAC settings. The TEP supported the updates to the measure across PAC settings, including the inclusion in the numerator of unstageable pressure ulcers due to slough and/or eschar that are new or worsened, new unstageable pressure ulcers due to a non-removable dressing or device, and new DTIs. The TEP recommended supplying additional guidance to providers regarding each type of unstageable pressure ulcer. This support was in agreement with earlier TEP meetings, held on June 13, and November 15, 2013, which had recommended that CMS update the specifications for the pressure ulcer measure to include unstageable pressure ulcers in the numerator.^{16 17} Exploratory

¹⁶ Schwartz, M., Nguyen, K.H., Swinson Evans, T.M., Ignaczak, M.K., Thaker, S., and Bernard, S.L.: Development of a Cross-Setting Quality Measure for Pressure Ulcers: OY2 Information Gathering, Final Report. Centers for Medicare & Medicaid Services, November 2013. Available: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-a-Cross-Setting-Quality-Measure-for-Pressure-Ulcers-Information-Gathering-Final-Report.pdf>.

¹⁷ Schwartz, M., Ignaczak, M.K., Swinson Evans, T.M., Thaker, S., and Smith, L.: The Development of a Cross-Setting Pressure Ulcer Quality Measure: Summary Report on November 15, 2013, Technical Expert Panel Follow-Up Webinar. Centers for Medicare & Medicaid Services, January 2014. Available: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-a-Cross-Setting-Pressure-Ulcer-Quality-Measure-Summary-Report-on-November-15-2013-Technical-Expert-Pa.pdf>.

data analysis conducted by our measure development contractor suggests that the addition of unstageable pressure ulcers, including DTIs, will increase the observed incidence and variation in the rate of new or worsened pressure ulcers at the facility level, which may improve the ability of the proposed quality measure to discriminate between poor- and high-performing facilities.

We solicited stakeholder feedback on this proposed measure by means of a public comment period held from October 17 through November 17, 2016. In general, we received considerable support for the proposed measure. A few commenters supported all of the changes to the current pressure ulcer measure that resulted in the proposed measure, with one commenter noting the significance of the work to align the pressure ulcer quality measure specifications across the PAC settings.

Many commenters supported the inclusion of unstageable pressure ulcers due to slough/eschar, due to non-removable dressing/device, and DTIs in the proposed quality measure. Other commenters did not support the inclusion of DTIs in the proposed quality measure because they stated that there is no universally accepted definition for this type of skin injury.

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>. This summary includes further detail about our responses to various concerns and ideas stakeholders raised at that time.

The NQF-convened Measures Application Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup met on December 14 and 15, 2016, and provided input to us about this proposed measure. The workgroup provided a recommendation of “support for rulemaking” for use of the proposed measure in the SNF QRP. The MAP Coordinating Committee met on January 24 and 25, 2017, and provided a recommendation of “conditional support for rulemaking” for use of the proposed measure in the SNF QRP. The MAP’s conditions of support include that, as a part of measure implementation, CMS provide guidance on the correct collection and calculation of the measure result, as well as guidance on public reporting Web sites explaining the impact of the specification changes on the measure result. The MAP’s conditions also specify that CMS continue analyzing the

proposed measure in order to investigate unexpected results reported in public comment. We intend to fulfill these conditions by offering additional training opportunities and educational materials in advance of public reporting, and by continuing to monitor and analyze the proposed measure. More information about the MAP’s recommendations for this measure is available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84452>.

We reviewed the NQF’s consensus endorsed measures and were unable to identify any NQF-endorsed pressure ulcer quality measures for PAC settings that are inclusive of unstageable pressure ulcers. There are related measures, but after careful review, we determined these measures are not applicable for use in SNFs based on the populations addressed or other aspects of the specifications. We are unaware of any other such quality measures that have been endorsed or adopted by another consensus organization for the SNF setting. Therefore, based on the evidence discussed above, we are proposing to adopt the quality measure entitled, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, for the SNF QRP beginning with the FY 2020 SNF QRP. We plan to submit the proposed measure to the NQF for endorsement consideration as soon as feasible.

(4) Data Collection

The data for this quality measure would be collected using the MDS, which is currently submitted by SNFs through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. The proposed standardized resident assessment data applicable to this measure that must be reported by SNFs for admissions, as well as discharges occurring on or after October 1, 2018 is described in section V.B.11.d. of this proposed rule. SNFs are already required to complete unstageable pressure ulcer data elements on the MDS. While the inclusion of unstageable wounds in the proposed measure results in a measure calculation methodology that is different from the methodology used to calculate the current pressure ulcer measure, the data elements needed to calculate the proposed measure are already included in the MDS. In addition, this proposed measure will further standardize the data elements used in risk adjustment of this measure. Our proposal to eliminate duplicative data elements will result in an overall reduced reporting burden for

SNFs for the proposed measure. To view the updated MDS, with the proposed changes, we refer to the reader to <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30rainmanual.html>. For more information on MDS submission using the QIES ASAP System, we refer readers to <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>.

For technical information about this proposed measure, including information about the measure calculation and the standardized patient assessment data elements used to calculate this measure, we refer readers to the document titled, *Proposed Measure Specifications for SNF QRP Measures in the FY 2018 SNF PPS proposed rule*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

We are proposing that SNFs begin reporting the proposed pressure ulcer measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, which will replace the current pressure ulcer measure, with data collection beginning October 1, 2018 for admissions as well as discharges.

We are inviting public comment on our proposal to replace the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), with a modified version of that measure, entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, beginning with the FY 2020 SNF QRP.

b. Proposed Functional Outcome Measures

In this proposed rule, we propose to adopt for the SNF QRP four measures that we are specifying under section 1899B(c)(1) of the Act for purposes of meeting the functional status, cognitive function, and changes in function and cognitive function domain: (1) Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633); (2) Application of the IRF Function Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634); (3) Application of the IRF Function Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation

Patients (NQF #2635); and (4) Application of the IRF Function Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). We finalized the same functional outcome measures for the IRF QRP in the FY 2016 IRF PPS final rule (80 FR 47111 through 47117). These measures are: (1) IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (NQF #2633); (2) IRF Functional outcome Measure: Change in Mobility Score for Medical Rehabilitation (NQF #2634); (3) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and (4) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). We believe these measures satisfy section 1899B(c)(1)(A) of the Act because they address functional status, cognitive function, and changes in function and cognitive function domain. We intend to propose functional outcome measures for the home health and long-term care hospital settings in the future.

In developing these SNF functional outcome quality measures, we sought to build on our cross-setting function work by leveraging data elements currently collected in the MDS section GG, which would minimize additional data collection burden while increasing the feasibility of cross-setting item comparisons.

SNFs provide skilled services, such as skilled nursing or therapy services. Residents receiving care in SNFs include those whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function. Treatment goals may include fostering residents' ability to manage their daily activities so that they can complete self-care and mobility activities as independently as possible, and, if feasible, return to a safe, active, and productive life in a community-based setting. Given that the primary goal of many SNF residents is improvement in function, SNF clinicians assess and document residents' functional status at admission and at discharge to evaluate not only the effectiveness of the rehabilitation care provided to individual residents but also the effectiveness of the SNF.

Examination of SNF data shows that SNF treatment practices directly influence resident outcomes. For example, therapy services provided to SNF residents have been found to be correlated with the functional improvement that SNF residents

achieve (that is, functional outcomes).¹⁸ Several studies found patients' functional outcomes vary based on treatment by physical and occupational therapists. Specifically, therapy was associated with significantly greater odds of improving mobility and self-care functional independence,¹⁹ shorter length of stay,²⁰ and a greater likelihood of discharge to community.²¹ Furthermore, Jung et al.²² found that an additional hour of therapy treatment per week was associated with approximately a 3.1 percentage-point increase in the likelihood of returning to the community among residents with a hip fracture. Achieving these targeted resident outcomes, including improved self-care and mobility functional independence, reduced length of stay, and increased discharges to the community, is a core goal of SNFs.

Among SNF residents receiving rehabilitation services, the amount of treatment received can vary. For example, the amount of therapy treatment provided varies by type (that is, for-profit versus not-for-profit) and location (that is, urban versus rural) of facility.^{23 24} Measuring residents' functional improvement across all SNFs on an ongoing basis would permit identification of SNF characteristics, such as ownership types or locations, associated with better or worse resident risk adjusted outcomes and thus help

SNFs optimally target quality improvement efforts.

MedPAC²⁵ noted that while there was an overall increase in the share of intensive therapy days between 2002 and 2012, the for-profit and urban facilities had higher shares of intensive therapy than not-for-profit facilities and those located in rural areas. Data from 2011 to 2014 indicate that this variation is not explained by patient characteristics, such as activities of daily living, comorbidities and age, as SNF residents with stays in 2011 were more independent on average than the average SNF resident with stays in 2014. Because more intense therapy is associated with more functional improvement for certain beneficiaries, this variation in rehabilitation services supports the need to monitor SNF residents' functional outcomes. Therefore, we believe there is an opportunity for improvement in this area.

In addition, a recent analysis that examined the incidence, prevalence, and costs of common rehabilitation conditions found that back pain, osteoarthritis, and rheumatoid arthritis are the most common and costly conditions affecting more than 100 million individuals and costing more than \$200 billion per year.²⁶ Persons with these medical conditions are admitted to SNFs for rehabilitation treatment.

The use of standardized mobility and self-care data elements would standardize the collection of functional status data, which could improve communication when residents are transferred between providers. Most SNF residents receive care in an acute care hospital prior to the SNF stay, and many SNF residents receive care from another provider after the SNF stay.

Recent research provides empirical support for the risk adjustment variables for these quality measures. In a study of resident functional improvement in SNFs, Wysocki et al.²⁷ found that several resident conditions were significantly related to resident

¹⁸ Jette, D.U., R.L. Warren, & C. Wirtalla. (2005). The relation between therapy intensity and outcomes of rehabilitation in skilled nursing facilities. *Archives of Physical Medicine and Rehabilitation*, 86 (3), 373–9.

¹⁹ Lenze, E.J., Host, H.H., Hildebrand, M.W., Morrow-Howell, N., Carpenter, B., Freedland, K.E., . . . & Binder, E.F. (2012). Enhanced medical rehabilitation increases therapy intensity and engagement and improves functional outcomes in post acute rehabilitation of older adults: A randomized-controlled trial. *Journal of the American Medical Directors Association*, 13(8), 708–712.

²⁰ Medicare Payment Advisory Commission (US). (2016). Report to the Congress: Medicare payment policy. Medicare Payment Advisory Commission.

²¹ Cary, M.P., Pan, W., Sloane, R., Bettger, J.P., Hoenig, H., Merwin, E.L., & Anderson, R.A. (2016). Self-Care and Mobility Following Postacute Rehabilitation for Older Adults With Hip Fracture: A Multilevel Analysis. *Archives of Physical Medicine and Rehabilitation*. <http://doi.org/10.1016/j.apmr.2016.01.012>.

²² Jung, H.Y., Trivedi, A.N., Grabowski, D.C., & Mor, V. (2016). Does More Therapy in Skilled Nursing Facilities Lead to Better Outcomes in Patients With Hip Fracture? *Physical therapy*, 96(1), 81–89.

²³ Grabowski, D.C., Feng, Z., Hirth, R., Rahman, M., & Mor, V. (2013). Effect of nursing home ownership on the quality of post-acute care: An instrumental variables approach. *Journal of Health Economics*, 32(1), 12–21.

²⁴ Medicare Payment Advisory Commission (US). (2016). Report to the Congress: Medicare payment policy. Medicare Payment Advisory Commission.

²⁵ Medicare Payment Advisory Commission (US). (2016). Report to the Congress: Medicare payment policy. Medicare Payment Advisory Commission.

²⁶ Ma V.Y., Chan L., Carruthers K.J. Incidence, Prevalence, Costs, and Impact on Disability of Common Conditions Requiring Rehabilitation in the United States: Stroke, Spinal Cord Injury, Traumatic Brain Injury, Multiple Sclerosis, Osteoarthritis, Rheumatoid Arthritis, Limb Loss, and Back Pain. *Archives of Phys Med and Rehab* 2014

²⁷ Wysocki, A., Thomas, K.S., & Mor, V. (2015). Functional Improvement Among Short-Stay Nursing Home Residents in the MDS 3.0. *Journal of the American Medical Directors Association*, 16(6), 470–474. <http://doi.org/10.1016/j.jamda.2014.11.018>.

functional improvement, including cognitive impairment, delirium, dementia, heart failure, and stroke. Also, Cary et al. found that several resident characteristics were significantly related to resident functional improvement, including age, cognitive function, self-care function at admission, and comorbidities.²⁸

These proposed outcome-based quality measures could inform SNF providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to resident function.

We describe each of the four proposed functional outcome quality measures below. We note that the outcome-based quality measures we are proposing in this proposed rule assess self-care and mobility activities. We recognize that SNFs can focus on recovery across many areas of resident functioning related to body structure and function, activities, and participation; however, additional research is warranted to develop quality measures for other areas of functioning.

(a) Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)

The proposed outcome quality measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), is an application of the outcome measure finalized in the IRF QRP entitled, IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633). The proposed quality measure estimates the mean risk-adjusted improvement in self-care score between admission and discharge among SNF residents. A summary of the NQF-endorsed quality measure specifications can be accessed on the NQF Web site: <http://www.qualityforum.org/qps/2633>. Detailed specifications for the NQF-endorsed quality measure can be accessed at <http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2633>.

The proposed functional outcome measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633),

requires the collection of admission and discharge functional status data by trained clinicians using standardized patient data elements that assess specific functional self-care activities such as shower/bathe self, dressing upper body and dressing lower body. These self-care items are daily activities that clinicians typically assess at the time of admission and/or discharge to determine residents' needs, evaluate resident progress, and/or prepare residents and families for a transition to home or to another provider. The standardized self-care function data elements are coded using a 6-level rating scale that indicates the resident's level of independence with the activity; higher scores indicate more independence. The proposed outcome quality measure also requires the collection of risk factor data, such as resident functioning prior to the current reason for admission, bladder continence, communication ability and cognitive function, at the time of admission.

The data elements included in the proposed quality measure were originally developed and tested as part of the PAC PRD version of the Continuity Assessment Record and Evaluation (CARE) Item Set,²⁹ which was designed to standardize assessment of patients' and residents' status across acute and post-acute providers, including IRFs, SNFs, HHAs and LTCHs. The development of the CARE Item Set and a description and rationale for each item is described in a report entitled "The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set: Volume 1 of 3."³⁰ Reliability and validity testing were conducted as part of CMS' Post-Acute Care Payment Reform Demonstration, and we concluded that the functional status items have acceptable reliability and validity. A description of the testing methodology and results are available in several reports, including the report entitled "The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report On Reliability Testing: Volume 2 of 3"³¹ and the report entitled "The Development and Testing of The

Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report on Care Item Set and Current Assessment Comparisons: Volume 3 of 3."³² The reports are available on CMS' Post-Acute Care Quality Initiatives Web page at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>.

(i) Stakeholder Input

A cross-setting function TEP convened by our measure development contractor on September 9, 2013 provided input on the initial technical specifications of this proposed quality measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633). The TEP was supportive of the implementation of this measure and supported CMS's efforts to standardize patient/resident assessment data elements. The 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 MAP met on December 14 and 15, 2015, and provided input on the proposed measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) for use in the SNF QRP. The MAP recognized that this proposed quality outcome measure is an adaptation of a currently endorsed measure for the IRF population, and encouraged continued development to ensure alignment of this measure across PAC settings. The MAP noted there should be some caution in the interpretation of measure results due to resident differentiation between facilities. The MAP also noted possible duplication as the MDS already includes function data elements. We note that the data elements for the proposed measure are similar, but not the same as the existing MDS Section G function data elements. The data elements for the proposed measure include those that are the proposed standardized patient assessment data for functional status under section 1899B(b)(1)(B)(i) of the Act. The MAP also stressed the importance of considering burden on providers when measures are considered for implementation. The MAP's overall recommendation was for "encourage further development." More information about the MAP's recommendations for

²⁸ Cary, M.P., Pan, W., Sloane, R., Bettger, J.P., Hoenig, H., Merwin, E.I., & Anderson, R.A. (2016). Self-Care and Mobility Following Postacute Rehabilitation for Older Adults With Hip Fracture: A Multilevel Analysis. *Archives of Physical Medicine and Rehabilitation*. <http://doi.org/10.1016/j.apmr.2016.01.012>.

²⁹ Barbara Gage et al., "The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set" (RTI International, 2012).

³⁰ Barbara Gage et al., "The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set" (RTI International, 2012).

³¹ Ibid.

³² Ibid.

this proposed measure is available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=81593>.

Since the MAP's review and recommendation for further development, we have continued to develop this measure by soliciting input via a TEP, providing a public comment opportunity, and providing an update on measure development to the MAP via the feedback loop. More specifically, our measure development contractor convened a SNF-specific function TEP on May 5, 2016, to provide further input on the technical specifications of this proposed quality measure by reviewing the IRF specifications and the specifications of competing and related function quality measures. Overall, the TEP was supportive of the measure and supported our efforts to standardize patient assessment data elements. The SNF-specific function 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>.

We also solicited stakeholder feedback on the development of this measure by means of a public comment period that was open from October 7, 2016, until November 4, 2016. There was general support of the measure concept and the importance of functional improvement. Comments on the measure varied, with some commenters supportive of the measure, while others were either not in favor of the measure, or in favor of suggested potential modifications to the measure specifications. 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>.

Further, we engaged with stakeholders when we presented an update on the development of this quality measure to the MAP on October 19, 2016, during a MAP feedback loop meeting. Slides from that meeting are available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=83640>.

(ii) Competing and Related Measures and Measure Justification

During the development of this proposed functional outcome measure, we have monitored and reviewed NQF-

endorsed measures that are competing and/or related to the proposed quality measures. We identified six competing and related quality measures focused on self-care functional improvement for residents in the SNF setting entitled: (1) CARE: Improvement in Self Care (NQF #2613); (2) Functional Change: Change in Self-Care Score for Skilled Nursing Facilities (NQF #2769); (3) Functional Status Change for Patients with Shoulder Impairments (NQF #0426); (4) Functional Status Change for Patients with Elbow, Wrist and Hand Impairments (NQF #0427); (5) Functional Status Change for Patients with General Orthopedic Impairments (NQF #0428); and (6) Change in Daily Activity Function as Measures by the AM-PAC (NQF #0430). We reviewed the technical specifications for these six quality measures and compared these specifications to those of our proposed outcome-based quality measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), and have noted the following differences in the technical specifications: (1) The number of risk adjusters and variance explained by these risk adjusters in the regression models; (2) the use of functional assessment items that were developed and tested for cross-setting use; (3) the use of items that are already on the MDS 3.0 and what this means for burden; (4) the handling of missing functional status data; and (5) the use of exclusion criteria that are baseline clinical conditions. We describe these key specifications of the proposed outcome measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), in detail below.

Our literature review, input from technical expert panels, public comment feedback, and data analyses demonstrated the importance of adequate risk adjustment of admission case mix factors for functional outcome measures. Inadequate risk adjustment of admission case mix factors may lead to erroneous conclusions about the quality of care delivered within the facility, and thus is a potential threat to the validity of a quality measure that examines outcomes of care, such as functional outcomes. The proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) risk adjusts for more than 60 risk factors, explaining approximately 25 percent of the variance in change in function, and includes all of the following risk factors:

Prior functioning, prior device use, age, functional status at admission, primary diagnosis, and comorbidities. These risk factors are key predictors of functional performance and should be accounted for in any facility-level comparison of functional outcomes.

Another key feature of the proposed measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), is that it uses the functional assessment data elements and the associated rating scale that were developed and tested for cross-setting use. The measure uses functional assessment items from the CARE Item Set, which were developed and tested as part of the PAC-PRD between 2006 and 2010. The items were designed to build on the existing science for functional assessment instruments, and included a review of the strengths and limitations of existing functional assessment instruments. An important strength of the standardized function items from the CARE instrument is that they allow comparison and tracking of patients' and residents' functional outcomes as they move across post-acute settings. Specifically, the CARE Item Set was designed to standardize assessment of patients' status across acute and post-acute settings, including SNFs, IRFs, LTCHs, and HHAs. The risk-adjustors for various setting-specific versions of this measure differ by the inclusion of adjustors such as comorbidities in the IRF measure. However, we believe that the differences in risk adjustment will not hinder future comparability across settings. Agencies such as MedPAC have supported a coordinated approach to measurement across settings using standardized patient data elements.

A third important consideration is that some of the data elements associated with the proposed measure are already included on the MDS in Section GG, because we adopted a cross-setting function process measure in the SNF QRP FY 2016 Final Rule (FR 80 46444 through 46453). Three of the self-care data elements necessary to calculate that quality measure, an Application of the Percent of Long-Term Care Hospital Patient with a Functional Assessment and a Care Plan that Addresses Function (NQF #2631) are used to calculate the proposed quality measure. Provider burden of reporting on multiple items was a key consideration discussed by stakeholders in our recent TEP 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.

We believe it is important to include the records of residents with missing functional assessment data when calculating a facility-level functional outcome quality measure for SNFs. The proposed measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), incorporates a method to address missing functional assessment data.

We believe certain clinically-defined exclusion criteria are important to specify in a functional outcome quality measure in order to maintain the validity of the quality measure. Exclusions for the proposed quality measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), were selected through a review of the literature, input from Technical Expert Panels, and input from the public comment process. The quality measure, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) is intended to capture improvement in self-care function from admission to discharge for residents who are admitted with an expectation of functional improvement. Therefore, we exclude residents with certain conditions, for example progressive neurologic conditions, because these residents are typically not expected to improve on self-care skills for activities such as lower body dressing. Furthermore, we exclude residents who are independent on all self-care items at the time of admission, because no improvement in self-care can be measured with the selected set of items by discharge. Including residents with limited expectation for improvement could introduce incentives for SNF providers to restrict access to these residents.

We would like to note that our measure developer presented and discussed these technical specification differentiations with TEP members during the May 6, 2016 TEP meeting in order to obtain TEP input on preferred specifications for valid functional outcome quality measures. The differences in measure specifications and the TEP feedback are presented in the TEP Summary Report, which 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>. Overall, the TEP supported the use of a risk adjustment model that

addressed all of the following risk factors: Prior functioning, admission functioning, prior diagnosis and comorbidities. In addition, they supported exclusion criteria that would address functional improvement expectations of residents.

Therefore, based on the evidence provided above, we are proposing to adopt the quality measure entitled, Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), beginning with the FY 2020 SNF QRP.

(iii) Proposed Data Collection Mechanism

Data for the proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), would be collected using the MDS, with the submission through the QIES ASAP system. For more information on SNF QRP reporting through the QIES ASAP system, refer to CMS Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The calculation of the proposed quality measure would be based on the data collection of standardized items to be included in the MDS. The function items used to calculate this measure are the same set of functional status data items that have been added to the IRF-PAI version 1.4, for the purpose of providing standardized data elements under the domain of functional status, which is required by the IMPACT Act.

If finalized for implementation into the SNF QRP, the MDS would be modified so as to enable us to calculate this proposed quality measure using additional data elements that are standardized with the IRF-PAI and such data would be obtained at the time of admission and discharge for all SNF residents covered under a Part A stay. The standardized items used to calculate this proposed quality measure do not duplicate existing Section G items currently used for data collection within the MDS. The quality measure and standardized data element specifications for the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) can be found on the SNF QRP Measures and Technical Information 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 invite public comments on our proposal to adopt the quality measure entitled, the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) for the SNF QRP, beginning with the FY 2020 SNF QRP, with data collection for residents admitted and discharged starting on October 1, 2018.

(b) Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

This quality measure is an application of the outcome measure finalized in the IRF QRP entitled, IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634). This proposed quality measure estimates the risk-adjusted mean improvement in mobility score between admission and discharge among SNF residents. A summary of this quality measure can be accessed on the NQF Web site: <http://www.qualityforum.org/qps/2634>. Detailed specifications for this quality measure can be accessed at <http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2634>.

As previously noted, residents seeking care in SNFs include those whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function. Several studies found patients' functional outcomes vary based on treatment. Physical and occupational therapy treatment was associated with greater functional gains, shorter stays, and a greater likelihood of a discharge to a community. Among SNF residents receiving rehabilitation services, the amount of therapy prescribed can vary widely, and this variation is not always associated with resident characteristics. This variation in rehabilitation services supports the need to monitor SNF resident's functional outcomes, as we believe there is an opportunity for improvement in this area.

The proposed functional outcome measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), requires the collection of admission and discharge functional status data by trained clinicians using standardized data elements that assess specific functional mobility activities such as

toilet transfer and walking. These mobility items are daily activities that clinicians typically assess at the time of admission and/or discharge to determine resident's needs, evaluate resident progress, and prepare residents and families for a transition to home or to another care provider. The standardized mobility function items are coded using a 6-level rating scale that indicates the resident's level of independence with the activity; higher scores indicate more independence.

The functional assessment items included in the proposed outcome quality measures were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set, which was designed to standardize assessment of patients' status across acute and post-acute providers, including SNFs, HHAs, IRFs, and LTCHs.

This proposed outcome quality measure also requires the collection of risk factors data, such as resident functioning prior to the current reason for admission, history of falls, bladder continence, communication ability and cognitive function, at the time of admission.

A cross-setting function TEP convened by our measure development contractor on September 9, 2013, provided input on the initial technical specifications of this proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634). The TEP was supportive of the implementation of this measure and supported our efforts to standardize patient/resident assessment data elements. The 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 list of measures under consideration for the SNF QRP, including this quality measure, was released to the public on November 27, 2015, and early comments were submitted between December 1 and December 7, 2015. The MAP met on December 14 and 15, 2015, sought public comment on this measure from December 23, 2015, to January 13, 2015, and met on January 26 and 27, 2016. The NQF provided the MAP's input to us as required under section 1890A(a)(3) of the Act in the final report, MAP 2016 Considerations for Selection of Measures for Federal Programs: Post-Acute/Long-Term Care, which is

available at http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx. The MAP recognized that this measure is an adaptation of currently endorsed measures for the IRF population, and encouraged continued development to ensure alignment across PAC settings. They also noted there should be some caution in the interpretation of measure results due to patient/resident differentiation between facilities. With regard to alignment across PAC settings, the self-care items included in the proposed quality measure are the same self-care items that are included in the IRF-PAI Version 1.4. We agree with the MAP that patient/resident populations can vary across IRFs and SNFs, and we have taken this issue into consideration while selecting and testing the risk adjustors, which include medical conditions, admission function, prior functioning and comorbidities. The risk-adjustors for the IRF and the SNF versions of this measure differ by the inclusion of adjustors such as comorbidities in the IRF measure. As noted, though there are differences between the measures we believe that the differences in risk adjustment will not hinder future comparability across measures. The MAP also noted possible duplication as the MDS already includes function data elements. The data elements for the proposed measure are similar, but not the same as the existing MDS Section G function data elements. The data elements for the proposed measures include those that are the proposed standardized data elements for function. The MAP also stressed the importance of considering burden on providers when measures are considered for implementation. We appreciate the issue of burden and have taken that into consideration in developing the measure. Please refer to the FY 2016 SNF PPS final rule (80 FR 46428) for more information on the MAP.

The MAP's overall recommendation was for "encourage further development." More information about the MAP's recommendations for this proposed measure is available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=r=id&ItemID=81593>.

Since the MAP's review and recommendation for further development, we have continued to develop this measure including soliciting input from a TEP, providing a public comment opportunity, and providing an update on measure development to the MAP via the feedback loop. More specifically, our measure development contractor

convened a SNF-specific TEP on May 5, 2016 to provide further input on the technical specifications of this proposed quality measure by reviewing the IRF specifications and the specifications of competing and related function quality measures. Overall, the TEP was supportive of the measure and supported our efforts to standardize patient/resident assessment data elements. The SNF-specific function 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>.

We also solicited stakeholder feedback on the development of this measure by means of a public comment period open from October 7, until November 4, 2016. There was general support of the measure concept and the importance of functional improvement. Comments on the measure varied, with some commenters supportive of the measure, while others were either not in favor of the measure, or in favor of suggested potential modifications to the measure specifications. 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>.

We also engaged with the NQF convened MAP when we presented an update on the development of this quality measure on October 19, 2016, during a MAP feedback loop meeting. Slides from that meeting are available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83640>.

During the development of this measure, we have monitored and reviewed NQF-endorsed measures that are competing and related. We identified seven competing and related quality measures focused on improvement in mobility for residents in the SNF setting entitled: (1) CARE: Improvement in Mobility (NQF #2612); (2) Functional Change: Change in Mobility Score (NQF 2774); (3) Functional Status Change for Patients with Knee Impairments (NQF #0422); (4) Functional Status Change for Patients with Hip Impairments (NQF #0423); (5) Functional Status Change for Patients with Foot and Ankle Impairments (NQF #0424); (6) Functional Status Change for Patients with Lumbar Impairments (NQF #0425); and (7) Change in Basic Mobility as

Measures by the AM-PAC (NQF #0429). We reviewed the technical specifications for these seven measures carefully and compared them with the specifications of the proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) and have noted the following differences in the technical specifications: (1) The number of risk adjusters and variance explained by these risk adjusters in the regression models; (2) the use of functional assessment items that were developed and tested for cross-setting use; (3) the use of items that are already on the MDS 3.0 and what this means for burden; (4) the handling of missing functional status data; and (5) the use of exclusion criteria that are baseline clinical conditions. We describe these key specifications of the proposed outcome measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), below in more detail.

Our literature review, input from technical expert panels, public comment feedback, and analyses demonstrated the importance of adequate risk adjustment of admission case mix factors for functional outcome measures. Inadequate risk adjustment of admission case mix factors may lead to erroneous conclusions about the quality of care delivered within the facility, and thus is a potential threat to the validity of a quality measure that examines outcomes of care, such as functional status. The proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) risk adjusts for more than 60 risk factors, explaining approximately 23 percent of the variance in change in function, and includes all of the following risk adjusters: Prior functioning, prior device use, age, functional status at admission, primary diagnosis and comorbidities. These are key predictors of functional performance and need to be accounted for in any facility-level functional outcome quality measure.

Another key feature of the proposed measure, Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), is that it uses the functional assessment data elements and the associated rating scale that were developed and tested for cross-setting use. The measure uses functional assessment items from the CARE Item Set, which were developed and tested as part of the PAC PRD between 2006 and

2010. The items were designed to build on the existing science for functional assessment instruments, and included a review of the strengths and limitations of existing functional assessment instruments. An important strength of the cross-setting function items from the CARE instrument is that they allow tracking of patients' and residents' functional outcomes as they move across post-acute settings. Specifically, the CARE Item Set was designed to standardize assessment of patients' and residents' status across acute and post-acute settings, including SNFs, IRFs, LTCHs, and HHAs. The MedPAC has publicly supported a coordinated approach to measurement across settings using standardized data elements.

A third important consideration is that some of the data elements associated with the proposed measure, Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) are already included on the MDS in Section GG, because we adopted a cross-setting function process measure in the SNF QRP FY 2016 Final Rule (FR 80 46444 through 46453), and seven of the mobility data elements necessary to calculate that quality measure, an Application of the Percent of Long-Term Care Hospital Patient with a Functional Assessment and a Care Plan that Addresses Function (NQF #2631) are used to calculate the proposed quality measure. Provider burden of reporting on multiple measures was a key consideration discussed by stakeholders in our recent TEP: <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 believe it is important to include the records of residents with missing functional assessment data in the calculating a facility-level functional outcome quality measure for SNFs. The proposed measure, Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), incorporates a method to address missing functional assessment data.

We believe certain clinically-defined exclusion criteria are important to specify in a functional outcome quality measure in order to maintain the validity of the quality measure. Exclusions for the proposed quality measure, Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), were selected through a literature review, input from TEPs, and input from the public comment process.

The Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) is intended to capture improvement in mobility from admission to discharge for residents who are admitted with an expectation of functional improvement. Therefore, we exclude patients with certain conditions, for example progressive neurologic conditions, because these residents are typically not expected to improve on mobility skills for activities such as walking. Furthermore, we exclude residents who are independent on all mobility items at the time of admission, because no improvement can be measured with the selected set of items by discharge. Inclusion of residents with limited expectation for improvement could introduce incentives for SNF providers to limited access to these residents.

Our measure developer contractor presented and discussed these technical specification differentiations during the May 6, 2016 TEP meeting in order to obtain TEP input on preferred specifications for valid functional outcome quality measures. The differences in measure specifications and the TEP feedback are presented in the TEP Summary Report, which 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>.

Therefore, based on the evidence provided above, we are proposing to adopt the quality measure entitled, Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), for use beginning with the FY 2020 SNF QRP.

Data for the proposed quality measure, the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), would be collected using the MDS, with the submission through the QIES ASAP system. For more information on SNF QRP reporting through the QIES ASAP system, refer to <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The calculation of the proposed quality measure would be based on the data collection of standardized items to be included in the MDS. The function items used to calculate this measure are

the same set of functional status data items that have been added to the IRF-PAI version 1.4, for the purpose of providing standardized data elements under the domain of functional status. If this proposed quality measure is finalized for implementation in the SNF QRP, the MDS would be modified so as to enable the calculation of these standardized items that are used to calculate this proposed quality measure. The collection of data by means of the standardized items would be obtained at admission and discharge. The standardized items used to calculate this proposed quality measure do not duplicate existing items currently used for data collection within the MDS. The quality measure and standardized data element specifications for the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) is available on the SNF QRP Measures and Technical Information 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 invite public comments on our proposal to adopt the quality measure, entitled Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) beginning with the FY 2020 SNF QRP.

(c) Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)

This quality measure is an application of the outcome quality measure finalized in the IRF QRP entitled, IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635). The proposed quality measure estimates the percentage of SNF residents who meet or exceed an expected discharge self-care score. A summary of this quality measure can be accessed on the NQF Web site at <http://www.qualityforum.org/qps/2635>. Detailed specifications for the quality measure can be accessed at <http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2635>.

As previously noted, residents seeking care in SNFs include individuals whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function. Several studies found patients' functional outcomes vary based on

treatment by physical and occupational therapists. Therapy was associated with greater functional gains, shorter stays, and a greater likelihood of discharge to community. Among SNF residents receiving rehabilitation services, the amount of treatment prescribed can vary widely, and this variation is not associated with resident characteristics. This variation in rehabilitation services supports the need to monitor SNF resident's functional outcomes, as we believe there is an opportunity for improvement in this area.

The proposed outcome quality measure, Application of IRF Functional Outcome Measure: Discharge Self-Care Score or Medical Rehabilitation Patients (NQF #2635), requires the collection of functional status data at admission and discharge by trained clinicians using standardized patient assessment data elements such as eating, oral hygiene, and lower body dressing. These self-care items are daily activities that clinicians typically assess at the time of admission and discharge to determine residents' needs, evaluate resident progress, and prepare residents and families for a transition to home or to another provider. The self-care function data elements are coded using a 6-level rating scale that indicates the resident's level of independence with the activity; higher scores indicate more independence.

The functional assessment items included in the proposed outcome quality measures were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set, which was designed to standardize assessment of patients' status across acute and post-acute providers, including SNFs, HHAs, IRFs, and LTCHs.

This proposed outcome quality measure also requires the collection of risk factors data, such as resident functioning prior to the current reason for admission, bladder continence, communication ability, and cognitive function at the time of admission.

A cross-setting function TEP convened by our measure development contractor on September 9, 2013 provided input on the initial technical specifications of this proposed quality measure, the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635). The TEP was supportive of the implementation of this measure and supported CMS's efforts to standardize patient/resident assessment data elements. The 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 MAP met on December 14 and 15, 2015, and provided input on the proposed measure, Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) for use in the SNF QRP. The MAP recognized that this proposed quality measure is an adaptation of a currently endorsed measure for the IRF population, and encouraged continued development to ensure alignment of this measure across PAC settings. The MAP also noted there should be some caution in the interpretation of measure results due to patient/resident differentiation between facilities. The MAP also stressed the importance of considering burden on providers when measures are considered for implementation. The MAP also noted possible duplication as the MDS already includes function data elements. The data elements for the proposed measure are similar, but not the same as the existing MDS function data elements. The data elements for the proposed measures include those that are the proposed standardized patient data elements for function. The MAP's overall recommendation was to "encourage further development." More information about the MAP's recommendations for this proposed measure is available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81593>.

Since the 2015 MAP's review and recommendation for further development, we have continued to develop this measure including soliciting input via a TEP, providing a public comment opportunity and providing an update on measure development to the MAP via the feedback loop. More specifically, our measure development contractor convened a SNF-specific TEP on May 5, 2016 to provide further input on the technical specifications of this proposed quality measure by reviewing the IRF specifications and the specifications of competing and related function quality measures. Overall, the TEP was supportive of the measure. Specifically, they supported the risk adjusters, suggested some additional risk adjusters, supported the exclusion criteria and supported CMS's efforts to standardize patient/resident assessment data elements. The SNF-specific function 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>.

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 by means of a public comment period open from October 7, 2016 until November 4, 2016. There was general support of the measure concept and the importance of functional improvement. Comments on the measure varied, with some commenters supportive of the measure, while others were either not in favor of the measure, or in favor of suggested potential modifications to the measure specifications. Some comments focused on suggestions for additional risk adjusters, and the data elements. 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>.

We also engaged with stakeholders when we presented an update on the development of this quality measure to the MAP on October 19, 2016, during a MAP feedback loop meeting. Slides from that meeting are available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83640>.

During the development of this measure, we have monitored and reviewed NQF-endorsed measures that are competing and related. We identified six competing and related quality measures focused on self-care functional improvement for residents in the SNF setting entitled: (1) CARE: Improvement in Self Care (NQF #2613); (2) Functional Change: Change in Self-Care Score (NQF #2286); (3) Functional Status Change for Patients with Shoulder Impairments (NQF #0426); (4) Functional Status Change for Patients with Elbow, Wrist and Hand Impairments (NQF #0427); (5) Functional Status Change for Patients with General Orthopedic Impairments (NQF #0428); and (6) Change in Daily Activity Function as Measures by the AM-PAC (NQF #0430).

As described above, we reviewed the technical specifications for these six measures and compared them with the specifications for the proposed the quality measure, Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) and, as described in detail above, we noted the following differences in the technical specifications: (1) The number

of risk adjusters and variance explained by these risk adjusters in the regression models; (2) the use of functional assessment items that were developed and tested for cross-setting use; (3) the use of items that are already on the MDS 3.0 and what this means for burden; (4) the handling of missing functional status data; and (5) the use of exclusion criteria that are baseline clinical conditions.

Consistent with the other functional outcome measures, the specifications for this proposed quality measure, Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635), were developed based on our literature review, input from technical expert panels, public comment feedback and data analyses. The details about the specifications for the measures described above also apply to this proposed quality measure. Overall, the TEP supported the use of a risk adjustment model that addressed prior functioning, admission functioning, prior diagnosis and comorbidities. In addition, they supported exclusion criteria that would address functional improvement expectations of residents.

Our measure developer contractor presented and discussed these technical specification differentiations during the May 6, 2016 TEP meeting in order to obtain TEP input on preferred specifications for valid functional outcome quality measures. The differences in measure specifications and the TEP feedback are presented in the TEP Summary Report, which 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>.

Therefore, based on the evidence provided above, we are proposing to adopt the quality measure entitled, the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635), for use in the SNF QRP beginning with the FY 2020 program.

Data for the proposed quality measure, the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635), would be collected using the MDS, with the submission through the QIES ASAP system. For more information on SNF QRP reporting through the QIES ASAP system, refer to CMS Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality->

Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

The calculation of the proposed quality measure would be based on the data collection of standardized items to be included in the MDS. The function items used to calculate this measure are the same set of functional status data items that have been added to the IRF-PAI version 1.4, for the purpose of providing standardized data elements under the domain of functional status. The collection of data by means of the standardized items would be obtained at admission and discharge. The standardized items used to calculate this proposed quality measure do not duplicate existing items currently used for data collection within the MDS. The quality measure and standardized data element specifications for the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) can be found on the SNF QRP Measures and Technical Information Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

If finalized for implementation into the SNF QRP, the MDS would be modified so as to enable us to calculate the proposed measure using additional data elements that are standardized with the IRF-PAI and such data would be obtained at the time of admission and discharge for all SNF residents covered under a Part A stay.

We invite public comments on our proposal to adopt the quality measure entitled, the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) beginning with the FY 2020 SNF QRP.

(d) Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

This proposed quality measure is an application of the outcome quality measure finalized in the IRF QRP entitled, IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). This proposed quality measure estimates the percentage of SNF residents who meet or exceed an expected discharge mobility score. A summary of this quality measure can be accessed on the NQF Web site: <http://www.qualityforum.org/qps/2636>.

Detailed specifications for this quality measure can be accessed at <http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2636>.

As previously noted, residents seeking care in SNFs include individuals whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function. Several studies found patients' functional outcomes vary based on treatment by physical and occupational therapists. Therapy was associated with greater functional gains, shorter stays, and a greater likelihood of discharge to community. Among SNF residents receiving rehabilitation services, the amount of treatment prescribed can vary widely, and this variation is not associated with resident characteristics. This variation in rehabilitation services supports the need to monitor SNF resident's functional outcomes, as we believe there is an opportunity for improvement in this area.

The proposed functional outcome measure, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636), requires the collection of admission and discharge functional status data by trained clinicians using standardized data elements that assess specific functional mobility activities such as bed mobility and walking. These standardized mobility items are daily activities that clinicians typically assess at the time of admission and/or discharge to determine residents' needs, evaluate resident progress and prepare residents and families for a transition to home or to another care provider. The standardized mobility function items are coded using a 6-level rating scale that indicates the resident's level of independence with the activity; higher scores indicate more independence.

The functional assessment items included in the proposed outcome quality measures were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set, which was designed to standardize assessment of patients' status across acute and post-acute providers, including SNFs, HHAs, IRFs, and LTCHs and Current Assessment Comparisons: Volume 3 of 3.³³ The reports are available on CMS' Post-Acute Care Quality Initiatives Web page at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality->

[Initiatives/CARE-Item-Set-and-B-CARE.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html).

This proposed quality measure requires the collection of risk factors data, such as resident functioning prior to the current reason for admission, history of falls, bladder continence, communication ability and cognitive function, at the time of admission.

A cross-setting function TEP convened by our measure development contractor on September 9, 2013 provided input on the initial technical specifications of this proposed quality measure, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). The TEP was supportive of the implementation of this measure and supported our efforts to standardize patient assessment data elements. The 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 MAP met on December 14 and 15, 2015, and provided input on the proposed measure, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636), for use in the SNF QRP. The MAP recognized that this proposed quality measure is an adaptation of a currently endorsed measure for the IRF population, and encouraged continued development to ensure alignment of this measure across PAC settings. The MAP noted there should be some caution in the interpretation of measure results due to patient/resident differentiation between facilities. The MAP also stressed the importance of considering burden on providers when measures are considered for implementation. The MAP also noted possible duplication as the MDS already includes function data elements. The data elements for the proposed measure are similar, but not the same as the existing MDS function data elements. The data elements for the proposed measure include those that are the proposed standardized patient data elements for function. The MAP's overall recommendation was to "encourage further development." More information about the MAP's recommendations for this proposed measure is available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81593>.

Since the MAP's review and recommendation for further development, we have continued to develop this measure including

soliciting input via a TEP, proving a public comment opportunity and providing an update on measure development to the MAP via the feedback loop. More specifically, our measure development contractor convened a SNF-specific TEP on May 5, 2016, to provide further input on the technical specifications of this proposed quality measure by reviewing the IRF specifications and the specifications of competing and related function quality measures. Overall, the TEP was supportive of the measure and supported our efforts to standardize patient/resident assessment data elements. The SNF-specific function 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>.

We also solicited stakeholder feedback on the development of this measure by means of a public comment period open from October 7, 2016, until November 4, 2016. There was general support of the measure concept and the importance of functional improvement. Comments on the measure varied, with some commenters supportive of the measure, while others were either not in favor of the measure, or suggested potential modifications to the measure specifications.

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>.

We also engaged with stakeholders when we presented an update on the development of this quality measure to the MAP on October 19, 2016, during a MAP feedback loop meeting. Slides from that meeting are available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83640>.

During the development of this measure, we have monitored and reviewed the NQF-endorsed measures that are competing and related. We identified seven competing and related quality measures focused on mobility functional improvement for residents in the SNF setting entitled: (1) CARE: Improvement in Mobility (NQF #2612); (2) Functional Change: Change in Mobility Score (NQF #2774); (3) Functional Status Change for Patients with Knee Impairments (NQF #0422); (4) Functional Status Change for

³³ Ibid.

Patients with Hip Impairments (NQF #0423); (5) Functional Status Change for Patients with Foot and Ankle Impairments (NQF #0424); (6) Functional Status Change for Patients with Lumbar Impairments (NQF #0425); and (7) Change in Basic Mobility as Measures by the AM-PAC (NQF #0429). As described above, we reviewed the technical specifications for these seven measures carefully and compared them with the specifications of the proposed quality measure, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) and have noted the following differences in the technical specifications: (1) The number of risk adjustors and variance explained by these risk adjustors in the regression models; (2) the use of functional assessment items that were developed and tested for cross-setting use; (3) the use of items that are already on the MDS 3.0 and what this means for burden; (4) the handling of missing functional status data; and (5) the use of exclusion criteria that are baseline clinical conditions.

Consistent with the other functional outcome measures, the specifications for this proposed quality measure, Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636), were developed based on our literature review, input from technical expert panels, public comment feedback and data analyses. The details about how the specifications for the measures differ as described in the previous functional outcome measure sections, also apply to this proposed quality measure.

Our measure developer contractor presented and discussed these technical specification differentiations during the May 6, 2016 TEP meeting in order to obtain TEP input on preferred specifications for valid functional outcome quality measures. The differences in measure specifications and the TEP feedback are presented in the TEP Summary Report, which 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>.

Therefore, based on the evidence provided above, we are proposing to adopt the quality measure entitled, the Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636), for use beginning with the FY 2020 SNF QRP.

Data for the proposed quality measure, the Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636), would be collected using the MDS, with the submission through the QIES ASAP system. Additional information on SNF QRP reporting through the QIES ASAP system can be found on the CMS Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The calculation of the proposed quality measure would be based on the data collection of standardized items to be included in the MDS. The function items used to calculate this measure are the same set of functional status data items that have been added to the IRF-PAI version 1.4, for the purpose of providing standardized data elements under the domain of functional status. The collection of data by means of the standardized items would be obtained at admission and discharge. The standardized items used to calculate this proposed quality measure do not duplicate existing items currently used for data collection within the MDS. The quality measure and standardized data element specifications for the Application of IRF Functional Outcome Measure: Discharge Change in Mobility Score for Medical Rehabilitation Patients (NQF #2636) can be found on the SNF QRP Measures and Technical Information Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

If finalized for implementation into the SNF QRP, the MDS would be modified so as to enable us to calculate the proposed measure using additional data elements that are standardized with the IRF-PAI and such data would be obtained at the time of admission and discharge for all SNF residents covered under a Part A stay.

We invite public comments on our proposal to adopt the quality measure entitled, the Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) beginning with the FY 2020 SNF QRP.

8. Proposed Modifications to Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

In the FY 2017 SNF PPS final rule (81 FR 52030 through 52034), we adopted the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP. This measure was developed to meet section 1899B(d)(1)(C) of the Act, which calls for measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates for PAC providers, including SNFs.

This measure was specified to be calculated using 1 year of Medicare FFS claims data; however, we are proposing to increase the measurement period to 2 years of claims data. The rationale for this proposed change is to expand the number of SNFs with 25 stays or more, which is the minimum number of stays that we require for public reporting. Furthermore, this modification will align the SNF measure more closely with other potentially preventable hospital readmission measures developed to meet the IMPACT Act requirements and adopted for the IRF and LTCH QRPs, which are calculated using 2 consecutive years of data.

We also propose to update the dates associated with public reporting of SNF performance on this measure. In the FY 2017 SNF PPS final rule (81 FR 52030 through 52034), we finalized initial confidential feedback reports by October 2017 for this measure based on 1 calendar year of claims data from discharges during CY 2016 and public reporting by October 2018 based on data from CY 2017. However, to make these measure data publicly available by October 2018, we propose to shift this measure from calendar year to fiscal year, beginning with publicly reporting on claims data for discharges in fiscal years 2016 and 2017.

Additional information regarding the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

We are inviting public comment on our proposal to increase the length of the measurement period and to update the public reporting dates for this measure.

9. SNF QRP Quality Measures Under Consideration for Future Years

We are inviting comment on the importance, relevance, appropriateness, and applicability of each of the quality measures listed in Table 19 for future years in the SNF QRP.

We are considering a measure focused on pain that relies on the collection of patient-reported pain data, and another measure regarding the Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine. Finally, we are considering a measure related to patient safety, that is, Patients Who Received an Antipsychotic Medication.

a. IMPACT Act Measure—Possible Future Update to Measure Specifications

In the FY 2017 SNF PPS final rule (81 FR 52021 through 52029), we finalized the Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) measure, which 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. We received public comments (see 81 FR 52025 through 52026) recommending exclusion of baseline nursing facility residents from the measure, as these residents did not live in the community prior to their SNF stay. At that time, we highlighted that using Medicare FFS claims alone, we were unable to accurately identify baseline nursing facility residents. We stated that potential future modifications of the measure could include assessment of the feasibility and impact of excluding baseline nursing facility residents from the measure through the addition of patient assessment-based data. In response to these public comments, we are considering a future modification of the Discharge to Community-PAC SNF QRP measure, which would exclude baseline nursing facility residents from the measure. Further, this measure is specified to be calculated using one year of Medicare FFS claims data. We are considering expanding the measurement period in the future to two consecutive years of data to increase SNF sample sizes and reduce the number of SNFs with fewer than 25 stays that would

otherwise be excluded from public reporting. This modification would also align the measurement period with that of the discharge to community measures adopted for the IRF and LTCH Quality Reporting Programs to meet the IMPACT Act requirements; both the IRF and LTCH measures have measurement periods of two consecutive years.

We are inviting public comment on these considerations for Discharge to Community-PAC SNF QRP measure in future years of the SNF QRP.

b. IMPACT Act Implementation Update

As a result of the input and suggestions provided by technical experts at the TEPs held by our measure developer, and through public comment, we are engaging in additional development work for two measures that would satisfy 1899B(c)(1)(E) of the Act, including performing additional testing. We intend to specify these measures under section 1899B(c)(1)(E) of the Act no later than October 1, 2018 and we intend to propose to adopt them for the FY 2021 SNF QRP, with data collection beginning on or about October 1, 2019.

TABLE 19—SNF QRP QUALITY MEASURES UNDER CONSIDERATION FOR FUTURE YEARS

NQS priority	Patient- and Caregiver-Centered Care
Measure	• Application of Percent of Residents Who Self-Report Moderate to Severe Pain.
NQS Priority	Health and Well-Being
Measure	• Application of 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.
NQS Priority	Communication and Care Coordination
Measure	• Modification of the Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) measure.

10. Proposed Standardized Resident Assessment Data Reporting for the SNF QRP

a. Proposed Standardized Resident Assessment Data Reporting for the FY 2019 SNF QRP

Section 1888(e)(6)(B)(i)(III) of the Act requires that for fiscal year 2019 and each subsequent year, SNFs report standardized patient assessment data required under section 1899B(b)(1) of the Act. As we describe in more detail above, we are proposing that the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(Short Stay) (NQF #0678), be replaced with the proposed pressure ulcer measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, beginning with the FY 2020 SNF QRP. The current pressure ulcer measure will remain in the SNF QRP until that time. Accordingly, for the requirement that SNFs report standardized patient assessment data for the FY 2019 SNF QRP, we are proposing that the data elements used to calculate that measure meet the definition of standardized patient assessment data for medical conditions and co-morbidities under section 1899B(b)(1)(B)(iv) and that the successful reporting of that data under

section 1888(e)(6)(B)(i)(II) for admissions as well as discharges occurring during fourth quarter CY 2017 would also satisfy the requirement to report standardized patient assessment data for the FY 2019 SNF QRP.

The collection of assessment data pertaining to skin integrity, specifically pressure related wounds, is important for multiple reasons. Clinical decision support, care planning, and quality improvement all depend on reliable assessment data collection. Pressure related wounds represent poor outcomes, are a serious medical condition that can result in death and disability, are debilitating, painful and

are often an avoidable outcome of medical care.^{34 35 36 37 38 39} Pressure related wounds are considered health care acquired conditions.

As we note above, the data elements needed to calculate the current pressure ulcer measure are already included on the MDS and reported for SNFs, and exhibit validity and reliability for use across PAC providers. Item reliability for these data elements was also tested for the nursing home setting during implementation of MDS 3.0. Testing results are from the RAND Development and Validation of MDS 3.0 project.⁴⁰ The RAND pilot test of the MDS 3.0 data elements showed good reliability and is also applicable to both the IRF-PAI and the LTCH CARE Data Set because the data elements tested are the same. Across the pressure ulcer data elements, the average gold-standard nurse to gold-standard nurse kappa statistic was 0.905. The average gold-standard nurse to facility-nurse kappa statistic was 0.937. Data elements used to risk adjust this quality measure were also tested under this same pilot test, and the gold-standard to gold-standard kappa statistic, or percent agreement (where kappa statistic not available), ranged from 0.91 to 0.99 for these data elements. These kappa scores indicate “almost perfect” agreement using the Landis and Koch standard for strength of agreement.⁴¹

The data elements used to calculate the current pressure ulcer measure received public comment on several occasions, including when that measure was proposed in the FY 2012 IRF PPS (76 FR 47876) and IPPS/LTCH PPS proposed rules (76 FR 51754). Further, they were discussed in the past by TEPs

held by our measure development contractor on June 13 and November 15, 2013, and recently by a TEP on July 18, 2016. TEP members supported the measure and its cross-setting use in PAC. The report, Technical Expert Panel Summary Report: Refinement of the Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) Quality Measure for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs), 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>.

We are inviting public comment on this proposal.

b. Proposed Standardized Resident Assessment Data Reporting Beginning With the FY 2020 SNF QRP

We describe below our proposals for the reporting of standardized patient assessment data by SNFs beginning with the FY 2020 SNF QRP. SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018, with the exception of two data elements (Hearing and Vision) that would be required for SNF admissions at the start of the Medicare Part A stay only that occur between October 1, 2018, and December 31, 2018. The Hearing and Vision data elements would be assessed at admission only due to the relatively stable nature of hearing impairment and vision impairment, making it unlikely that these assessments would change between the start and end of the SNF stay. Assessment of the Hearing and Vision data elements at discharge would introduce additional burden without improving the quality or usefulness of the data, and is unnecessary. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting. In selecting the data elements described below, we carefully weighed the balance of burden in assessment-based data collection and aimed to minimize additional burden through the utilization of existing data in the assessment instruments. We also note that the patient and resident assessment instruments are considered part of the medical record, and sought the inclusion of data elements relevant to patient care.

We also took into consideration the following factors for each data element: Overall clinical relevance; ability to support clinical decisions, care planning and interoperable exchange to facilitate care coordination during transitions in care; and the ability to capture medical complexity and risk factors that can inform both payment and quality. Additionally the data elements had to have strong scientific reliability and validity; be meaningful enough to inform longitudinal analysis by providers; had to have received general consensus agreement for its usability; and had to have the ability to collect such data once but support multiple uses. Further, to inform the final set of data elements for proposal, we took into account technical and clinical subject matter expert review, public comment and consensus input in which such principles were applied. We also took into account the consensus work and empirical findings from the PAC-PRD. We acknowledge that during the development process that led to these proposals, some providers expressed concern that changes to the MDS to accommodate standardized patient assessment data reporting would lead to an overall increased reporting burden. However, we note that there is no additional data collection burden for standardized data already collected and submitted on the quality measures.

c. Proposed Standardized Resident Assessment Data by Category

(1) Functional Status Data

We are proposing that the data elements currently reported by SNFs to calculate the measure, 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), would also meet the definition of standardized patient assessment data for functional status under section 1899B(b)(1)(B)(i) of the Act, and that the successful reporting of that data under section 1886(m)(5)(F)(i) of the Act would also satisfy the requirement to report standardized patient assessment data under section 1886(m)(5)(F)(ii) of the Act.

These patient assessment data for functional status are from the CARE Item Set. The development of the CARE Item Set and a description and rationale for each item is described in a report entitled “The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE

³⁴ Casey, G. (2013). “Pressure ulcers reflect quality of nursing care.” *Nurs N Z* 19(10): 20–24.

³⁵ Gorzoni, M.L. and S.L. Pires (2011). “Deaths in nursing homes.” *Rev Assoc Med Bras* 57(3): 327–331.

³⁶ Thomas, J.M., et al. (2013). “Systematic review: health-related characteristics of elderly hospitalized adults and nursing home residents associated with short-term mortality.” *J Am Geriatr* 61(6): 902–911.

³⁷ White-Chu, E.F., et al. (2011). “Pressure ulcers in long-term care.” *Clin Geriatr Med* 27(2): 241–258.

³⁸ Bates-Jensen BM. Quality indicators for prevention and management of pressure ulcers in vulnerable elders. *Ann Int Med*. 2001;135 (8 Part 2), 744–51.

³⁹ Bennet, G., Dealy, C., Posnett, J. (2004). The cost of pressure ulcers in the UK. *Age and Aging*, 33(3):230–235.

⁴⁰ Saliba, D., & Buchanan, J. (2008, April). *Development and validation of a revised nursing home assessment tool: MDS 3.0*. Contract No. 500–00–0027/Task Order #2. Santa Monica, CA: Rand Corporation. Retrieved from <http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf>.

⁴¹ Landis, R., & Koch, G. (1977, March). The measurement of observer agreement for categorical data. *Biometrics* 33(1), 159–174.

Item Set: Volume 1 of 3.”⁴² Reliability and validity testing were conducted as part of CMS’ Post-Acute Care Payment Reform Demonstration, and we concluded that the functional status items have acceptable reliability and validity. A description of the testing methodology and results are available in several reports, including the report entitled “The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report On Reliability Testing: Volume 2 of 3”⁴³ and the report entitled “The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report on Care Item Set and Current Assessment Comparisons: Volume 3 of 3.”⁴⁴ The reports are available on CMS’ Post-Acute Care Quality Initiatives Web page at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>. For more information about this quality measure, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46444 through 46453).

We are inviting public comment on this proposal.

(2) Cognitive Function and Mental Status Data

Cognitive function and mental status in PAC patient and resident populations can be affected by a number of underlying conditions, including dementia, stroke, traumatic brain injury, side effects of medication, metabolic and/or endocrine imbalances, delirium, and depression.⁴⁵ The assessment of cognitive function and mental status by PAC providers is important because of the high percentage of patients and residents with these conditions,⁴⁶ and the opportunity for improving the quality of care. Symptoms of dementia may improve with pharmacotherapy, occupational therapy, or physical activity,^{47 48 49} and promising treatments

for severe traumatic brain injury are currently being tested.⁵⁰ For older patients and residents diagnosed with depression, treatment options to reduce symptoms and improve quality of life include antidepressant medication and psychotherapy,^{51 52 53 54} and targeted services, such as therapeutic recreation, exercise, and restorative nursing, to increase opportunities for psychosocial interaction.⁵⁵

Accurate assessment of cognitive function and mental status of patients and residents in PAC would be expected to have a positive impact on the National Quality Strategy’s domains of patient and family engagement, patient safety, care coordination, clinical process/effectiveness, and efficient use of health care resources. For example, standardized assessment of cognitive function and mental status of patients and residents in PAC will support establishing a baseline for identifying changes in cognitive function and mental status (for example, delirium), anticipating the patient or resident’s ability to understand and participate in treatments during a PAC stay, ensuring patient and resident safety (for example, risk of falls), and identifying appropriate support needs at the time of discharge or transfer. Standardized assessment data elements will enable or support clinical decision-making and early clinical intervention; person-centered,

high quality care through: Facilitating better care continuity and coordination; better data exchange and interoperability between settings; and longitudinal outcome analysis. Hence, reliable data elements assessing cognitive impairment and mental status are needed in order to initiate a management program that can optimize a patient or resident’s prognosis and reduce the possibility of adverse events.

(a) Brief Interview for Mental Status (BIMS)

We are proposing that the data elements that comprise the Brief Interview for Mental Status meet the definition of standardized patient assessment data for cognitive function and mental status under section 1899B(b)(1)(B)(ii) of the Act. The proposed data elements consist of seven BIMS questions that result in a cognitive function score. For more information on the BIMS, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Dementia and cognitive impairment are associated with long-term functional dependence and, consequently, poor quality of life and increased health care costs and mortality.⁵⁶ This makes assessment of mental status and early detection of cognitive decline or impairment critical in the PAC setting. The burden of cognitive impairment in PAC is high. The intensity of routine nursing care is higher for patients and residents with cognitive impairment than those without, and dementia is a significant variable in predicting readmission after discharge to the community from PAC providers.⁵⁷ The BIMS data elements are currently in use in two of the PAC assessments: The MDS 3.0 in SNFs and the IRF-PAI in IRFs. The BIMS was tested in the PAC PRD where it was found to have substantial to almost perfect agreement for inter-rater reliability (kappa range of 0.71 to 0.91) when tested in all four PAC

⁴² Graff M.J., Vernooij-Dassen M.J., Thijssen M., Dekker J., Hoefnagels W.H., Rikkert M.G.O. (2006). Community Based Occupational Therapy for Patients with Dementia and their Care Givers: Randomised Controlled Trial. *BMJ*, 333(7580): 1196.

⁴⁹ Bherer L., Erickson K.I., Liu-Ambrose T. (2013). A Review of the Effects of Physical Activity and Exercise on Cognitive and Brain Functions in Older Adults. *Journal of Aging Research*, 657508.

⁵⁰ Giacino J.T., Whyte J., Bagiella E., et al. (2012). Placebo-controlled trial of amantadine for severe traumatic brain injury. *New England Journal of Medicine*, 366(9), 819–826.

⁵¹ Alexopoulos G.S., Katz I.R., Reynolds C.F. 3rd, Carpenter D., Docherty J.P., Ross R.W. (2001). Pharmacotherapy of depression in older patients: A summary of the expert consensus guidelines. *Journal of Psychiatric Practice*, 7(6), 361–376.

⁵² Arean P.A., Cook B.L. (2002). Psychotherapy and combined psychotherapy/pharmacotherapy for late life depression. *Biological Psychiatry*, 52(3), 293–303.

⁵³ Hollon S.D., Jarrett R.B., Nierenberg A.A., Thase M.E., Trivedi M., Rush A.J. (2005). Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? *Journal of Clinical Psychiatry*, 66(4), 455–468.

⁵⁴ Wagenaar D, Colenda CC, Kreft M, Sawade J, Gardiner J, Povorejan E. (2003). Treating depression in nursing homes: practice guidelines in the real world. *J Am Osteopath Assoc*. 103(10), 465–469.

⁵⁵ Crespy SD, Van Haitsma K, Kleban M, Hann CJ. Reducing Depressive Symptoms in Nursing Home Residents: Evaluation of the Pennsylvania Depression Collaborative Quality Improvement Program. *J Health Qual*. 2016. Vol. 38, No. 6, pp. e76–e88.

⁵⁶ Agüero-Torres, H., Fratiglioni, L., Guo, Z., Viitanen, M., von Strauss, E., & Winblad, B. (1998). “Dementia is the major cause of functional dependence in the elderly: 3-year follow-up data from a population-based study.” *Am J of Public Health* 88(10): 1452–1456.

⁵⁷ RTI International. Proposed Measure Specifications for Measures Proposed in the FY 2017 LTCH QRP NPRM. Research Triangle Park, NC. 2016.

⁴² Barbara Gage et al., “The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set” (RTI International, 2012).

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ National Institute on Aging. (2014). Assessing Cognitive Impairment in Older Patients. A Quick Guide for Primary Care Physicians. Retrieved from <https://www.nia.nih.gov/alzheimers/publication/assessing-cognitive-impairment-older-patients>.

⁴⁶ Gage B., Morley M., Smith L., et al. (2012). Post-Acute Care Payment Reform Demonstration (Final report, Volume 4 of 4). Research Triangle Park, NC: RTI International.

⁴⁷ Casey D.A., Antimisiaris D., O’Brien J. (2010). Drugs for Alzheimer’s Disease: Are They Effective? *Pharmacology & Therapeutics*, 35, 208–11.

settings.⁵⁸ Clinical and subject matter expert advisors working with our data element contractor agreed that the BIMS is a feasible data element for use by PAC providers. Additionally, discussions during a TEP convened on April 6 and 7, 2016, demonstrated support for the BIMS. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel 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>.

To solicit additional feedback on the BIMS, we requested public comment from August 12 to September 12, 2016. Many commenters expressed support for use of the BIMS, noting that it is reliable, feasible to use across settings, and will provide useful information about patients and residents. These comments noted that the data collected through the BIMS will provide a clearer picture of patient or resident complexity, help with the care planning process, and be useful during care transitions and when coordinating across providers. A full report of the comments 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>.

Therefore, we are proposing to adopt the BIMS for use in the SNF QRP. As noted above in this section, the BIMS is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(b) Confusion Assessment Method (CAM)

We are proposing that the data elements that comprise the Confusion Assessment Method (CAM) meet the definition of standardized patient assessment data for cognitive function and mental status under section 1899B(b)(1)(B)(ii) of the Act. The CAM is a six-question instrument that screens for overall cognitive impairment, as well as distinguishes delirium or reversible

confusion from other types of cognitive impairment. For more information on the CAM, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The CAM was developed to identify the signs and symptoms of delirium. It results in a score that suggests whether the patient or resident should be assigned a diagnosis of delirium. Because patients and residents with multiple comorbidities receive services from PAC providers, it is important to assess delirium, which is associated with a high mortality rate and prolonged duration of stay in hospitalized older adults.⁵⁹ Assessing these signs and symptoms of delirium is clinically relevant for care planning by PAC providers.

The CAM is currently in use in two of the PAC assessments: The MDS 3.0 in SNFs and the LCDS in LTCHs. The CAM was tested in the PAC PRD where it was found to have substantial agreement for inter-rater reliability for the “Inattention and Disorganized Thinking” questions (kappa range of 0.70 to 0.73); and moderate agreement for the “Altered Level of Consciousness” question (kappa of 0.58).⁶⁰

Clinical and subject matter expert advisors working with our data element contractor agreed that the CAM is feasible for use by PAC providers, that it assesses key aspects of cognition, and that this information about patient or resident cognition would be clinically useful both within and across PAC provider types. The CAM was also supported by a TEP that discussed and rated candidate data elements during a meeting on April 6 and 7, 2016. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel Summary Report is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute->

⁵⁹ Fick, D.M., Steis, M.R., Waller, J.L., & Inouye, S.K. (2013). “Delirium superimposed on dementia is associated with prolonged length of stay and poor outcomes in hospitalized older adults.” *J of Hospital Med* 8(9): 500–505.

⁶⁰ Gage B., Morley M., Smith L., et al. (2012). *Post-Acute Care Payment Reform Demonstration* (Final report, Volume 2 of 4). Research Triangle Park, NC: RTI International.

Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html. We requested public comment on the CAM from August 12 to September 12, 2016. Many commenters expressed support for use of the CAM, noting that it would provide important information for care planning and care coordination, and therefore, contribute to quality improvement. The commenters noted it is particularly helpful in distinguishing delirium and reversible confusion from other types of cognitive impairment. A full report of the comments 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>.

Therefore, we are proposing to adopt the CAM for use in the SNF QRP. As noted above, the CAM is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(c) Behavioral Signs and Symptoms

We are proposing that the Behavioral Signs and Symptoms data elements meet the definition of standardized patient assessment data for cognitive function and mental status under section 1899B(b)(1)(B)(ii) of the Act. The proposed data elements consist of three Behavioral Signs and Symptoms questions and result in three scores that categorize respondents as having or not having certain types of behavioral signs and symptoms. For more information on the Behavioral Signs and Symptoms data elements, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The questions included in the Behavioral Signs and Symptoms group assess whether the patient or resident has exhibited any behavioral symptoms

that may indicate cognitive impairment or other mental health issues during the assessment period, including physical, verbal, and other disruptive or dangerous behavioral symptoms, but excluding patient wandering. Such behavioral disturbances can indicate unrecognized needs and care preferences and are associated most commonly with dementia and other cognitive impairment, and less commonly with adverse drug events, mood disorders, and other conditions. Assessing behavioral disturbances can lead to early intervention, patient- and resident-centered care planning, clinical decision support, and improved staff and patient or resident safety through early detection. Assessment and documentation of these disturbances can help inform care planning and patient transitions and provide important information about resource use.

Data elements that capture behavioral symptoms are currently included in two of the PAC assessments: The MDS 3.0 in SNFs and the OASIS-C2 in HHAs. In the MDS, each question includes four response options ranging from “behavior not exhibited” (0) to behavior “occurred daily” (3). The OASIS-C2 includes some similar data elements which record the frequency of disruptive behaviors on a 6-point scale ranging from “never” (0) to “at least daily” (5). Data elements that mirror those used in the MDS and serve the same assessment purpose were tested in post-acute providers in the PAC PRD and found to be clinically relevant, meaningful for care planning, and feasible for use in each of the four PAC settings.⁶¹

The proposed data elements were supported by comments from the Standardized Patient Assessment Data TEP held by our data element contractor. The TEP identified patient and resident behaviors as an important consideration for resource intensity and care planning, and affirmed the importance of the standardized assessment of patient behaviors through data elements such as those in use in the MDS. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel Summary Report is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/>

⁶¹Gage B., Morley M., Smith L., et al. (2012). Post-Acute Care Payment Reform Demonstration (Final report, Volume 2 of 4). Research Triangle Park, NC: RTI International.

IMPACT-Act-Downloads-and-Videos.html

Because the PAC PRD version of the Behavioral Signs and Symptoms data elements were previously tested across PAC providers, we solicited additional feedback on this version of the data elements by including these data elements in a call for public comment that was open from August 12 to September 12, 2016. Consistent with the TEP discussion on the importance of patient and resident behaviors, many commenters expressed support for use of the Behavioral Signs and Symptoms data elements, noting that they would provide useful information about patient and resident behavior at both admission and discharge and contribute to care planning related to what treatment is appropriate for the patient or resident and what resources are needed. Public comment also supported the use of highly similar MDS version of the data element in order to provide continuity with existing assessment processes in SNFs. A full report of the comments 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>.

Therefore, we are proposing the MDS version of the Behavioral Signs and Symptoms data elements because they focus more closely on behavioral symptoms than the OASIS data elements, and include more detailed response categories than those used in the PAC PRD version, capturing more information about the frequency of behaviors. As noted above, the Behavioral Signs and Symptoms data elements are already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(d) Patient Health Questionnaire-2 (PHQ-2)

We are proposing that the PHQ-2 data elements meet the definition of standardized patient assessment data for cognitive function and mental status under section 1899B(b)(1)(B)(ii) of the Act. The proposed data elements consist

of the PHQ-2 two-item questionnaire that assesses the cardinal criteria for depression: Depressed mood and anhedonia (inability to feel pleasure). For more information on the PHQ-2, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Depression is a common mental health condition often missed and under-recognized. Assessments of depression help PAC providers better understand the needs of their patients and residents by: Prompting further evaluation (that is, to establish a diagnosis of depression); elucidating the patient's or resident's ability to participate in therapies for conditions other than depression during their stay; and identifying appropriate ongoing treatment and support needs at the time of discharge. A PHQ-2 score beyond a predetermined threshold signals the need for additional clinical assessment in order to determine a depression diagnosis.

The proposed data elements that comprise the PHQ-2 are currently used in the OASIS-C2 for HHAs and the MDS 3.0 for SNFs (as part of the PHQ-9). The PHQ-2 data elements were tested in the PAC PRD, where they were found to have almost perfect agreement for inter-rater reliability (kappa range of 0.84 to 0.91) when tested by all four PAC providers.⁶²

Clinical and subject matter expert advisors working with our data element contractor agreed that the PHQ-2 is feasible for use in PAC, that it assesses key aspects of mental status, and that this information about patient or resident mood would be clinically useful both within and across PAC provider types. We note that both the PHQ-9 and the PHQ-2 were supported by TEP members who discussed and rated candidate data elements during a meeting on April 6 and 7, 2016. They particularly noted that the brevity of the PHQ-2 made it feasible with low burden for both assessors and PAC patients or residents. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel

⁶²Gage B., Smith L., Ross J. et al. (2012). The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set (Final Report on Reliability Testing, Volume 2 of 3). Research Triangle Park, NC: RTI International.

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>.

To solicit additional feedback on the PHQ-2, we requested public comment from August 12 to September 12, 2016. Many commenters provided feedback on using the PHQ-2 for the assessment of mood. Overall, commenters believed that collecting these data elements across PAC provider types was appropriate, given the role that depression plays in well-being. Several commenters expressed support for an approach that would use PHQ-2 as a gateway to the longer PHQ-9 and would maintain the reduced burden on most patients and residents, as well as test administrators, which is a benefit of the PHQ-2, while ensuring that the PHQ-9, which exhibits higher specificity,⁶³ would be administered for patients and residents who showed signs and symptoms of depression on the PHQ-2. Specific comments are described in a full report 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>.

Therefore, we are proposing to adopt the PHQ-2 data elements for use in the SNF QRP. As noted above, the PHQ-2 data elements are already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(3) Special Services, Treatments, and Interventions Data

Special services, treatments, and interventions performed in PAC can have a major effect on an individual's health status, self-image, and quality of life. The assessment of these special

services, treatments, and interventions in PAC is important to ensure the continuing appropriateness of care for the patients and residents receiving them, and to support care transitions from one PAC provider to another, an acute care hospital, or discharge.

Accurate assessment of special services, treatments, and interventions of patients and residents served by PAC providers are expected to have a positive impact on the National Quality Strategy's domains of patient and family engagement, patient safety, care coordination, clinical process/effectiveness, and efficient use of health care resources.

For example, standardized assessment of special services, treatments, and interventions used in PAC can promote patient and resident safety through appropriate care planning (for example, mitigating risks such as infection or pulmonary embolism associated with central intravenous access), and identifying life-sustaining treatments that must be continued, such as mechanical ventilation, dialysis, suctioning, and chemotherapy, at the time of discharge or transfer. Standardized assessment of these data elements will enable or support: Clinical decision-making and early clinical intervention; person-centered, high quality care through, for example, facilitating better care continuity and coordination; better data exchange and interoperability between settings; and longitudinal outcome analysis. Hence, reliable data elements assessing special services, treatments, and interventions are needed to initiate a management program that can optimize a patient or resident's prognosis and reduce the possibility of adverse events.

For payment and care planning purposes in SNFs, the MDS already collects information on many special services, treatments, and interventions that residents have received over the prior 14 days, and distinguishes whether the treatments were received in or outside of the facility. In order to standardize across PAC provider types, data elements on the proposed special services, treatments and interventions adopted for cross-setting use to fulfill the requirements of the IMPACT Act also assess treatments and interventions during the first 3 days of a resident's stay, and during the last 7 days of the stay (for Nutritional Therapies) and as currently collected, at the last 14 days of the stay (for all other treatments and therapies). The look-back time frames of the standardized items were designed to collect timely and accurate information to inform care planning at the current site of care and to support continuity of

care and transfer of key health information at the time of discharge or transfer to another PAC setting. The new response options will be embedded in the MDS, and all existing items will be retained for their current uses of payment and care planning.

We are proposing 15 special services, treatments, and interventions as presented below grouped by cancer treatments, respiratory treatments, other treatments, and nutritional approaches. A TEP convened by our data element contractor provided input on the 15 data elements for Special Services, Treatments, and Interventions. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice, and that the collection of these data by means of a list and checkbox format would conform with common workflow for PAC providers. A full report of the TEP discussion 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>.

(a) Cancer Treatment: Chemotherapy (IV, Oral, Other)

We are proposing that the Chemotherapy (IV, Oral, Other) data elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal Chemotherapy data element and three sub-elements: IV Chemotherapy, Oral Chemotherapy, and Other. For more information on the Chemotherapy data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Chemotherapy is a type of cancer treatment that uses drugs to destroy cancer cells. It is sometimes used when a patient has a malignancy (cancer), which is a serious, often life-threatening or life-limiting condition. Both intravenous (IV) and oral chemotherapy

⁶³ Arroll B, Goodyear-Smith F, Crengle S, Gunn J, Kerse N, Fishman T, et al. Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *Annals of family medicine*. 2010;8(4):348–53. doi: 10.1370/afm.1139 pmid:20644190; PubMed Central PMCID: PMC2906530.

have serious side effects, including nausea/vomiting, extreme fatigue, risk of infection due to a suppressed immune system, anemia, and an increased risk of bleeding due to low platelet counts. Oral chemotherapy can be as potent as chemotherapy given by IV, but can be significantly more convenient and less resource-intensive to administer. Because of the toxicity of these agents, special care must be exercised in handling and transporting chemotherapy drugs. IV chemotherapy may be given by peripheral IV, but is more commonly given via an indwelling central line, which raises the risk of bloodstream infections. Given the significant burden of malignancy, the resource intensity of administering chemotherapy, and the side effects and potential complications of these highly-toxic medications, assessing the receipt of chemotherapy is important in the PAC setting for care planning and determining resource use.

The need for chemotherapy predicts resource intensity, both because of the complexity of administering these potent, toxic drug combinations under specific protocols, and because of what the need for chemotherapy signals about the patient's underlying medical condition. Furthermore, the resource intensity of IV chemotherapy is higher than for oral chemotherapy, as the protocols for administration and the care of the central line (if present) require significant resources.

The Chemotherapy (IV, Oral, Other) data elements consist of a principal data element and three sub-elements: IV chemotherapy, which is generally resource-intensive; oral chemotherapy, which is less invasive and generally less intensive with regard to administration protocols; and a third category provided to enable the capture of other less common chemotherapeutic approaches. This third category is potentially associated with higher risks and is more resource intensive due to delivery by other routes (for example, intraventricular or intrathecal).

The principal Chemotherapy data element is currently in use in the MDS 3.0. One proposed sub-element, IV Chemotherapy, was tested in the PAC PRD and found feasible for use in each of the four PAC settings. We solicited public comment on IV Chemotherapy from August 12 to September 12, 2016. Several commenters provided support for the data element and suggested it be included as standardized patient assessment data. Commenters stated that assessing the use of chemotherapy services is relevant to share across the care continuum to facilitate care coordination and care transitions and

noted the validity of the data element. Commenters also noted the importance of capturing all types of chemotherapy, regardless of route, and stated that collecting data only on patients and residents who received chemotherapy by IV would limit the usefulness of this standardized data element. A full report of the comments 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>.

As a result of the comments and input received from clinical and subject matter experts, we are proposing a principal Chemotherapy data element with three sub-elements, including Oral and Other for standardization. Our data element contractor then presented the proposed data elements to the Standardized Patient Assessment Data TEP on January 5 and 6, 2017, who supported these data elements for standardization. A full report of the TEP discussion 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>. Therefore, we are proposing that the Chemotherapy (IV, Oral, Other) data elements with a principal data element and three sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing Chemotherapy data element in the MDS to include sub-elements for IV, Oral, and Other, and that SNFs would be required to report these data for the FY 2020 SNF QRP for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(b) Cancer Treatment: Radiation

We are proposing that the Radiation data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Radiation data element. For more information on the Radiation data

element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Radiation is a type of cancer treatment that uses high-energy radioactivity to stop cancer by damaging cancer cell DNA, but it can also damage normal cells. Radiation is an important therapy for particular types of cancer, and the resource utilization is high, with frequent radiation sessions required, often daily for a period of several weeks. Assessing whether a patient or resident is receiving radiation therapy is important to determine resource utilization because PAC patients and residents will need to be transported to and from radiation treatments, and monitored and treated for side effects after receiving this intervention. Therefore, assessing the receipt of radiation therapy, which would compete with other care processes given the time burden, would be important for care planning and care coordination by PAC providers.

The Radiation data element is currently in use in the MDS 3.0. This data element was not tested in the PAC PRD. However, public comment and other expert input on the Radiation data element supported its importance and clinical usefulness for patients in PAC settings, due to the side effects and consequences of radiation treatment on patients that need to be considered in care planning and care transitions. To solicit additional feedback on the Radiation data element we are proposing, we requested public comment from August 12 to September 12, 2016. Several commenters provided support for the data element, noting the relevance of this data element to facilitating care coordination and supporting care transitions, the feasibility of the item, and the potential for it to improve quality. A full report of the comments 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 proposed data element was presented to and supported by the TEP held by our data element contractor on January 5–6, 2017, which opined that Radiation was important corollary

information about cancer treatment to collect alongside Chemotherapy (IV, Oral, Other), and that, because capturing this information is a customary part of clinical practice, the proposed data element would be feasible, reliable, and easily incorporated into existing workflow.

Therefore, we are proposing that the Radiation data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Radiation data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(c) Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)

We are proposing that the Oxygen Therapy (Continuous, Intermittent) data elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal Oxygen data element and two sub-elements, "Continuous" (whether the oxygen was delivered continuously, typically defined as ≥ 14 hours per day), or "Intermittent." For more information on the Oxygen Therapy (Continuous, Intermittent) data elements, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Oxygen therapy provides a patient or resident with extra oxygen when medical conditions such as chronic obstructive pulmonary disease, pneumonia, or severe asthma prevent the patient or resident from getting enough oxygen from breathing. Oxygen administration is a resource-intensive intervention, as it requires specialized equipment such as a source of oxygen,

delivery systems (for example, oxygen concentrator, liquid oxygen containers, and high-pressure systems), the patient interface (for example, nasal cannula or mask), and other accessories (for example, regulators, filters, tubing). These data elements capture patient or resident use of two types of oxygen therapy (continuous and intermittent) which are reflective of intensity of care needs, including the level of monitoring and bedside care required. Assessing the receipt of this service is important for care planning and resource use for PAC providers.

The proposed data elements were developed based on similar data elements that assess oxygen therapy, currently in use in the MDS 3.0 ("Oxygen Therapy") and OASIS-C2 ("Oxygen (intermittent or continuous)"), and a data element tested in the PAC PRD that focused on intensive oxygen therapy ("High O2 Concentration Delivery System with FiO2 > 40%").

As a result of input from expert advisors, we solicited public comment on the single data element, Oxygen (inclusive of intermittent and continuous oxygen use), from August 12 to September 12, 2016. Several commenters supported the importance of the Oxygen data element, noting feasibility of this item in PAC, and the relevance of it to facilitating care coordination and supporting care transitions, but suggesting that the extent of oxygen use be documented. A full report of the comments 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>.

As a result of public comment and input from expert advisors about the importance and clinical usefulness of documenting the extent of oxygen use, we expanded the single data element to include two sub-elements, intermittent and continuous.

Therefore, we are proposing that the Oxygen Therapy (Continuous, Intermittent) data elements with a principal data element and two sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing Oxygen Therapy data element in the MDS to include sub-elements for Continuous and Intermittent, and that SNFs would be required to report these data for the FY 2020 SNF QRP for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the

end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(d) Respiratory Treatment: Suctioning (Scheduled, as Needed)

We are proposing that the Suctioning (Scheduled, As needed) data elements meet the definition of standardized patient assessment data element for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal Suctioning data element, and two sub-elements, "Scheduled" and "As needed." These sub-elements capture two types of suctioning. "Scheduled" indicates suctioning based on a specific frequency, such as every hour; "As needed" means suctioning only when indicated. For more information on the Suctioning (Scheduled, As needed) data elements, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Suctioning is a process used to clear secretions from the airway when a person cannot clear those secretions on his or her own. It is done by aspirating secretions through a catheter connected to a suction source. Types of suctioning include oropharyngeal and nasopharyngeal suctioning, nasotracheal suctioning, and suctioning through an artificial airway such as a tracheostomy tube. Oropharyngeal and nasopharyngeal suctioning are a key part of many patients' care plans, both to prevent the accumulation of secretions than can lead to aspiration pneumonias (a common condition in patients with inadequate gag reflexes), and to relieve obstructions from mucus plugging during an acute or chronic respiratory infection, which often lead to desaturations and increased respiratory effort. Suctioning can be done on a scheduled basis if the patient is judged to clinically benefit from regular interventions; or can be done as needed, such as when secretions become so prominent that gurgling or choking is noted, or a sudden

desaturation occurs from a mucus plug. As suctioning is generally performed by a care provider rather than independently, this intervention can be quite resource-intensive if it occurs every hour, for example, rather than once a shift. It also signifies an underlying medical condition that prevents the patient from clearing his/her secretions effectively (such as after a stroke, or during an acute respiratory infection). Generally, suctioning is necessary to ensure that the airway is clear of secretions which can inhibit successful oxygenation of the individual. The intent of suctioning is to maintain a patent airway, the loss of which can lead to death, or complications associated with hypoxia.

The proposed data elements are based on an item currently in use in the MDS 3.0 ("Suctioning" without the two sub-elements), and data elements tested in the PAC PRD that focused on the frequency of suctioning required for patients with tracheostomies ("Trach Tube with Suctioning; Specify most intensive frequency of suctioning during stay [Every ___ hours]").

Clinical and subject matter expert advisors working with our data element contractor agreed that the proposed Suctioning (Scheduled, As needed) data elements are feasible for use in PAC, and that they indicate important treatment that would be clinically useful to capture both within and across PAC providers. We solicited public comment on the suctioning data element currently included in the MDS 3.0 between August 12, to September 12, 2016. Several commenters wrote in support of this data element, noting feasibility of this item in PAC, and the relevance of this data element to facilitating care coordination and supporting care transitions. We also received comments suggesting that we examine the frequency of suctioning in order to better understand the use of staff time, the impact on a patient or resident's capacity to speak and swallow, and intensity of care required. Based on these comments, we decided to add two sub-elements (scheduled and as needed) to the suctioning element. The proposed data elements, Suctioning (Scheduled, As needed) includes both the principal suctioning data element that is included on the MDS 3.0 and two sub-elements, "scheduled" and "as needed." A full report of the comments 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>.

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Suctioning (Scheduled, As needed) data elements with a principal data element and two sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing Suctioning data element in the MDS to include sub-elements for Scheduled and As needed, and that SNFs would be required to report these data for the FY 2020 SNF QRP for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(e) Respiratory Treatment:
Tracheostomy Care

We are proposing that the Tracheostomy Care data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Tracheostomy Care data element. For more information on the Tracheostomy Care data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

A tracheostomy provides an air passage to help a patient or resident

breathe when the usual route for breathing is obstructed or impaired. Generally, in all of these cases, suctioning is necessary to ensure that the tracheostomy is clear of secretions which can inhibit successful oxygenation of the individual. Often, individuals with tracheostomies are also receiving supplemental oxygenation. The presence of a tracheostomy, albeit permanent or temporary, warrants careful monitoring and immediate intervention if the tracheostomy becomes occluded or in the case of a temporary tracheostomy, the device used becomes dislodged. While in rare cases the presence of a tracheostomy is not associated with increased care demands (and in some of those instances, the care of the ostomy is performed by the patient) in general the presence of such as device is associated with increased patient risk, and clinical care services will necessarily include close monitoring to ensure that no life-threatening events occur as a result of the tracheostomy, often considered part of the patient's life line. In addition, tracheostomy care, which primarily consists of cleansing, dressing changes, and replacement of the tracheostomy cannula (tube), is also a critical part of the care plan. Regular cleansing is important to prevent infection such as pneumonia and to prevent any occlusions with which there are risks for inadequate oxygenation.

The proposed data element is currently in use in the MDS 3.0 ("Tracheostomy care"). Data elements ("Trach Tube with Suctioning") that were tested in the PAC PRD included an equivalent principal data element on the presence of a tracheostomy. This data element was found feasible for use in each of the four PAC settings as the data collection aligned with usual work flow.

Clinical and subject matter expert advisors working with our data element contractor agreed that the Tracheostomy Care data element is feasible for use in PAC and that it assesses an important treatment that would be clinically useful both within and across PAC provider types.

We solicited public comment on this data element from August 12 to September 12, 2016. Several commenters wrote in support of this data element, noting the feasibility of this item in PAC, and the relevance of this data element to facilitating care coordination and supporting care transitions. A full report of the comments 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.

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Tracheostomy Care data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Tracheostomy Care data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(f) Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)

We are proposing that the Non-invasive Mechanical Ventilator (Bilevel Positive Airway Pressure [BiPAP], Continuous Positive Airway Pressure [CPAP]) data elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal Non-invasive Mechanical Ventilator data element and two sub-elements, BiPAP and CPAP. For more information on the Non-invasive Mechanical Ventilator (BiPAP, CPAP) data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/>

Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.

BiPAP and CPAP are respiratory support devices that prevent the airways from closing by delivering slightly pressurized air via electronic cycling throughout the breathing cycle (Bilevel PAP, referred to as BiPAP) or through a mask continuously (Continuous PAP, referred to as CPAP). Assessment of non-invasive mechanical ventilation is important in care planning, as both CPAP and BiPAP are resource-intensive (although less so than invasive mechanical ventilation) and signify underlying medical conditions about the patient or resident who requires the use of this intervention. Particularly when used in settings of acute illness or progressive respiratory decline, additional staff (for example, respiratory therapists) are required to monitor and adjust the CPAP and BiPAP settings and the patient or resident may require more nursing resources.

Data elements that assess BiPAP and CPAP are currently included on the OASIS-C2 for HHAs (“Continuous/Bilevel positive airway pressure”), LCDS for the LTCH setting (“Non-invasive Ventilator (BiPAP, CPAP)”), and the MDS 3.0 for the SNF setting (“BiPAP/CPAP”). A data element that focused on CPAP was tested across the four PAC providers in the PAC-PRD study and found to be feasible for standardization. All of these data elements assess BiPAP or CPAP with a single check box, not separately.

Clinical and subject matter expert advisors working with our data element contractor agreed that the standardized assessment of Non-invasive Mechanical Ventilator (BiPAP, CPAP) data elements would be feasible for use in PAC, and assess an important treatment that would be clinically useful both within and across PAC provider types.

To solicit additional feedback on the form of the Non-invasive Mechanical Ventilator (BiPAP, CPAP) data elements best suited for standardization, we requested public comment on a single data element, BiPAP/CPAP, equivalent (but for labeling) to what is currently in use on the MDS, OASIS, and LCDS, from August 12 to September 12, 2016. Several commenters wrote in support of this data element, noting the feasibility of these items in PAC, and the relevance of these data elements for facilitating care coordination and supporting care transitions. In addition, there was support in the public comment responses for separating out BiPAP and CPAP as distinct sub-elements, as they are therapies used for different types of

patients and residents. A full report of the comments 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>.

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Non-invasive Mechanical Ventilator (BiPAP, CPAP) data elements with a principal data element and two sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing BiPAP/CPAP data element on the MDS, retaining and relabeling the BiPAP/CPAP data element to be Non-invasive Mechanical Ventilator (BiPAP, CPAP), and adding two sub-elements for BiPAP and CPAP. For the purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(g) Respiratory Treatment: Invasive Mechanical Ventilator

We are proposing that the Invasive Mechanical Ventilator data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of a single Invasive Mechanical Ventilator data element. For more information on the Invasive Mechanical

Ventilator data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Invasive mechanical ventilation includes ventilators and respirators that ventilate the patient through a tube that extends via the oral airway into the pulmonary region or through a surgical opening directly into the trachea. Thus, assessment of invasive mechanical ventilation is important in care planning and risk mitigation. Ventilation in this manner is a resource-intensive therapy associated with life-threatening conditions without which the patient or resident would not survive. However, ventilator use has inherent risks requiring close monitoring. Failure to adequately care for the patient or resident who is ventilator dependent can lead to iatrogenic events such as death, pneumonia and sepsis. Mechanical ventilation further signifies the complexity of the patient's underlying medical and or surgical condition. Of note, invasive mechanical ventilation is associated with high daily and aggregate costs.⁶⁴

Data elements that capture invasive mechanical ventilation, but vary in their level of specificity, are currently in use in the MDS 3.0 ("Ventilator or respirator") and LCDS ("Invasive Mechanical Ventilator: Weaning" and "Invasive Mechanical Ventilator: Non-weaning"), and related data elements that assess invasive ventilator use and weaning status were tested in the PAC PRD ("Ventilator—Weaning" and "Ventilator—Non-Weaning") and found feasible for use in each of the four PAC settings.

Clinical and subject matter expert advisors working with our data element contractor agreed that assessing Invasive Mechanical Ventilator use is feasible in PAC, and would be clinically useful both within and across PAC providers.

To solicit additional feedback on the form of a data element on this topic that would be appropriate for standardization, data element that assess invasive ventilator use and weaning status that were tested in the PAC PRD ("Ventilator—Weaning" and

"Ventilator—Non-Weaning") were included in a call for public comment that was open from August 12 to September 12, 2016 because they were being considered for standardization. Several commenters wrote in support of these data elements, highlighting the importance of this information in supporting care coordination and care transitions. Some commenters expressed concern about the appropriateness for standardization, given the prevalence of ventilator weaning across PAC providers; the timing of administration; how weaning is defined; and how weaning status in particular relates to quality of care. These comments guided the decision to propose a single data element focused on current use of invasive mechanical ventilation only, and does not attempt to capture weaning status. A full report of the comments 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>.

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Invasive Mechanical Ventilator data element that assesses the use of an invasive mechanical ventilator, but does not assess weaning status, meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Ventilator or Respirator data element, with the same definition as the Invasive Mechanical Ventilator data element, is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the

initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(h) Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)

We are proposing that the IV Medications (Antibiotics, Anticoagulation, Other) data elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal IV Medications data element and three sub-elements, Antibiotics, Anticoagulation, and Other. For more information on the IV Medications (Antibiotics, Anticoagulation, Other) data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

IV medications are solutions of a specific medication (for example, antibiotics, anticoagulants) administered directly into the venous circulation via a syringe or intravenous catheter (tube). IV medications are administered via intravenous push (bolus), single, intermittent, or continuous infusion through a tube placed into the vein (for example, commonly referred to as central, midline, or peripheral ports). Further, IV medications are more resource intensive to administer than oral medications, and signify a higher patient complexity (and often higher severity of illness).

The clinical indications for each of the sub-elements of the IV Medication data element (Antibiotics, Anticoagulants, and Other) are very different. IV antibiotics are used for severe infections when: (1) The bioavailability of the oral form of the medication would be inadequate to kill the pathogen; (2) an oral form of the medication does not exist; or (3) the patient is unable to take the medication by mouth. IV anticoagulants refer to anti-clotting medications (that is, "blood thinners"), often used for the prevention and treatment of deep vein thrombosis and other thromboembolic complications. IV anticoagulants are

⁶⁴ Wunsch, H., Linde-Zwirble, W.T., Angus, D.C., Hartman, M.E., Milbrandt, E.B., & Kahn, J.M. (2010). "The epidemiology of mechanical ventilation use in the United States." *Critical Care Med* 38(10): 1947–1953.

commonly used in patients with limited mobility (either chronically or acutely, in the post-operative setting), who are at risk of deep vein thrombosis, or patients with certain cardiac arrhythmias such as atrial fibrillation. The indications, risks, and benefits of each of these classes of IV medications are distinct, making it important to assess each separately in PAC. Knowing whether or not patients are receiving IV medication and the type of medication provided by each PAC provider will improve quality of care.

The principal IV Medication data element is currently in use on the MDS 3.0 and there is a related data element in OASIS-C2 that collects information on Intravenous and Infusion Therapies. One sub-element of the proposed data elements, IV Anti-coagulants, and two other data elements related to IV therapy (IV Vasoactive Medications and IV Chemotherapy), were tested in the PAC PRD and found feasible for use in that the data collection aligned with usual work flow in each of the four PAC settings, demonstrating the feasibility of collecting IV medication information, including type of IV medication, through similar data elements in these settings.

Clinical and subject matter expert advisors working with our data element contractor agreed that standardized collection of information on medications, including IV medications, would be feasible in PAC, and assess an important treatment that would be clinically useful both within and across PAC provider types.

We solicited public comment on a related data element, Vasoactive Medications, from August 12 to September 12, 2016. While commenters supported this data element with one noting the importance of this data element in supporting care transitions, others criticized the need for collecting specifically on Vasoactive Medications, giving feedback that the data element was too narrowly focused. Additionally, comment received indicated that the clinical significance of vasoactive medications administration alone was not high enough in PAC to merit mandated assessment, noting that related and more useful information could be captured in an item that assessed all IV medication use.

Overall, public comment indicated the importance of including the additional check box data elements to distinguish particular classes of medications. A full report of the comments 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

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>.

Therefore, we are proposing that the IV Medications (Antibiotics, Anticoagulation, Other) data elements with a principal data element and three sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing IV Medications data element in the MDS to include sub-elements for Antibiotics, Anticoagulation, and Other. For the purposes of the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(i) Other Treatment: Transfusions

We are proposing that the Transfusions data element meets the definition of standardized patient assessment data element for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Transfusions data element. For more information on the Transfusions data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html)

Reporting-Program-Measures-and-Technical-Information.html

Transfusion refers to introducing blood, blood products, or other fluid into the circulatory system of a person. Blood transfusions are based on specific protocols, with multiple safety checks and monitoring required during and after the infusion in case of adverse events. Coordination with the provider's blood bank is necessary, as well as documentation by clinical staff to ensure compliance with regulatory requirements. In addition, the need for transfusions signifies underlying patient complexity that is likely to require care coordination and patient monitoring, and impacts planning for transitions of care, as transfusions are not performed by all PAC providers.

The proposed data element was selected from three existing assessment items on transfusions and related services, currently in use in the MDS 3.0 ("Transfusions") and OASIS-C2 ("Intravenous or Infusion Therapy"), and a data element tested in the PAC PRD ("Blood Transfusions"), that was found feasible for use in each of the four PAC settings. We chose to propose the MDS version because of its greater level of specificity over the OASIS-C2 data element. This selection was informed by expert advisors and reviewed and supported in the proposed form by the Standardized Patient Assessment Data TEP held by our data element contractor on January 5 and 6, 2017. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Transfusions data element that is currently in use in the MDS meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Transfusions data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(j) Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)

We are proposing that the Dialysis (Hemodialysis, Peritoneal dialysis) data elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal Dialysis data element and two sub-elements, Hemodialysis and Peritoneal dialysis. For more information on the Dialysis (Hemodialysis, Peritoneal dialysis) data elements, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Dialysis is a treatment primarily used to provide replacement for lost kidney function. Both forms of dialysis (hemodialysis and peritoneal dialysis) are resource intensive, not only during the actual dialysis process but before, during and following. Patients and residents who need and undergo dialysis procedures are at high risk for physiologic and hemodynamic instability from fluid shifts and electrolyte disturbances as well as infections that can lead to sepsis. Further, patients or residents receiving hemodialysis are often transported to a different facility, or at a minimum, to a different location in the same facility. Close monitoring for fluid shifts, blood pressure abnormalities, and other adverse effects is required prior to, during and following each dialysis session. Nursing staff typically perform peritoneal dialysis at the bedside, and as with hemodialysis, close monitoring is required.

The principal Dialysis data element is currently included on the MDS 3.0 and the LCDS v3.0 and assesses the overall use of dialysis. The sub-elements for Hemodialysis and Peritoneal dialysis were tested across the four PAC providers in the PAC PRD study, and found to be feasible for standardization. Clinical and subject matter expert advisors working with our data element contractor opined that the standardized assessment of dialysis is feasible in PAC, and that it assesses an important treatment that would be clinically useful both within and across PAC providers. As the results of expert and

public feedback, described below, we decided to propose a data element that includes both the principal Dialysis data element and the two sub-elements (hemodialysis and peritoneal dialysis).

The Hemodialysis data element, which was tested in the PAC PRD, was included in a call for public comment that was open from August 12 to September 12, 2016. Commenters supported the assessment of hemodialysis and recommended that the data element be expanded to include peritoneal dialysis. Several commenters supported the Hemodialysis data element, noting the relevance of this information for sharing across the care continuum to facilitate care coordination and care transitions, the potential for this data element to be used to improve quality, and the feasibility for use in PAC. In addition, we received comment that the item would be useful in improving patient and resident transitions of care. Several commenters also stated that peritoneal dialysis should be included in a standardized data element on dialysis and recommended collecting information on peritoneal dialysis in addition to hemodialysis. The rationale for including peritoneal dialysis from commenters included the fact that patients and residents receiving peritoneal dialysis will have different needs at post-acute discharge compared to those receiving hemodialysis or not having any dialysis. Based on these comments, the Hemodialysis data element was expanded to include a principal Dialysis data element and two sub-elements, hemodialysis and peritoneal dialysis; these are the same two data elements that were tested in the PAC PRD. This expanded version, Dialysis (Hemodialysis, Peritoneal dialysis), are the data elements being proposed. A full report of the comments 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>.

We note that the Dialysis (Hemodialysis, Peritoneal dialysis) data elements were also supported by the TEP that discussed candidate data elements for Special Services, Treatments, and Interventions during a meeting on January 5 and 6, 2017. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Dialysis (Hemodialysis, Peritoneal dialysis) data elements with a principal data element and two sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to expand the existing Dialysis data element in the MDS to include sub-elements for Hemodialysis and Peritoneal dialysis. For the purposes of the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(k) Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)

We are proposing that the IV Access (Peripheral IV, Midline, Central line, Other) data elements meet the definition of standardized patient assessment data element for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data elements consist of the principal IV Access data element and four sub-elements, Peripheral IV, Midline, Central line, and Other. For more information on the IV Access data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Patients or residents with central lines, including those peripherally inserted or who have subcutaneous central line “port” access, always require vigilant nursing care to keep patency of the lines and ensure that such invasive lines remain free from any potentially life-threatening events such as infection, air embolism, or bleeding from an open lumen. Clinically complex patients and residents are likely to be receiving medications or nutrition intravenously. The sub-elements included in the IV Access data elements distinguish between peripheral access and different types of central access.

The rationale for distinguishing between a peripheral IV and central IV access is that central lines confer higher risks associated with life-threatening events such as pulmonary embolism, infection, and bleeding.

The proposed IV Access (Peripheral IV, Midline, Central line, Other) data elements are not currently included on any of the mandated PAC assessment instruments. However, related data elements (for example, IV Medication in MDS 3.0 for SNF, Intravenous or infusion therapy in OASIS-C2 for HHAs) currently assess types of IV access. Several related data elements that describe types of IV access (for example, Central Line Management, IV Vasoactive Medications) were tested across the four PAC providers in the PAC PRD study, and found to be feasible for standardization.

Clinical and subject matter expert advisors working with our data element contractor agreed that assessing type of IV access would be feasible for use in PAC and that it assesses an important treatment that would be clinically useful both within and across PAC provider types.

We requested public comment on one of the PAC PRD data elements, Central Line Management, from August 12 to September 12, 2016. A central line is one type of IV access. Commenters supported the assessment of central line management and recommended that the data element be broadened to also include other types of IV access. Several commenters supported the data element, noting feasibility and importance for facilitating care coordination and care transitions. However, a few commenters recommended that the definition of this data element be broadened to include peripherally inserted central catheters (“PICC lines”) and midline IVs. Based on public comment feedback and in consultation with clinical and subject matters experts, we expanded the Central Line Management data element to include more types of IV access (Peripheral IV, Midline, Central line, Other). This expanded version, IV Access (Peripheral IV, Midline, Central line, Other), are the data elements being proposed. A full report of the comments 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>.

We note that the IV Access (Peripheral IV, Midline, Central line, Other) data elements were supported by the TEP that discussed candidate data elements for Special Services,

Treatments, and Interventions during a meeting on January 5 and 6, 2017. A full report of the TEP discussion 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>.

Therefore, we are proposing that the IV access (Peripheral IV, Midline, Central line, Other) data elements with a principal data element and four sub-elements meet the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. We are proposing to add the IV Access (Peripheral IV, Midline, Central line, Other) data elements to the MDS, and that, for the purposes of the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(I) Nutritional Approach: Parenteral/IV Feeding

We are proposing that the Parenteral/IV Feeding data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Parenteral/IV Feeding data element. For more information on the Parenteral/IV Feeding data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Parenteral/IV Feeding refers to a patient or resident being fed intravenously using an infusion pump, bypassing the usual process of eating and digestion. The need for IV/parenteral feeding indicates a clinical complexity that prevents the patient or resident from meeting his/her nutritional needs enterally, and is more resource intensive than other forms of nutrition, as it often requires monitoring

of blood chemistries, and maintenance of a central line. Therefore, assessing a patient or resident’s need for parenteral feeding is important for care planning and resource use. In addition to the risks associated with central and peripheral intravenous access, total parenteral nutrition is associated with significant risks such as embolism and sepsis.

The Parenteral/IV Feeding data element is currently in use in the MDS 3.0, and equivalent or related data elements are in use in the LCDS, IRF-PAI, and the OASIS-C2. An equivalent data element was tested in the PAC PRD (“Total Parenteral Nutrition”) and found feasible for use in each of the four PAC settings, demonstrating the feasibility of collecting information about this nutritional service in these settings.

Total Parenteral Nutrition (an item with the same meaning as the proposed data element, but with the label used in the PAC PRD) was included in a call for public comment that was open from August 12 to September 12, 2016.

Several commenters supported this data element, noting its relevance to facilitating care coordination and supporting care transitions. After the public comment period, the Total Parenteral Nutrition data element was re-named Parenteral/IV Feeding, to be consistent with how this data element is referred to in the MDS. A full report of the comments 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>.

A TEP convened by the data element contractor provided input on the proposed data elements. This TEP, held on January 5 and 6, 2017, opined that these data elements are appropriate for standardization because they would provide useful clinical information to inform care planning and care coordination. The TEP affirmed that assessment of these services and interventions is standard clinical practice. A full report of the TEP discussion 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>. Therefore, we are proposing that the Parenteral/IV Feeding data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Parenteral/IV Feeding

data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(m) Nutritional Approach: Feeding Tube

We are proposing that the Feeding Tube data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Feeding Tube data element. For more information on the Feeding Tube data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The majority of patients admitted to acute care hospitals experience deterioration of their nutritional status during their hospital stay, making assessment of nutritional status and method of feeding if unable to eat orally very important in PAC. A feeding tube can be inserted through the nose or the skin on the abdomen to deliver liquid nutrition into the stomach or small intestine. Feeding tubes are resource intensive and are therefore important to assess for care planning and resource use. Patients with severe malnutrition are at higher risk for a variety of complications.⁶⁵ In PAC settings, there are a variety of reasons that patients and residents may not be able to eat orally (including clinical or cognitive status).

The Feeding Tube data element is currently included in the MDS 3.0 for SNFs, and in the OASIS-C2 for HHAs, where it is labeled Enteral Nutrition. A related data element, collected in the IRF-PAI for IRFs (Tube/Parenteral Feeding), assesses use of both feeding

tubes and parenteral nutrition. The testing of similar nutrition-focused data elements in the PAC PRD, and the current assessment of feeding tubes and related nutritional services and devices, demonstrates the feasibility of collecting information about this nutritional service in these settings.

Clinical and subject matter expert advisors working with our data element contractor opined that the Feeding Tube data element is feasible for use in PAC, and supported its importance and clinical usefulness for patients in PAC settings, due to the increased level of nursing care and patient monitoring required for patients who received enteral nutrition with this device.

We solicited additional feedback on an Enteral Nutrition data element (an item with the same meaning as the proposed data element, but with the label used in the OASIS) in a call for public comment that was open from August 12 to September 12, 2016. Several commenters supported the data element, noting the importance of assessing enteral nutrition status for facilitating care coordination and care transitions. After the public comment period, the Enteral Nutrition data element used in public comment was renamed Feeding Tube, indicating the presence of an assistive device. A full report of the comments 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>.

We note that the Feeding Tube data element was also supported by the TEP that discussed candidate data elements for Special Services, Treatments, and Interventions during a meeting on January 5 and 6, 2017. A full report of the TEP discussion 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>. Therefore, we are proposing that the Feeding Tube data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Feeding Tube data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018.

Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(n) Nutritional Approach: Mechanically Altered Diet

We are proposing that the Mechanically Altered Diet data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Mechanically Altered Diet data element. For more information on the Mechanically Altered Diet data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

The Mechanically Altered Diet data element refers to food that has been altered to make it easier for the patient or resident to chew and swallow, and this type of diet is used for patients and residents who have difficulty performing these functions. Patients with severe malnutrition are at higher risk for a variety of complications.⁶⁶ In PAC settings, there are a variety of reasons that patients and residents may have impairments related to oral feedings, including clinical or cognitive status. The provision of a mechanically altered diet may be resource intensive, and can signal difficulties associated with swallowing/eating safety, including dysphagia. In other cases, it signifies the type of altered food source, such as ground or puree, that will enable the safe and thorough ingestion of nutritional substances and ensure safe and adequate delivery of nourishment to the patient. Often, patients on mechanically altered diets also require additional nursing supports such as individual feeding, or direct observation, to ensure the safe consumption of the food product. Assessing whether a patient or resident requires a mechanically altered diet is

⁶⁵ Dempsey, D.T., Mullen, J.L., & Buzby, G.P. (1988). "The link between nutritional status and clinical outcome: can nutritional intervention modify it?" *Am J of Clinical Nutrition* 47(2): 352-356.

⁶⁶ Dempsey, D.T., Mullen, J.L., & Buzby, G.P. (1988). "The link between nutritional status and clinical outcome: can nutritional intervention modify it?" *Am J of Clinical Nutrition* 47(2): 352-356.

therefore important for care planning and resource identification.

The proposed data element for a mechanically altered diet is currently included on the MDS 3.0 for SNFs. A related data element for modified food consistency/supervision is currently included on the IRF-PAI for IRFs. A related data element is included in the OASIS-C2 for HHAs that collects information about independent eating that requires “a liquid, pureed or ground meat diet.” The testing of similar nutrition-focused data elements in the PAC PRD, and the current assessment of various nutritional services across the four PAC settings, demonstrates the feasibility of collecting information about this nutritional service in these settings.

Clinical and subject matter expert advisors working with our data element contractor agreed that the proposed Mechanically Altered Diet data element is feasible for use in PAC, and it assesses an important treatment that would be clinically useful both within and across PAC settings. Expert input on the Mechanically Altered Diet data element highlighted its importance and clinical usefulness for patients in PAC settings, due to the increased monitoring and resource use required for patients on special diets. We note that the Mechanically Altered Diet data element was also supported by the TEP that discussed candidate data elements for Special Services, Treatments, and Interventions during a meeting on January 5 and 6, 2017. A full report of the TEP discussion 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>.

Therefore, we are proposing that the Mechanically Altered Diet data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Mechanically Altered Diet data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(o) Nutritional Approach: Therapeutic Diet

We are proposing that the Therapeutic Diet data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. The proposed data element consists of the single Therapeutic Diet data element. For more information on the Therapeutic Diet data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>. Therapeutic Diet refers to meals planned to increase, decrease, or eliminate specific foods or nutrients in a patient or resident’s diet, such as a low-salt diet, for the purpose of treating a medical condition. The use of therapeutic diets among patients in PAC provides insight on the clinical complexity of these patients and their multiple comorbidities. Therapeutic diets are less resource intensive from the bedside nursing perspective, but do signify one or more underlying clinical conditions that preclude the patient from eating a regular diet. The communication among PAC providers about whether a patient is receiving a particular therapeutic diet is critical to ensure safe transitions of care.

The Therapeutic Diet data element is currently in use in the MDS 3.0. The testing of similar nutrition-focused data elements in the PAC PRD, and the current assessment of various nutritional services across the four PAC settings, demonstrates the feasibility of collecting information about this nutritional service in these settings.

Clinical and subject matter expert advisors working with our data element contractor supported the importance and clinical usefulness of the proposed Therapeutic Diet data element for patients in PAC settings, due to the increased monitoring and resource use required for patients on special diets, and agreed that it is feasible for use in PAC and that it assesses an important treatment that would be clinically useful both within and across PAC settings. We note that the Therapeutic Diet data element was also supported by the TEP that discussed candidate data elements for Special Services,

Treatments, and Interventions during a meeting on January 5 and 6, 2017.

Therefore, we are proposing that the Therapeutic Diet data element meets the definition of standardized patient assessment data for special services, treatments, and interventions under section 1899B(b)(1)(B)(iii) of the Act. As noted above, the Therapeutic Diet data element is already included on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting.

We are inviting public comment on these proposals.

(4) Medical Condition and Comorbidity Data

We are proposing that the data elements needed to calculate the current measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), and the proposed measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, meet the definition of standardized patient assessment data for medical conditions and co-morbidities under section 1899B(b)(1)(B)(iv) of the Act, and that the successful reporting of that data under section 1888(e)(6)(B)(i)(II) of the Act would also satisfy the requirement to report standardized patient assessment data under section 1888(e)(6)(B)(i)(III) of the Act.

“Medical conditions and comorbidities” and the conditions addressed in the standardized data elements used in the calculation and risk adjustment of these measures, that is, the presence of pressure ulcers, diabetes, incontinence, peripheral vascular disease or peripheral arterial disease, mobility, as well as low body mass index, are all health-related conditions that indicate medical complexity that can be indicative of underlying disease severity and other comorbidities.

Specifically, the data elements used in the measure are important for care planning and provide information pertaining to medical complexity. Pressure ulcers are serious wounds representing poor outcomes, and can result in sepsis and death. Assessing skin condition, care planning for pressure ulcer prevention and healing, and informing providers about their

presence in patient transitions of care is a customary and best practice. Venous and arterial disease and diabetes are associated with low blood flow which may increase the risk of tissue damage. These diseases are indicators of factors that may place individuals at risk for pressure ulcer development and are therefore important for care planning. Low BMI, which may be an indicator of underlying disease severity, may be associated with loss of fat and muscle, resulting in potential risk for pressure ulcers. Bowel incontinence and the possible maceration to the skin associated, can lead to higher risk for pressure ulcers. In addition, the bacteria associated with bowel incontinence can complicate current wounds and cause local infection. Mobility is an indicator of impairment or reduction in mobility and movement which is a major risk factor for the development of pressure ulcers. Taken separately and together, these data elements are important for care planning, transitions in services and identifying medical complexities.

In sections VI.B.7.a and VI.B.10.a, we discuss our rationale for proposing that the data elements used in the measures meet the definition of standardized patient assessment data. In summary, we believe that the collection of such assessment data is important for multiple reasons, including clinical decision support, care planning, and quality improvement, and that the data elements assessing pressure ulcers and the data elements used to risk adjust showed good reliability. We solicited stakeholder feedback on the quality measure, and the data elements from which it is derived, by means of a public comment period and TEPs, as described in section V.B.7.a of this proposed rule. We are inviting public comment on this proposal.

(5) Impairment Data

Hearing and vision impairments are conditions that, if unaddressed, affect activities of daily living, communication, physical functioning, rehabilitation outcomes, and overall quality of life. Sensory limitations can lead to confusion in new settings, increase isolation, contribute to mood disorders, and impede accurate assessment of other medical conditions. Failure to appropriately assess, accommodate, and treat these conditions increases the likelihood that patients and residents will require more intensive and prolonged treatment. Onset of these conditions can be gradual, so individualized assessment with accurate screening tools and follow-up evaluations are essential to determining which patients and

residents need hearing- or vision-specific medical attention or assistive devices, and accommodations, including auxiliary aids and/or services, in order to effectively participate in the rehabilitation environment and treatment, and to ensure that person-directed care plans are developed to accommodate a patient's needs. Accurate diagnosis and management of hearing or vision impairment would likely improve rehabilitation outcomes and care transitions, including transition from institutional-based care to the community. Accurate assessment of hearing and vision impairment would be expected to lead to appropriate treatment, accommodations, including the provision of auxiliary aids and services during the stay, and ensure that patients and residents continue to have their vision and hearing needs met when they leave the facility.

Accurate individualized assessment, treatment, and accommodation of hearing and vision impairments of patients and residents in PAC would be expected to have a positive impact on the National Quality Strategy's domains of patient and family engagement, patient safety, care coordination, clinical process/effectiveness, and efficient use of health care resources. For example, standardized assessment of hearing and vision impairments used in PAC will support ensuring patient and resident safety (for example, risk of falls), identifying accommodations needed during the stay, and appropriate support needs at the time of discharge or transfer. Standardized assessment of these data elements will enable or support clinical decision-making and early clinical intervention; person-centered, high quality care (for example, facilitating better care continuity and coordination); better data exchange and interoperability between settings; and longitudinal outcome analysis. Hence, reliable data elements assessing hearing and vision impairments are needed to initiate a management program that can optimize a patient or resident's prognosis and reduce the possibility of adverse events.

(a) Hearing

We are proposing that the Hearing data element meets the definition of standardized patient assessment data for impairments under section 1899B(b)(1)(B)(v) of the Act. The proposed data element consists of the single Hearing data element. This data element assesses level of hearing impairment, and consists of one question. For more information on the Hearing data element, we refer readers to the document titled, *Proposed*

Specifications for SNF QRP Quality Measures and Standardized Data Elements, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Accurate assessment of hearing impairment is important in the PAC setting for care planning and resource use. Hearing impairment has been associated with lower quality of life, including poorer physical, mental, and social functioning, and emotional health.^{67,68} Treatment and accommodation of hearing impairment led to improved health outcomes, including but not limited to quality of life.⁶⁹ For example, hearing loss in elderly individuals has been associated with depression and cognitive impairment,^{70,71,72} higher rates of incident cognitive impairment and cognitive decline,⁷³ and less time in occupational therapy.⁷⁴ Accurate assessment of hearing impairment is important in the PAC setting for care planning and defining resource use.

The proposed data element was selected from two forms of the Hearing data element based on expert and stakeholder feedback. We considered the two forms of the Hearing data element, one of which is currently in use in the MDS 3.0 (Hearing) and another data element with different

⁶⁷ Dalton DS, Cruickshanks KJ, Klein BE, Klein R, Wiley TL, Nondahl DM. The impact of hearing loss on quality of life in older adults. *Gerontologist*. 2003;43(5):661-668.

⁶⁸ Hawkins K, Bottone FG, Jr., Ozminkowski RJ, et al. The prevalence of hearing impairment and its burden on the quality of life among adults with Medicare Supplement Insurance. *Qual Life Res*. 2012;21(7):1135-1147.

⁶⁹ Horn KL, McMahon NB, McMahon DC, Lewis JS, Barker M, Gherini S. Functional use of the Nucleus 22-channel cochlear implant in the elderly. *The Laryngoscope*. 1991;101(3):284-288.

⁷⁰ Sprinzi GM, Riechelmann H. Current trends in treating hearing loss in elderly people: A review of the technology and treatment options—a mini-review. *Gerontology*. 2010;56(3):351-358.

⁷¹ Lin FR, Thorpe R, Gordon-Salant S, Ferrucci L. Hearing Loss Prevalence and Risk Factors Among Older Adults in the United States. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*. 2011;66A(5):582-590.

⁷² Hawkins K, Bottone FG, Jr., Ozminkowski RJ, et al. The prevalence of hearing impairment and its burden on the quality of life among adults with Medicare Supplement Insurance. *Qual Life Res*. 2012;21(7):1135-1147.

⁷³ Lin FR, Metter EJ, O'Brien RJ, Resnick SM, Zonderman AB, Ferrucci L. Hearing Loss and Incident Dementia. *Arch Neurol*. 2011;68(2):214-220.

⁷⁴ Cimarolli VR, Jung S. Intensity of Occupational Therapy Utilization in Nursing Home Residents: The Role of Sensory Impairments. *J Am Med Dir Assoc*. 2016;17(10):939-942.

wording and fewer response option categories that is currently in use in the OASIS-C2 (Ability to Hear). Ability to Hear was also tested in the PAC PRD and found to have substantial agreement for inter-rater reliability across PAC settings (kappa of 0.78).⁷⁵ It was also found to be clinically relevant, meaningful for care planning, and feasible for use in each of the four PAC settings.

Several data elements that assess hearing impairment were presented to the Standardized Patient Assessment Data TEP held by our data element contractor. The TEP did not reach consensus on the ideal number of response categories or phrasing of response options, which are the primary differences between the current MDS (Hearing) and OASIS (Ability to Hear) items. The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel 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 PAC PRD form of the data element (Ability to Hear) was included in a call for public comment that was open from August 12 to September 12, 2016. This data element includes three response choices, in contrast to the Hearing data element (in use in the MDS 3.0 and being proposed for standardization), which includes four response choices. Several commenters supported the use of the Ability to Hear data element, although some commenters raised concerns that the three-level response choice was not compatible with the current, four-level response used in the MDS, and favored the use of the MDS version of the Hearing data element. In addition, we received comments stating that standardized assessment related to hearing impairment has the ability to improve quality of care if information on hearing is included in medical records of patients and residents, which would improve care coordination and facilitate the development of patient- and resident-centered treatment plans. Based on comments that the three-level response choice (Ability to Hear) was not congruent with the current, four-level response used in the MDS (Hearing), and support for the use of the

MDS version of the Hearing data element received in the public comment, we are proposing the Hearing data element. A full report of the comments 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>.

Therefore, we are proposing the Hearing data element currently in use on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting. The Hearing data element would be assessed at admission at the start of the Medicare Part A stay only due to the relatively stable nature of hearing impairment, making it unlikely that a patient's score on this assessment would change between the start and end of the PAC stay. Assessment at discharge at the end of the Medicare Part A stay would introduce additional burden without improving the quality or usefulness of the data, and is deemed unnecessary.

We are inviting public comment on these proposals.

(b) Vision

We are proposing that the Vision data element meets the definition of standardized patient assessment data element for impairments under section 1899B(b)(1)(B)(v) of the Act. The proposed data element consists of the single Vision (Ability To See in Adequate Light) data element that consists of one question with five response categories. For more information on the Vision data element, we refer readers to the document titled, *Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements*, available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program-SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

Evaluation of an individual's ability to see is important for assessing for risks such as falls and provides opportunities for improvement through treatment and the provision of accommodations, including auxiliary aids and services, which can safeguard patients and

improve their overall quality of life. Further, vision impairment is often a treatable risk factor associated with adverse events and poor quality of life. For example, individuals with visual impairment are more likely to experience falls and hip fracture, have less mobility, and report depressive symptoms.^{76 77 78 79 80 81 82}

Individualized initial screening can lead to life-improving interventions such as accommodations, including the provision of auxiliary aids and services, during the stay and/or treatments that can improve vision and prevent or slow further vision loss. For patients with some types of visual impairment, use of glasses and contact lenses can be effective in restoring vision.⁸³ Other conditions, including glaucoma⁸⁴ and age-related macular degeneration,^{85 86} have responded well to treatment. In addition, vision impairment is often a treatable risk factor associated with adverse events which can be prevented and accommodated during the stay. Accurate assessment of vision

⁷⁶ Colon-Emeric CS, Biggs DP, Schenck AP, Lyles KW. Risk factors for hip fracture in skilled nursing facilities: who should be evaluated? *Osteoporos Int*. 2003;14(6):484–489.

⁷⁷ Freeman EE, Munoz B, Rubin G, West SK. Visual field loss increases the risk of falls in older adults: the Salisbury eye evaluation. *Invest Ophthalmol Vis Sci*. 2007;48(10):4445–4450.

⁷⁸ Keepnews D, Capitman JA, Rosati RJ. Measuring patient-level clinical outcomes of home health care. *J Nurs Scholarsh*. 2004;36(1):79–85.

⁷⁹ Nguyen HT, Black SA, Ray LA, Espino DV, Markides KS. Predictors of decline in MMSE scores among older Mexican Americans. *J Gerontol A Biol Sci Med Sci*. 2002;57(3):M181–185.

⁸⁰ Prager AJ, Liebmann JM, Cioffi GA, Blumberg DM. Self-reported Function, Health Resource Use, and Total Health Care Costs Among Medicare Beneficiaries With Glaucoma. *JAMA Ophthalmology*. 2016;134(4):357–365.

⁸¹ Rovner BW, Ganguli M. Depression and disability associated with impaired vision: the MoVies Project. *J Am Geriatr Soc*. 1998;46(5):617–619.

⁸² Tinetti ME, Ginter SF. The nursing home life-space diameter. A measure of extent and frequency of mobility among nursing home residents. *J Am Geriatr Soc*. 1990;38(12):1311–1315.

⁸³ Rein DB, Wittenborn JS, Zhang X, et al. The Cost-effectiveness of Welcome to Medicare Visual Acuity Screening and a Possible Alternative Welcome to Medicare Eye Evaluation Among Persons Without Diagnosed Diabetes Mellitus. *Archives of Ophthalmology*. 2012;130(5):607–614.

⁸⁴ Leske M, Heijl A, Hussein M, et al. Factors for glaucoma progression and the effect of treatment: The early manifest glaucoma trial. *Archives of Ophthalmology*. 2003;121(1):48–56.

⁸⁵ Age-Related Eye Disease Study Research G. A randomized, placebo-controlled, clinical trial of high-dose supplementation with vitamins c and e, beta carotene, and zinc for age-related macular degeneration and vision loss: AREDS report no. 8. *Archives of Ophthalmology*. 2001;119(10):1417–1436.

⁸⁶ Takeda AL, Colquitt J, Clegg AJ, Jones J. Pegaptanib and ranibizumab for neovascular age-related macular degeneration: a systematic review. *The British Journal of Ophthalmology*. 2007;91(9):1177–1182.

⁷⁵ Gage B, Smith L, Ross J, et al. (2012). The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set (Final Report on Reliability Testing, Volume 2 of 3). Research Triangle Park, NC: RTI International.

impairment is important in the PAC setting for care planning and defining resource use.

The Vision data element that we are proposing for standardization was tested as part of the development of the MDS 3.0 and is currently in use in that assessment. Similar data elements, but with different wording and fewer response option categories, are in use in the OASIS-C2 and were tested in post-acute providers in the PAC PRD and found to be clinically relevant, meaningful for care planning, reliable (kappa of 0.74),⁸⁷ and feasible for use in each of the four PAC settings.

Several data elements that assess vision were presented to the TEP held by our data element contractor. The TEP did not reach consensus on the ideal number of response categories or phrasing of response options, which are the primary differences between the current MDS and OASIS items; some members preferring more granular response options (for example, mild impairment and moderate impairment) while others were comfortable with collapsed response options (that is, mild/moderate impairment). The Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data Technical Expert Panel 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>.

We solicited public comment from August 12 to September 12, 2016, on the Ability to See in Adequate Light data element (version tested in the PAC PRD with three response categories). The data element in public comment differed from the proposed data element, but the comments supported the assessment of vision in PAC settings and the useful information a vision data element would provide. The commenters stated that the Ability to See item would provide important information that would facilitate care coordination and care planning, and consequently improve the quality of care. Other commenters suggested it would be helpful as an indicator of resource use and noted that the item would provide useful information about the abilities of patients and residents to care for themselves. Additional commenters noted that the item could feasibly be implemented across PAC

providers and that its kappa scores from the PAC PRD support its validity. Some commenters noted a preference for MDS version of the Vision data element over the form put forward in public comment, citing the widespread use of this data element. A full report of the comments 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>.

Therefore, we are proposing the Vision data element currently in use on the MDS. For purposes of reporting for the FY 2020 SNF QRP, SNFs would be required to report these data for SNF admissions at the start of the Medicare Part A stay that occur between October 1, 2018 and December 31, 2018. Following the initial reporting year for the FY 2020 SNF QRP, subsequent years for the SNF QRP would be based on a full calendar year of such data reporting. The Vision data element would be assessed at admission at the start of the Medicare Part A stay only due to the relatively stable nature of vision impairment, making it unlikely that a patient or resident's score on this assessment would change between the start and end of the PAC stay. Assessment at discharge at the end of the Medicare Part A stay would introduce additional burden without improving the quality or usefulness of the data, and is deemed unnecessary.

We are inviting public comment on these proposals.

11. Proposals Relating to the Form, Manner, and Timing of Data Submission Under the SNF QRP

a. Proposed Start Date for Standardized Resident Assessment Data Reporting by New SNFs

In the FY 2016 SNF PPS final rule (80 FR 46455), we adopted timing for new SNFs to begin reporting quality data under the SNF QRP beginning with the FY 2018 SNF QRP. We are proposing in this proposed rule that new SNFs will be required to begin reporting standardized patient assessment data on the same schedule.

We are inviting public comment on this proposal.

b. Proposed Mechanism for Reporting Standardized Resident Assessment Data Beginning With the FY 2019 SNF QRP

Under our current policy, SNFs report data by completing applicable sections of the MDS, and submitting the MDS-RAI to CMS through the Quality Improvement and Evaluation System

(QIES), Assessment Submission and Processing System (ASAP) system. 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. In addition to the data currently submitted on quality measures as previously finalized and discussed in section VI.B.6. of this proposed rule, we are proposing that SNFs would be required to begin submitting the proposed standardized resident assessment data for SNF Medicare resident admissions and discharges that occur on or after October 1, 2018 using the MDS, as described here. Details on the modifications and assessment collection for the MDS for the proposed standardized assessment data are available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>.

We are inviting public comments on this proposal.

c. Proposed Schedule for Reporting Standardized Resident Assessment Data Beginning With the FY 2019 SNF QRP

Starting with the FY 2019 SNF QRP, we are proposing to apply our current schedule for the reporting of measure data to the reporting of standardized resident assessment data. Under that policy, except for the first program year for which a measure is adopted, SNFs must report data on measures for SNF Medicare admissions that occur during the 12-month calendar year (CY) period that apply to the program year. For the first program year for which a measure is adopted, SNFs are only required to report data on SNF Medicare admissions that occur on or after October 1 and discharged from the SNF up to and including December 31 of the calendar year that applies to that program year. For example, for the FY 2018 SNF QRP, data on measures adopted for earlier program years must be reported for all CY 2016 SNF Medicare admissions that occur on or after October 1, 2016 and discharges that occur on or before December 31, 2016. However, data on new measures adopted for the first time for the FY 2018 SNF QRP program year must only be reported for SNF Medicare

⁸⁷ Gage B., Smith L., Ross J. et al. (2012). The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set (Final Report on Reliability Testing, Volume 2 of 3). Research Triangle Park, NC: RTI International.

admissions and discharges that occur during the last calendar quarter of 2016. Tables 20 and 21 illustrate this policy using the FY 2019 and FY 2020 SNF QRP as examples.

TABLE 20—SUMMARY ILLUSTRATION OF INITIAL REPORTING CYCLE FOR NEWLY ADOPTED MEASURE AND STANDARDIZED PATIENT ASSESSMENT DATA REPORTING USING CY Q4 DATA *

Proposed data collection/submission quarterly reporting period *	Proposed data submission quarterly deadlines beginning with FY 2019 SNF QRP * ^
Q4: CY 2017 10/1/2017–12/31/2017	CY 2017 Q4 Deadline: May 15, 2018.

* We note that submission of the MDS must also adhere to the SNF PPS deadlines.
 ^ The term “FY 2019 SNF QRP” means the fiscal year for which the SNF QRP requirements applicable to that fiscal year must be met in order for a SNF to receive the full market basket percentage when calculating the payment rates applicable to it for that fiscal year.

TABLE 21—SUMMARY ILLUSTRATION OF CALENDAR YEAR QUARTERLY REPORTING CYCLES FOR MEASURE AND STANDARDIZED PATIENT ASSESSMENT DATA REPORTING *

Proposed data collection/submission quarterly reporting period *	Proposed data submission quarterly deadlines beginning with FY 2020 SNF QRP * ^
Q1: CY 2018 1/1/2018–3/31/2018	CY 2018 Q1 Deadline: August 15, 2018.
Q2: CY 2018 4/1/2018–6/30/2018	CY 2018 Q2 Deadline: November 15, 2018.
Q3: CY 2018 7/1/2018–9/30/2018	CY 2018 Q3 Deadline: February 15, 2019.
Q4: CY 2018 10/1/2018–12/31/2018	CY 2018 Q4 Deadline: May 15, 2019.

* We note that submission of the MDS must also adhere to the SNF PPS deadlines.
 ^ The term “FY 2020 SNF QRP” means the fiscal year for which the SNF QRP requirements applicable to that fiscal year must be met in order for a SNF to receive the full market basket percentage when calculating the payment rates applicable to it for that fiscal year.

We are inviting comment on our proposal to extend our current policy governing the schedule for reporting the quality measure data to the reporting of standardized resident assessment data beginning with the FY 2019 SNF QRP.

d. Proposed Schedule for Reporting the Proposed Quality Measures Beginning With the FY 2020 SNF QRP

As discussed in section V.B.7. of this proposed rule, we are proposing to adopt five quality measures beginning with the FY 2020 SNF QRP: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, Application of IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (NQF #2633), Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634), Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635), and Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). We are proposing that SNFs would report data on these measures using the MDS that is submitted through the QIES ASAP system. For the FY 2020 SNF QRP, SNFs would be required to report these data for admissions as well discharges that occur between October 1, 2018 and December 31, 2018. More information on SNF reporting using the QIES ASAP system is located at <https://www.cms.gov/Medicare/Quality->

Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage.

Starting in CY 2019, SNFs would be required to submit data for the entire calendar year beginning with the FY 2021 SNF QRP.

We are inviting public comment on this proposal.

e. Input Sought on Data Reporting Related to Assessment Based Measures

Through various means of public input, including that through previous rules, public comment on measures and the Measures Application Partnership, we received input suggesting that we expand the quality measures to include all residents and patients regardless of payer status so as to ensure representation of the quality of the services provided on the population as a whole, rather than a subset limited to Medicare. While we appreciate that many SNF residents are also Medicare beneficiaries, we agree that collecting quality data on all residents in the SNF setting supports our mission to ensure quality care for all individuals, including Medicare beneficiaries. We also agree that collecting data on all patients provides the most robust and accurate reflection of quality in the SNF setting. Accurate representation of quality provided in SNFs is best conveyed using data on all SNF residents, regardless of payer. We also

appreciate that collecting quality data on all SNF residents regardless of payer source may create additional burden, however, we also note that the effort to separate out SNF residents covered by other non-FFS Medicare payers could have clinical and work flow implications with an associated burden, and we further appreciate that it is common practice for SNFs to collect MDS data on all residents regardless of payer source. Additionally, we note that data collected through MDS for Medicare beneficiaries should match that beneficiary’s claims data in certain key respects (for example, diagnoses and procedures); this makes it easier for us to evaluate the accuracy of reporting in the MDS, such as by comparing diagnoses at hospital discharge to diagnoses at the follow-on SNF admission. However, we would not have access to such claims data for non-Medicare beneficiaries. Thus, we are seeking input on whether we should require quality data reporting on all SNF residents, regardless of payer, where feasible—noting that Part A claims data are limited to only Medicare beneficiaries.

We are seeking comments on this topic.

12. Proposal To Apply the SNF QRP Data Completion Thresholds to the Submission of Standardized Resident Assessment Data Beginning With the FY 2019 SNF QRP

We have gotten questions surrounding the data completion policy we adopted

beginning with the FY 2018 program year, in particular for how that policy applies to patients who reside in the SNF for part of an applicable period (for example, a patient who is admitted to a SNF during one reporting period but discharged in another, or a patient who is assessed upon admission using one version of the MDS but assessed at discharge using another version. We previously finalized that SNFs must report all of the data necessary to calculate the measures that apply to that program year on at least 80 percent of the MDS assessments that they submit (80 FR 46458). We also stated, in response to a comment, that we would consider data to have been satisfactorily submitted for a program year if the SNF reported all of the data necessary to calculate the measures if the data actually can be used for purposes of such calculations (as opposed to, for example, the use of a dash [-]).

Some stakeholders have interpreted our requirement that data elements be necessary to calculate the measures to mean that if a patient is assessed, for example, using one version of the MDS at admission and another version of the MDS at discharge, the two assessments are included in the pool of assessments used to determine data completion only if the data elements at admission and discharge can be used to calculate the measures. Our intention, however, was not to exclude assessments on this basis. Rather, our intention was solely to clarify that for purposes of determining whether a SNF has met the data completion threshold, we would only look at the completeness of the data elements in the MDS for which reporting is required under the SNF QRP.

To clarify our intended policy, we are proposing that the for purposes of determining whether a SNF has met the data completion threshold, we will consider all whether the SNF has reported all of the required data elements applicable to the program year on at least 80 percent of the MDS assessments that they submit for that program year. For example, if a resident is admitted on December 20, 2017 but discharged on January 10, 2018, (1) the resident's 5-Day PPS assessment would be used to determine whether the SNF met the data completion threshold for the 2017 reporting period (and associated program year), and (2) the discharge assessment would be used to determine whether the SNF met the data completion threshold for the 2018 reporting period (and associated program year) We also wish to clarify in this proposed rule that some assessment data will not invoke a response and in

those circumstances, data are not "missing" or incomplete. For example, in the case of a patient who does not have any of the medical conditions in a check all that apply listing, the absence of a response indicates that the condition is not present, and it would be incorrect to consider the absence of such data as missing in a threshold determination.

We are also proposing to apply this policy to the submission of standardized resident assessment data, and to codify it at § 413.360 of our regulations. We welcome comment on these proposals.

13. SNF QRP Data Validation Requirements

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.

14. SNF QRP Submission Exception and Extension Requirements

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 SNF QRP. At this time, we are not proposing any changes to the SNF QRP requirements that we adopted in these final rules. However, we are proposing to codify the SNF QRP Submission Exception and Extension Requirements at new § 413.360. We remind readers that, in the FY 2016 SNF PPS final rule (80 FR 46459 through 46460) we stated that SNF's must request an exception or extension by submitting a written request along with all supporting documentation to CMS via email to the SNF Exception and Extension mailbox at SNFQRPreconsiderations@cms.hhs.gov. We further stated that exception or extension requests sent to CMS through any other channel would not be considered as a valid request for an exception or extension from the SNF QRP's reporting requirements for any payment determination. In order to be considered, a request for an exception or extension must contain all of the requirements as outlined on our Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.html>. We are inviting public

comments on our proposal to codify the SNF QRP submission exception and extension requirements.

15. SNF QRP Submission Reconsideration and Appeals Procedures

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 beginning with the FY 2018 SNF QRP. We are not proposing any changes to these procedures. However, we are proposing to codify the SNF QRP Reconsideration and Appeals procedures at new § 413.360. Under these procedures, a SNF must follow a defined process to file a request for reconsideration if it believes that the finding of noncompliance with the reporting requirements for the applicable fiscal year is erroneous, and the SNF can file a request for reconsideration only after it has been found to be noncompliant. In order to be considered, a request for a reconsideration must contain all of the elements outlined on our Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.html>. We stated that we would not review any reconsideration request that is not accompanied by the necessary documentation and evidence, and that the request should be emailed to CMS at the following email address: SNFQRPreconsiderations@cms.hhs.gov. We further stated that reconsideration requests sent to CMS through any other channel would not be considered. We are inviting public comments on our proposal to codify the SNF QRP reconsideration and appeals procedures.

16. Proposals and Policies Regarding Public Display of Measure Data for the SNF QRP

Section 1899B(g) of the Act requires the Secretary to establish procedures for the public reporting of SNFs' performance, including the performance of individual SNFs, on the measures specified under section (c)(1) and resource use and other measures specified under section (d)(1) of the Act (collectively, IMPACT Act measures) beginning not later than 2 years after the specified application date under section 1899B(a)(2)(E) of the Act. This is consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act, which refers to the public display and review requirements for the Hospital Inpatient Quality Reporting

(IQR) Program. In addition, for a more detailed discussion about the provider's confidential review process prior to public display of measures, we refer readers to the FY 2017 SNF PPS final rule (81 FR 52045 through 52048).

In this FY 2018 SNF PPS proposed rule, pending the availability of data, we are proposing to publicly report data in CY 2018 for the following 3 assessment-based measures: (1) Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); (2) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678); and (3) Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF # 0674). Data collection for these 3 assessment-based measures began on October 1, 2016. We are proposing to display data for the assessment-based measures based on rolling quarters of data, and we would initially use discharges from January 1, 2016 through December 31, 2016.

In addition, we are proposing to publicly report 3 claims-based measures for: (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 measures were adopted for the SNF QRP in the FY 2017 SNF PPS rule to be based on data from one calendar year. As previously adopted in the FY 2017 SNF PPS final rule (81 FR 52045 through 52047), confidential feedback reports for these 3 claims-based measures will be based on data collected for discharges beginning January 1, 2016 through December 31, 2016. However, our current proposal revises the dates for public reporting

and we are proposing to transition from calendar year to fiscal year to make these measure data publicly available by October 2018.

For the Medicare Spending Per Beneficiary—PAC SNF QRP and Discharge to Community—PAC SNF QRP measures, we propose public reporting beginning in calendar year 2018 based on data collected from discharges beginning October 1, 2016, through September 30, 2017 and rates will be displayed based on one fiscal year of data. For the Potentially Preventable 30-day Post-Discharge Readmission Measure for SNF QRP, we are also proposing in this rule to increase the years of data used to calculate this measure from one year to two years and to update the associated reporting dates. If the proposed revisions to the Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP are finalized as proposed, data will be publicly reported for this measure beginning with discharges beginning October 1, 2015, through September 30, 2017 and rates will be displayed based on two consecutive fiscal years of data.

Also, we propose to replace the assessment-based measure “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) with a modified version of the measure entitled “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury” for the SNF QRP for future public reporting, if finalized. We refer readers to section V.B.7.a of this proposed rule for additional information regarding the proposed modification of the measure for quality reporting and public display.

For the assessment-based measures, Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional

Assessment and a Care Plan That Addresses Function (NQF #2631); Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678); and Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674), to ensure the statistical reliability of the measures, we are proposing to assign SNFs with fewer than 20 eligible cases during a performance period to a separate category: “The number of cases/resident stays is too small to report”. If a SNF had fewer than 20 eligible cases, the SNF's performance would not be publicly reported for the measure for that performance period.

For the claims-based measures, Medicare Spending Per Beneficiary—PAC SNF QRP; Discharge to Community—PAC SNF QRP; and Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP, to ensure the statistical reliability of the measures, we are proposing to assign SNFs with fewer than 25 eligible cases during a performance period to a separate category: “The number of cases/resident stays is too small to report.” If a SNF had fewer than 25 eligible cases, the SNF's performance would not be publicly reported for the measure for that performance period. For Medicare Spending Per Beneficiary—PAC SNF QRP, to ensure the statistical reliability of the measure, we are proposing to assign SNFs with fewer than 20 eligible cases during a performance period to a separate category: “The number of cases/resident stays is too small to report.” If a SNF has fewer than 20 eligible cases, the SNF's performance would not be publicly reported for the measure for that performance period.

TABLE 22—SUMMARY OF PROPOSED MEASURES FOR CY 2018 PUBLIC DISPLAY

Proposed Measures:

- Percent of Residents or Patients with Pressure Ulcers that Are New or Worsened (Short Stay) (NQF #0678).
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
- Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP.
- Discharge to Community—(PAC) SNF QRP.
- Medicare Spending Per Beneficiary (PAC) SNF QRP.

We invite public comment on the proposal for the public display of these 3 assessment-based measures and 3 claims-based measures, and the replacement of “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678) with a modified version of the measure,

“Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury” described above.

17. Mechanism for Providing Confidential Feedback Reports to SNFs

Section 1899B(f) of the Act requires the Secretary to provide confidential

feedback reports to PAC providers on their performance on the measures specified under subsections (c)(1) and (d)(1) of section 1899B of the Act, beginning one year after the specified application date that applies to such measures and PAC providers. In the FY 2017 SNF PPS final rule (81 FR 52046

through 52048), we finalized processes to provide SNF providers the opportunity to review their data and information using confidential feedback reports that will enable SNFs to review their performance on the measures required under the SNF QRP.

Information on how to obtain these and other reports available to the SNF QRP can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Spotlights-and-Announcements.html>. We are not proposing any changes to this policy.

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

1. Background

Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) authorized the SNF VBP Program (the “Program”) by adding sections 1888(g) and (h) to the Act. As a prerequisite to implementing the SNF VBP Program, in the FY 2016 SNF PPS final rule (80 FR 46409 through 46426) we adopted an all-cause, all-condition hospital readmission measure, as required by section 1888(g)(1) of the Act. In the FY 2017 SNF PPS final rule (81 FR 51986 through 52009), we adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs, as required by section 1888(g)(2) of the Act. In this proposed rule, we are making proposals related to the implementation of the Program.

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

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

readmission measure, scoring, and other topics.

In this rule, we are proposing to implement requirements for the SNF VBP Program, as well as codify some of those requirements at § 413.338, including certain definitions, the process for making value-based incentive payments, limitations on review, and other requirements.

2. Measures

a. Background

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

b. Request for Comment on Measure Transition

Section 1886(h)(2)(B) of the Act requires us to apply the SNFPPR to the SNF VBP Program instead of the SNFRM “as soon as practicable.” We intend to propose a timeline for replacing the SNFRM with the SNFPPR in future rulemaking, after we have had a sufficient opportunity to analyze the potential effects of this replacement on SNFs’ measured performance. We believe we must approach the decision about when it is practicable to replace the SNFRM thoughtfully, and we continue to welcome public feedback on when it is practicable to replace the SNFRM with the SNFPPR.

In the FY 2017 SNF PPS final rule (81 FR 51995), we summarized the public comments we received in response to our request for when we should begin to measure SNFs on their performance on the SNFPPR instead of the SNFRM. Commenters’ views were mixed; one suggested that we replace the SNFRM immediately, while others requested that we wait until the SNFPPR receives NQF endorsement, or that we allow SNFs to receive and understand their SNFPPR data for at least 1 year prior to beginning to use it. Another commenter suggested that we decline to use the SNFPPR until the measure receives additional support from the Measure Application Partnership and is the subject of additional public comment.

We would like to thank stakeholders for their input on this issue. We believe

the first opportunity to replace the SNFRM with the SNFPPR would be the FY 2021 program year, which would give SNFs experience with the SNFRM and other measures of readmissions such as those adopted under the SNF QRP. However, we have not yet determined if it would be practicable to replace the SNFRM at that time. We intend to continue to analyze SNF performance on the SNFPPR in comparison to the SNFRM and assess how the replacement of the SNFRM with the SNFPPR will affect the quality of care provided to Medicare beneficiaries.

We again request public comments on when we should replace the SNFRM with the SNFPPR, particularly in light of our proposal (discussed further in this section) to adopt performance and baseline periods based on the federal FY rather than on the calendar year.

c. Updates to the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (NQF #2510)

Since finalizing the SNFRM for use in the SNF VBP Program, we have continued to conduct analyses using more recent data, as well as to make some necessary non-substantive measure refinements. Results of this work and all refinements are detailed in a *Technical Report Supplement* that is available on the following CMS Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html>.

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

We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. One of our core objectives is to improve beneficiary outcomes including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care. In addition, we seek to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible under our programs while ensuring that beneficiaries have adequate access to excellent care.

We have been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation

(ASPE)⁸⁸ and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS' value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. On December 21, 2016, ASPE submitted a Report to Congress on a study it was required to conduct under section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The study analyzed the effects of certain social risk factors in Medicare beneficiaries on quality measures and measures of resource use used in one or more of nine Medicare value-based purchasing programs, including the SNF VBP Program.⁸⁹ The report also included considerations for strategies to account for social risk factors in these programs. In a January 10, 2017 report released by The National Academies of Sciences, Engineering, and Medicine, that body provided various potential methods for measuring and accounting for social risk factors, including stratified public reporting.⁹⁰

As noted in the FY 2017 IPPS/LTCH PPS final rule, the NQF has undertaken a 2-year trial period in which certain new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for selected social risk factors is appropriate for these measures. This trial entails temporarily allowing inclusion of social risk factors in the risk-adjustment approach for these measures. At the conclusion of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures, and we will closely review its findings.

The SNF VBP section of ASPE's report examined the relationship between social risk factors and performance on the 30-day SNF readmission measure for beneficiaries in SNFs. Findings indicated that beneficiaries with social risk factors

were more likely to be re-hospitalized but that this effect was significantly smaller when the measure's risk adjustment variables were applied (including adjustment for age, gender, and comorbidities), and that the effect of dual enrollment disappeared. In addition, being at a SNF with a high proportion of beneficiaries with social risk factors was associated with an increased likelihood of readmissions, regardless of a beneficiary's social risk factors. We encourage readers to examine this chapter of ASPE's report, and we seek any comments on the report's analysis and findings.

As we continue to consider the analyses and recommendations from these reports and await the results of the NQF trial on risk adjustment for quality measures, we are continuing to work with stakeholders in this process. As we have previously communicated, we are concerned about holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. Keeping this concern in mind, while we sought input on this topic previously, we continue to seek public comment on whether we should account for social risk factors in the SNF VBP Program, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include: Adjustment of the payment adjustment methodology under the SNF VBP Program; adjustment of provider performance scores (for instance, stratifying providers based on the proportion of their patients who are dual eligible); confidential reporting of stratified measure rates to providers; public reporting of stratified measure rates; risk adjustment of measures as appropriate based on data and evidence; and redesigning payment incentives (for instance, rewarding improvement for providers caring for patients with social risk factors or incentivizing providers to achieve health equity). While we consider whether and to what extent we currently have statutory authority to implement one or more of the above-described methods, we are seeking comments on whether any of these methods should be considered, and if so, which of these methods or combination of methods would best account for social risk factors in the SNF VBP Program.

In addition, we are seeking public comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk

adjustment of a particular measure. Examples of social risk factors include, but are not limited to, dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence. We are seeking comments on which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk. We will take commenters' input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in the SNF VBP Program. We note that any such changes would be proposed through future notice-and-comment rulemaking.

We look forward to working with stakeholders as we consider the issue of accounting for social risk factors and reducing health disparities in CMS programs. Of note, implementing any of the above methods would be taken into consideration in the context of how this and other CMS programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of data calculations, among others), and we also welcome comment on operational considerations. CMS is committed to ensuring that its beneficiaries have access to and receive excellent care, and that the quality of care furnished by providers and suppliers is assessed fairly in CMS programs.

3. Proposed FY 2020 Performance Standards

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

In this proposed rule, we are providing estimates of the numerical values of the achievement threshold and the benchmark for the FY 2020 program year. We have based these values on the FY 2016 MedPAR files including a 3-month run-out period. We intend to include the final numerical values in the FY 2018 SNF PPS final rule. However, as finalized in the FY 2017 SNF PPS final rule (81 FR 51998), if we are unable to complete the necessary calculations in time to include the final numerical values in the FY 2018 SNF

⁸⁸ Office of the Assistant Secretary for Planning and Evaluation. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Available at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

⁸⁹ Office of the Assistant Secretary for Planning and Evaluation. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Available at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

⁹⁰ National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press.

PPS final rule, we will publish the numerical values not later than 60 days prior to the beginning of the performance period that applies to the FY 2020 program year, and we will notify SNFs and the public of those final numerical values through a listserv

email and a posting on the QualityNet News portion of the Web site. Additionally, as discussed further below, we are proposing to adopt baseline and performance periods for the FY 2020 program year based on the federal fiscal year rather than the calendar year as we had finalized for the

FY 2019 program year. The estimated numerical values for the achievement threshold and benchmark in Table 23 reflect this proposal by using FY 2016 claims data. As we have done in prior rulemaking, we have inverted the SNFRM rates in Table 23 so that higher values represent better performance.

TABLE 23—ESTIMATED FY 2020 SNF VBP PROGRAM PERFORMANCE STANDARDS

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

We welcome public comments on these estimated achievement threshold and benchmark values.

4. Proposed FY 2020 Performance Period and Baseline Period

a. Background

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

b. FY 2020 Proposals

Although we continue to believe that a 12-month performance and baseline period are appropriate for the Program, we are concerned about the operational challenges of linking the 12-month periods to the calendar year. Specifically, the allowance of an approximately 90-day claims run out period following the last date of discharge, coupled with the length of time needed to calculate the measure rates using multiple sources of claims needed for statistical modeling, determine achievement and improvement scores, allow SNFs to review their measure rates, and determine the amount of payment adjustments could risk delay in meeting requirement at section 1888(h)(7) of the Act to notify SNFs of their value-based incentive payment percentages not later than 60 days prior to the fiscal year involved.

We therefore considered what policy options we had to mitigate this risk and ensure that we comply with the statutory deadline to notify SNFs of their payment adjustments under the Program.

We continue to believe that a 12-month performance and baseline period

provide a sufficiently reliable and valid data set for the SNF VBP Program. We also continue to believe that, where possible and practicable, the baseline and performance period should be aligned in length and in months included in the selections. Taking those considerations and beliefs into account, we propose to adopt FY 2018 (October 1, 2017, through September 30, 2018) as the performance period for the FY 2020 SNF VBP Program, with FY 2016 (October 1, 2015, through September 30, 2016) as the baseline period for purposes of calculating performance standards and measuring improvement. This proposed policy, will, if finalized, give us an additional 3 months between the conclusion of the performance period and the 60-day notification deadline prescribed by section 1888(h)(7) of the Act to complete the activities described above.

We are aware that making this transition from the calendar year to the federal FY will result in our measuring SNFs on their performance during Q4 of 2017 (October 1, 2017, through December 31, 2017) for both the FY 2019 program year and the FY 2020 program year. During the FY 2019 program year, that quarter will fall at the end of the finalized performance period (January 1, 2017, through December 31, 2017), while during the FY 2020 program year, that quarter will fall at the beginning of the proposed performance period (October 1, 2017, through September 30, 2018). We believe that, on balance, this overlap in data is more beneficial than the alternative. We considered proposing not to use that quarter of measured performance during the FY 2020 program year, but, as a result, we would be left with fewer than 12 months of data with which to score SNFs under the program. As we have stated, we believe it is important to use 12 months of data to avoid seasonality issues and to assess SNFs fairly. We therefore believe that meeting these operational challenges, in total,

outweighs any cost to SNFs associated with including a single quarter's SNFRM data in their SNF performance scores twice.

However, as an alternative, we request comments on whether or not we should instead consider adopting for the FY 2020 Program a one-time, three-quarter performance period of January 1, 2018, through September 30, 2018, and a one-time, three-quarter baseline period of January 1, 2016 through September 30, 2016 in order to avoid the overlap in performance period quarters that we describe above. We believe this option could provide us with sufficiently reliable SNFRM data for purposes of the Program's scoring while ensuring that SNFs are not scored on the same quality measure data in successive Program years. However, we note that the shorter measurement period could result in lower denominator counts and seasonal variations in care, as well as disparate effects of cold weather months on SNFs' care could also create variations in quality measurement, and could potentially disproportionately affect SNFs in different areas of the country. Under this alternative, we would resume a 12-month performance and baseline period beginning with the FY 2021 program year

We welcome public comments on our proposal and alternative. In addition, as we continue considering potential policy changes once we replace the SNFRM with the SNFPPR, we also seek comment on whether or not we should consider other potential performance and baseline periods for that measure. We specifically request comments on whether or not we should attempt to align the SNF VBP Program's performance and baseline periods with other CMS value-based purchasing programs, such as the Hospital VBP Program or Hospital Readmissions Reduction Program, which could mean proposing to adopt performance and baseline periods that run from July 1st to June 30th.

5. SNF VBP Performance Scoring

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52000 through 52005) for a detailed discussion of the scoring methodology that we have finalized for the Program, along with responses to public comments on our policies and examples of scoring calculations.

a. Proposed Rounding Clarification for SNF VBP Scoring

In the FY 2017 SNF PPS final rule (81 FR 52001), we adopted formulas for scoring SNFs on achievement and improvement. The final step in these calculations is rounding the scores to the nearest whole number.

As we have continued examining SNFRM data, we have identified a concern related to that rounding step. Specifically, we are concerned that rounding SNF performance scores to the nearest whole number is insufficiently precise for purposes of establishing value-based incentive payments under the Program. Rounding scores in this manner has the effect of producing significant numbers of tie scores, since SNFs have between 0 and 100 points available under the Program, and we estimate that more than 16,000 SNFs will participate in the Program. As discussed further in this section, the exchange function methodology that we are proposing to adopt is most easily implemented when we are able to differentiate precisely among SNF performance scores in order to provide each SNF with a unique value-based incentive payment percentage.

We therefore propose to change the rounding policy from that previously finalized for SNF VBP Program scoring methodology, and instead to award points to SNFs using the formulas that we adopted in last year's rule by rounding the results to the nearest ten-thousandth of a point. Using significant digits terminology, we propose to use no more than five significant digits to the right of the decimal point when calculating SNF performance scores and subsequently calculating value-based incentive payments. We view this policy change as necessary to ensure that the Program scores SNFs as precisely as possible and to ensure that value-based incentive payments reflect SNF performance scores as accurately as possible.

We welcome public comments on this proposal.

b. Request for Comments on Policies for Facilities With Zero Readmissions During the Performance Period

In our analyses of historical SNFRM data, we identified a unit imputation issue associated with certain SNFs' measured performance. Specifically, we found that a small number of facilities had zero readmissions during the applicable performance period. An observed readmission rate of zero is a desirable outcome; however, due to risk-adjustment and the statistical approach used to calculate the measure, outlier values are shifted towards the mean, particularly for smaller SNFs. As a result, observed readmission rates of zero result in risk-standardized readmission rates that are greater than zero. Analysis conducted by our measure development contractor revealed that it may be possible—although rare—for SNFs with zero readmissions to receive a negative value-based incentive payment adjustment. We are concerned that assigning a net negative value-based incentive payment to a SNF that achieved zero readmissions during the applicable performance period would not support the Program's goals.

We considered our policy options for SNFs that could be affected by this issue, including excluding SNFs with zero readmissions from the Program entirely in order to ensure that they are not unduly harmed by being assigned a non-zero RSRR by the measure's finalized methodology. However, because the Program's statute requires us to include all SNFs in the Program, we do not believe we have the authority to exclude any SNFs from the payment withhold and from value-based incentive payments. We also considered proposing to replace SNF performance scores for those SNFs in this situation with the median SNF performance score. But because we must pay SNFs ranked in the lowest 40 percent less than the amount they would otherwise be paid in the absence of the SNF VBP, we do not believe that assigning these SNFs the median performance rate on the applicable measure would necessarily protect them from receiving net negative value-based incentive payments, even though they had accomplished a clinical goal set out specifically by the Program.

We are considering different policy options to ensure that SNFs achieving zero readmissions among their patient populations during the performance period do not receive a negative

payment adjustment. We intend to address this topic in future rulemaking, and we request public comments on what accommodations, if any, we should employ to ensure that SNFs meeting our quality goals are not penalized under the Program. We specifically request comments on the form this potential accommodation should take.

c. Request for Comments on Extraordinary Circumstances Exception Policy

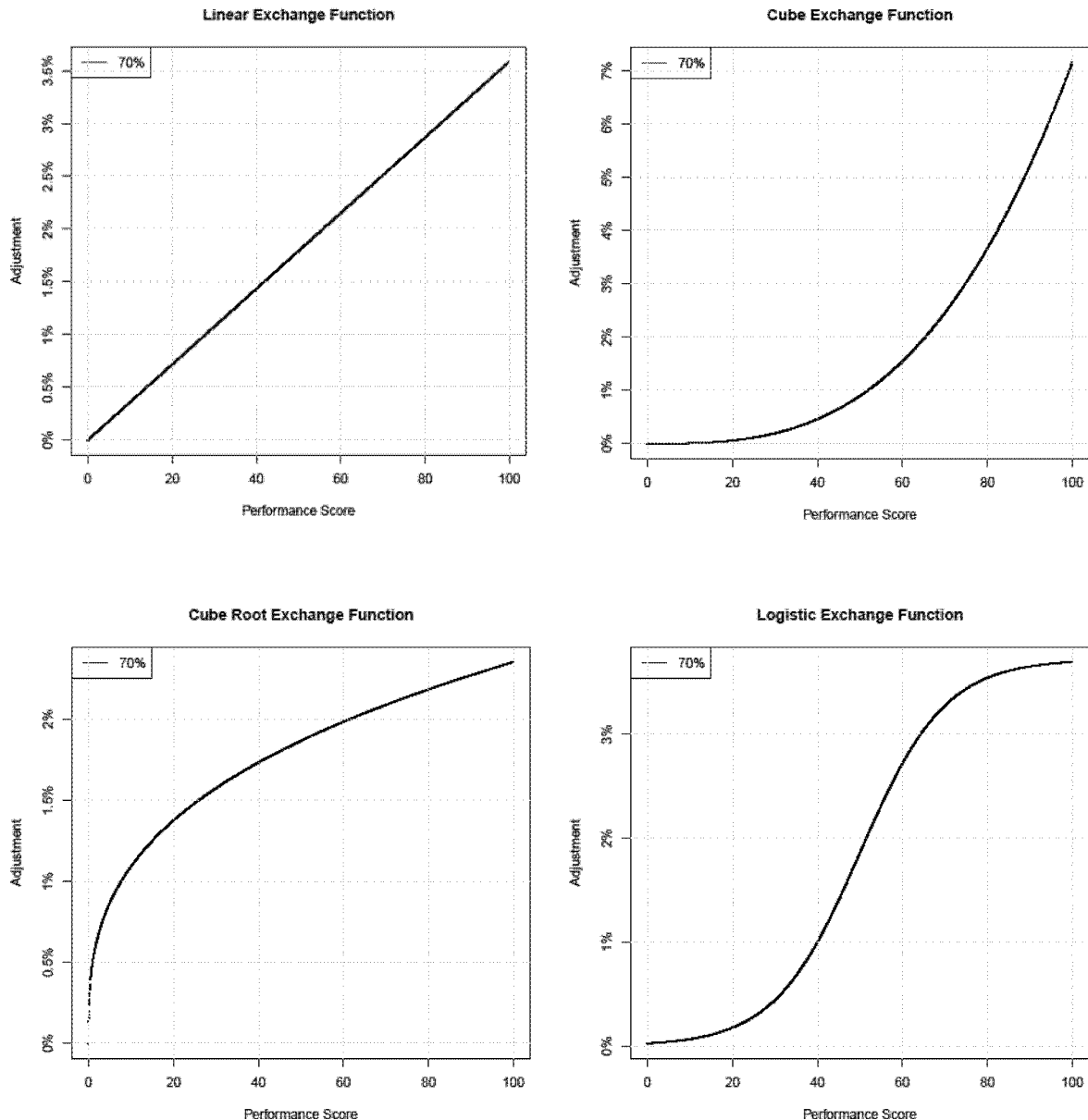
In other value-based purchasing programs, such as the Hospital VBP Program (see 78 FR 50704 through 50706), as well as several of our quality reporting programs, we have adopted Extraordinary Circumstances Exceptions policies intended to allow participating facilities to receive administrative relief from program requirements due to natural disasters or other circumstances beyond the facility's control that may affect the facility's ability to provide high-quality health care.

We are considering whether or not this type of policy would be appropriate for the SNF VBP Program. We intend to address this topic in future rulemaking. We therefore request public comments on whether or not we should implement such a policy, and if so, the form the policy should take and the authority we should employ. If we propose such a policy in the future, our preference would be to align it with the Extraordinary Circumstances Exception policy adopted under our other quality programs.

6. SNF Value-Based Incentive Payments

a. Proposed Exchange Function

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52005 through 52006) for discussion of four possible exchange functions that we considered adopting in order to translate SNFs' performance scores into value-based incentive payments. We have created new graphical representations of the four functions that we have considered in the past—linear, cube, cube root, and logistic—and present those updated representations here. We note that the actual exchange functions' forms and slopes will vary depending on the distributions of SNFs' performance scores from the FY 2019 performance period, and wish to emphasize that these representations are presented solely for the reader's clarity as we discuss our proposed exchange function policy.

FIGURE 1: SNF VBP Exchange Function Forms That We Considered

We have continued examining historical SNFRM data while considering our policy options for this program. We have attempted to assess how each of the four possible exchange functions that we set out in the FY 2017 SNF PPS final rule, as well as potential variations, would affect SNFs' incentive payments under the Program. We specifically considered the effects of the statutory constraints on the Program's value-based incentive payments and our belief that in order to create an effective incentive payment program, SNFs' value-based incentive payments must be widely distributed to reward higher performing SNFs through increased

payment and to make reduced payments to lower performing SNFs. We also considered our desire to avoid unintended consequences of the Program's incentive payments, particularly since the Program is limited by statute to using a single measure at a time, and our view that an equitable distribution of value-based incentive payments would be most appropriate to ensure that all SNFs, including SNFs serving at-risk populations, could potentially qualify for incentive payments.

In our view, important factors when adopting an exchange function include the number of SNFs that receive more

in value-based incentive payments than the number of SNFs for which a reduction is applied to their Medicare payments, as well as the incentive for SNFs to reduce hospital readmissions. We hold this view because we believe that the Program will be most effective at encouraging SNFs to improve the quality of care that they provide to Medicare beneficiaries if SNFs have the opportunity to earn incentives, rather than simply avoid penalties, through high performance on the applicable quality measure. We also believe that SNFs must have incentives to reduce hospital readmissions for their patients

no matter where their performance lies in comparison to their peers.

Taking those considerations into account, we analyzed the four exchange functions on which we have previously sought comment—linear, cube, cube root, and logistic—as well as variations of those exchange functions. We scored SNFs using historical SNFRM data and modeled SNFs' value-based incentive payments using each of the functions in turn. We evaluated the distribution of value-based incentive payments that resulted from each function, as well as the number of SNFs with positive payment adjustments and the value-based incentive payment percentages that resulted from each function. We also evaluated the functions' results for the statutory requirements in section 1888(h)(5)(C)(ii) of the Act, including the requirements in subclause (I) that the percentage be based on the SNF performance score for each SNF, in subclause (II) that the application of all such percentages results in an appropriate distribution, and in items (aa), (bb), and (cc) of subclause (II), specifying that SNFs with the highest rankings receive the highest value-based incentive payment amounts, that SNFs with the lowest rankings receive the lowest value-based incentive payment amounts, and that the SNFs in the lowest 40 percent of the ranking receive a lower payment rate than would otherwise apply.

In our analyses, of the four baseline functions, we found that the logistic function maximized the number of SNFs with positive payment adjustments among SNFs measured using the SNFRM. We also found that the logistic function best fulfills the requirement that the SNFs in the lowest 40 percent of the ranking receive a lower payment rate than would otherwise apply, resulted in an appropriate distribution of value-based incentive payment percentages, and fulfilled the other statutory requirements described in this proposed rule. Specifically, we noted that the logistic function provided a broad range of SNFs with net-positive value-based incentive payments, and while it did not provide the highest value-based incentive payment percentage to the top performers of all of the functions, we viewed the number of SNFs with positive payment adjustments as a more important consideration than the highest value-based incentive payment percentages being awarded.

We also considered alignment of VBP payment methodologies across fee-for-service Medicare VBP programs, including the Hospital VBP program and Quality Payment Program (QPP).

We recognize that aligning payment methodologies would help stakeholders that use VBP payment information across care settings better understand the SNF VBP payment methodology. Both the Hospital VBP program and QPP use some form of a linear exchange function for payment. Three key program aspects that facilitate the use of a linear exchange function are the programs' number of measures, measure weights, and correlation across program measures. These three aspects in tandem contribute to the approximately normal distribution of scores expected in the Hospital VBP program and QPP. No single measure is the key driver that might "tilt" scores to a non-normal distribution. Since both programs are required to be budget neutral, our modeling estimates that scores translate into an approximately equal number of providers with positive payment adjustments and providers receiving a net payment reduction.

In contrast, the SNF VBP payment adjustment is driven, in part, by two specific SNF VBP statutory requirements: The program use of a single measure; and the requirement that the total amount of value-based incentive payments for all SNFs in a fiscal year be between 50 and 70 percent of the total amount of reductions to payments for that fiscal year, as estimated by the Secretary. Our analysis of the linear exchange function showed that more SNFs would receive a net payment reduction than a payment incentive because the total amount available for incentive payments in a fiscal year is limited to between 50 and 70 percent of the total amount of the reduction to SNF payments for that fiscal year. The linear exchange function also results in the provision of a net payment reduction to a higher percentage of SNFs that exceeded the 50th percentile of national performance, relative to the logistic payment function. We believe that these findings are unique to the SNF VBP program, relative to other fee-for-service Medicare programs, because of the limitation on the total amount that we can use for incentive payments, coupled with the use of a single measure and the corresponding scoring distribution.

In addition to the four baseline functions described further above, we considered adjusting the linear function in order to be able to make positive payment adjustments to a greater number of SNFs. Specifically, we tested an alternative where we reduced the baseline linear function by 20 percent, then redistributed the resulting funds to the middle 40 percent of SNFs. We found that the use of this linear function

with adjustment would enable us to make a positive payment adjustment to a slightly greater number of SNFs than we would be able to make using the logistic function. However, we were concerned with the additional complexity involved in implementing this type of two-step adjustment to the linear exchange function.

Taking all of these considerations into account, we propose to adopt a logistic function for the FY 2019 SNF VBP Program and subsequent years. Under this policy, we will:

1. Estimate Medicare spending on SNF services for the FY 2019 payment year;
2. Estimate the total amount of reductions to SNFs' adjusted Federal per diem rates for that year, as required by statute;
3. Calculate the amount realized under the payback percentage proposal (discussed further below);
4. Order SNFs by their SNF performance scores; and
5. Assign a value-based incentive payment multiplier to each SNF that corresponds to a point on the logistic exchange function that corresponds to its SNF performance score.

As proposed and discussed further in this proposed rule, we will model the logistic exchange function in such a form that the estimated total amount of value-based incentive payments equals not more than 60 percent of the amounts withheld from SNFs' claims. While the function's specific form will also depend on the distribution of SNF performance scores during the performance period, the formula that we have used to construct the logistic exchange function and that we intend to use for FY 2019 program calculations is:

$$y_i = \frac{1}{1 + e^{-0.1(x_i - 50)}}$$

where x_i is the SNF's performance score.

We welcome public comments on this proposal, and in particular, on whether a linear function with adjustment would alternatively be feasible for the SNF VBP Program, potentially beginning with FY 2019.

b. Payback Percentage Proposal

Section 1888(h)(6)(A) of the Act requires the Secretary to reduce the adjusted federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished by that SNF during a fiscal year by the applicable percent (which, under section 1888(h)(6)(B) of the Act is 2 percent for FY 2019 and succeeding fiscal years) to fund the value-based incentive

payments for that fiscal year. Section 1888(h)(5)(C)(ii)(III) of the Act further specifies that the total amount of value-based incentive payments under the Program for all SNFs in a fiscal year 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 that fiscal year under the Program, as estimated by the Secretary. Thus, we must decide what percentage of the total amount of the reductions to payments for a fiscal year we will pay as value-based incentive payments to SNFs based on their performance under the Program for that fiscal year.

As with our exchange function proposal described in this proposed rule, we view the important factors when specifying a payback percentage as the number of SNFs that receive a positive payment adjustment and the marginal incentives for all SNFs to reduce hospital readmissions and make broad-based care quality improvements, as well as the Medicare Program's long-term sustainability through the additional estimated Medicare trust fund savings. We intend for the proposed payback percentage to appropriately balance these factors. We analyzed the distribution of value-based incentive payments using historical data, focusing on the full range of available payback percentages.

Taking these considerations into account, we propose that the total amount of funds that would be available to pay as value-based incentive payments in a fiscal year would be 60 percent of the reductions to payments otherwise applicable to SNF Medicare payments for that fiscal year, as estimated by the Secretary. We believe that 60 percent is the most appropriate payback percentage to balance the considerations described in this proposed rule.

We note that we intend to monitor the effects of the payback percentage policy on Medicare beneficiaries, on participating SNFs, and on their measured performance closely. We intend to consider proposing to adjust the payback percentage in future rulemaking. In our consideration, we would include the program's effects on readmission rates, potential unintended consequences of SNF care to beneficiaries included in the measure, and SNF profit margins. Since the SNF VBP Program is a new, single measure value-based purchasing program and will continue to evolve as we implement it—including, for example, changing from the SNF Readmission Measure to the SNFPPR as required by statute—we intend to evaluate its effects carefully.

We note also that the Medicare Payment Advisory Commission's research has shown that for-profit SNFs' average Medicare margins are significantly positive,⁹¹ though not-for-profit SNFs' average Medicare margins are substantially lower, and we request comment on the extent to which that should be considered in our policy. We also recognize that there is some evidence that not-for-profit SNFs tend to perform better on measures of hospital readmissions than for-profit SNFs,⁹² and we request comment on whether our proposed payback percentage appropriately balances Medicare's long-term sustainability with the need to provide strong incentives for quality improvement to top-performing but lower-margin SNFs.

We welcome public comments on this proposal.

7. SNF VBP Reporting

a. Confidential Feedback Reports

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52006 through 52007) for discussion of our intention to use the QIES system CASPER files to fulfill the requirement in section 1888(g)(5) of the Act that we provide quarterly confidential feedback reports to SNFs on their performance on the Program's measures. We also responded in that final rule to public comments on the appropriateness of the QIES system.

We provided SNFs with a test report in September 2016, followed by data on SNFs' CY 2013 performance on the SNFRM in December 2016 and SNFs' CY 2014 performance on the SNFRM in March 2017. We intend to continue providing SNFs with their performance data each quarter as required by the statute.

We welcome feedback from SNFs on the contents of the quarterly reports and what additional elements, if any, we should consider including that would be useful for quality improvement efforts. We specifically seek comment on what patient-level data would be most helpful to SNFs if they were to request such data from us as part of their quality improvement efforts.

⁹¹ Medicare Payment Advisory Commission, March 2017 Report to the Congress, ch. 8: Skilled nursing facility services, Table 8–6. http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

⁹² Neuman, M.D., Wirtalla, C., Werner, R.M. Association Between Skilled Nursing Facility Quality Indicators and Hospital Readmissions. *JAMA*. 2014;312(15):1542–1551. doi:10.1001/jama.2014.13513. Retrieved from <http://jamanetwork.com/journals/jama/fullarticle/1915609>.

b. Review and Corrections Process: Phase Two

In the FY 2017 SNF PPS final rule (81 FR 52007 through 52009), we adopted a two-phase review and corrections process for SNFs' quality measure data that will be made public under section 1888(g)(6) of the Act and SNF performance information that will be made public under section 1888(h)(9) of the Act. We explained that we would accept corrections to the quality measure data used to calculate the measure rates that is included in any SNF's quarterly confidential feedback report, and also that we would provide SNFs with an annual confidential feedback report containing the performance information that will be made public. We detailed the process for requesting Phase One corrections and finalized a policy whereby we would accept Phase One corrections to SNFs' quarterly reports through March 31 following the report's issuance via the CASPER system.

In this proposed rule, we are proposing to adopt additional specific requirements for the Phase Two review and correction process. Specifically, we are proposing to limit Phase Two correction requests to the SNF's performance score and ranking because all SNFs would have already had the opportunity to correct their quality measure data through the Phase One corrections process.

We are proposing to provide these reports to SNFs at least 60 days prior to the FY involved. SNFs will not be allowed to request corrections to their value-based incentive payment adjustments. However, we will make confirming corrections to a SNF's value-based incentive payment adjustment if a SNF successfully requests a correction to its SNF performance score.

As with Phase One, we propose that Phase Two correction requests must be submitted to the *SNFVBPInquiries@cms.hhs.gov* mailbox, and must contain the following information:

- SNF's CMS Certification Number (CCN);
- SNF Name;
- The correction requested and the SNF's basis for requesting the correction.

Specifically, the SNF must identify the error for which it is requesting correction, and explain the reason for requesting the correction. The SNF must also submit documentation or other evidence, if available, supporting the request. As noted above, corrections requested during Phase Two will be limited to SNFs' performance score and ranking. However, we note that the

SNFVBPinquiries@cms.hhs.gov mailbox cannot receive secured email messages. If any SNF believes it needs to submit patient-sensitive information as part of a correction request, we request that the SNF contact us at the mailbox to arrange a secured transfer.

We further propose that SNFs must make any correction requests no later than 30 days following the date of our posting of their annual SNF performance score report via the QIES system CASPER files. For example, if we post the reports on August 1, 2017, SNFs must review these reports and submit any correction requests by 11:59 p.m. Eastern Standard Time on August 31, 2017 (or the next business day, if the 30th day following the date of the posting is a weekend or federal holiday). We will not consider any requests for corrections to SNF performance scores or rankings that are received after this deadline.

We will review all timely Phase Two correction requests that we receive and will provide responses to SNFs that have requested corrections as soon as practicable. We will re-issue an updated SNF performance score report to any SNF that requests a correction with which we agree, and if necessary, will update any public postings on *Nursing Home Compare* and value-based incentive payment percentages, as applicable.

We welcome public comments on this proposed Phase Two corrections process.

c. SNF VBP Program Public Reporting Proposal

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52009) for discussion of the statutory requirements governing the public reporting of SNFs' performance information under the SNF VBP Program. We also sought and responded to public comments on issues that we should take into account when posting performance information on *Nursing Home Compare* or a successor Web site.

We propose to begin publishing SNF performance information under the SNF VBP Program on *Nursing Home Compare* not later than October 1, 2017. We will only publish performance information for which SNFs have had the opportunity to review and submit corrections. We welcome comments on this proposal.

d. Proposed Ranking of SNFs' Performance

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52009) for discussion of the statutory requirement that we rank SNFs based on their

performance on the Program. In that rule, we discussed the statutory requirements to order SNF performance scores from low to high and publish those rankings on both the *Nursing Home Compare* and QualityNet Web sites, and to publish the ranking after August 1, 2018, when performance scores and value-based incentive payment adjustments will be made available to SNFs. We intend to publish the ranking for each program year once performance scores and value-based incentive payment adjustments are made available to SNFs.

Having considered those statutory requirements, we propose to rank SNFs for the FY 2019 program year and to publish the ranking after August 1, 2018. We further propose that the ranking include the following data elements:

- Rank,
- Provider ID,
- Facility name,
- Address,
- Baseline period (CY 2015) risk-standardized readmission rate,
- Performance period (CY 2017) risk-standardized readmission rate,
- Achievement score,
- Improvement score, and
- SNF performance score.

We believe that these data elements will provide consumers and other stakeholders with the necessary information to evaluate SNFs' performance under the program, including each component of the SNF performance score, including both achievement and improvement. We welcome public comments on these proposals. We will address rankings for future program years in subsequent rulemaking.

D. Survey Team Composition

1. Background

To participate in the Medicare and Medicaid programs, long term care facilities, including skilled nursing facilities (SNFs) in Medicare and nursing facilities (NFs) in Medicaid, must be certified as meeting Federal participation requirements, which are specified in 42 CFR part 483. Section 1864(a) of the Act authorizes the Secretary to enter into agreements with state survey agencies to determine whether SNFs meet the federal participation requirements for Medicare and section 1902(a)(33)(B) of the Act provides for state survey agencies to perform the same survey tasks for NFs participating or seeking to participate in the Medicaid program. We also conduct surveys directly and also contract out for certain surveys. The results of these

surveys are used by us and the Medicaid state agency as the basis for a determination to enter into, deny, or terminate a provider agreement with the facility, or to impose a remedy or remedies on a facility, as appropriate. To assess compliance with federal participation requirements, surveyors conduct onsite inspections (surveys) of facilities. In the survey process, surveyors gather evidence and directly observe the actual provision of care and services to residents and the effect or possible effects of that care to assess whether the care provided meets the assessed needs of individual residents.

Sections 1819(g) and 1919(g) of the Act, and corresponding regulations at 42 CFR part 488, subpart E, specify the requirements for the types and periodicity of surveys that are to be performed for each facility. Specifically, sections 1819(g)(2) and 1919(g)(2) of the Act reference standard, special, and extended surveys. Sections 1819(g)(2)(E) and 1919(g)(2)(E) of the Act specify that surveys under section 1819(g)(2) of the Act in general must consist of a multidisciplinary team of professionals, including a registered nurse. In addition, the statutory requirements governing the investigation of complaints and for monitoring on-site a SNF's or NF's compliance with participation requirements are found in sections 1819(g)(4) and 1919(g)(4) of the Act and § 488.332.

These sections specify that a specialized team, including an attorney, an auditor, and appropriate health care professionals may be maintained and utilized in the investigation of complaints for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against SNFs and NFs, respectively.

Consistent with the statutory provisions noted above, two separate regulations address survey team composition. The implementing regulation at § 488.314, Survey Teams, reflects the statutory language under sections 1819(g)(2)(E)(i) and 1919(g)(2)(E)(i) of the Act, and states that "[s]urvey teams must be conducted by an interdisciplinary team of professions, which must include a registered nurse." The implementing regulation at § 488.332, investigation of complaints of violations and monitoring of compliance, reflects the statutory language under sections 1819(g)(4) and 1919(g)(4) of the Act, and states that the state survey agency may use a specialized team, which may include an attorney, auditor, and appropriate health professionals, but not necessarily a registered nurse, to investigate

complaints and conduct on-site monitoring. A survey conducted to monitor on-site a SNF's or NF's compliance with participation requirements, such as an on-site revisit survey to determine whether a noncompliant facility has achieved substantial compliance, is also subject to the provisions of § 488.332, and not § 488.314.

The regulation under § 488.308(e) also addresses complaint investigations, but as currently written, it combines special surveys, which are authorized under sections 1819(g)(2)(A)(iii)(II) and 1919(g)(2)(A)(iii)(II) of the Act, with the requirements associated with the investigations of complaints, which are governed by sections 1819(g)(4) and 1919(g)(4) of the Act. In the statute, "special surveys" are referenced at sections 1819(g)(2)(A)(iii)(II) and 1919(g)(2)(A)(iii)(II) of the Act, while the investigation of complaints is referenced at sections 1819(g)(4) and 1919(g)(4) of the Act.

The regulations as currently written do not clearly indicate which survey team requirement applies to complaint surveys. The language at § 488.314 could be broadly interpreted to cover the survey team composition for all surveys, including those used to investigate a complaint. Such an interpretation, however, would ignore the provisions of § 488.332, which allow a state survey agency to utilize a specialized investigative team that does not necessarily include a registered nurse to survey a facility in connection with a complaint investigation. The placement of surveys to investigate a complaint together with special surveys under § 488.308(e) further places into question which survey team requirement applies to complaint surveys. However, CMS' State Operations Manual (SOM) (Internet Only Manual Pub. 100-07) notes that "Section 488.332 provides the Federal regulatory basis for the investigation of complaints about nursing homes," thus indicating CMS' view that provisions related to survey team composition in § 488.332 apply to complaint surveys. See SOM, Ch. 5, Section 5300; see also SOM, Ch. 7, Sections 7203.5 and 7205.2(3).

The lack of clarity as to which regulatory provision, that is, § 488.314 or § 488.332, applies to the survey team composition related to the investigation of complaints has been the cause of recent administrative litigation. We thus believe that regulatory changes are needed to clarify that only surveys conducted under sections 1819(g)(2) and 1919(g)(2) of the Act are subject to the requirement at § 488.314 that a

survey team consist of an interdisciplinary team that must include a registered nurse. Complaint surveys and surveys related to on-site monitoring, including revisit surveys, are subject to the requirements of sections 1819(g)(4) and 1919(g)(4) of the Act and § 488.332, which allow the state survey agency to use a specialized investigative team that may include appropriate health care professionals but need not include a registered nurse.

2. Major Provisions

We propose to make changes to §§ 488.30, 488.301, 488.308, and 488.314 to clarify the regulatory requirements for team composition for surveys conducted for investigating a complaint and to align regulatory provisions for investigation of complaints with the statutory requirements found in sections 1819 and 1919 of the Act.

(1) Proposed revision of the definition of "complaint survey" under § 488.30 to add a provision stating that the requirements of sections 1819(g)(4) and 1919(g)(4) of the Act and § 488.332 apply to complaint surveys.

(2) Proposed revision of the definition of "abbreviated standard survey" under § 488.301 to clarify that abbreviated standard surveys conducted to investigate a complaint or to conduct on-site monitoring to verify compliance with participation requirements are subject to the requirements of § 488.332.

(3) Proposed relocation of the requirements included in § 488.308(e)(2) and (3) related to surveys conducted to investigate a complaint from under the heading "Special Surveys" to a new subsection, titled "Investigations of Complaints."

(4) Proposed revision of the language at § 488.314(a)(1) to specify that the team composition requirements at § 488.314(a)(1) apply only to surveys under sections 1819(g)(2) and 1919(g)(2) of the Act.

E. Proposal To Correct the Performance Period for the National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Immunization Reporting Measure in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Year (PY) 2020

In the CY 2017 ESRD PPS final rule (81 FR 77834), we finalized that the performance period for the NHSN Healthcare Personnel Influenza Vaccination Reporting Measure for Payment Year (PY) 2020 would be from October 1, 2016, through March 31, 2017 (81 FR 77915). We are proposing to revise that performance period so that

it aligns with the schedule we previously set for this measure. Specifically, we previously finalized that for the PY 2018 ESRD QIP, the performance period for this measure would be from October 1, 2015 through March 31, 2016, which is consistent with the length of the 2015–2016 influenza season (79 FR 66209), and that for the PY 2019 ESRD QIP, the performance period for this measure would be from October 1, 2016 through March 31, 2017, which is consistent with the length of the 2016–2017 influenza season (80 FR 69059–60). Maintaining the performance period we finalized in the CY 2017 ESRD PPS final rule would result in scoring facilities on the same data twice, and would not be consistent with our intended schedule to collect data on the measure in successive influenza seasons. Therefore, we are proposing to revise the performance period for the NHSN HCP Influenza Vaccination Reporting Measure for the PY 2020 ESRD QIP. Specifically, we are proposing that for the PY 2020 ESRD QIP, the performance period for this measure would be October 1, 2017, through March 31, 2018, which is consistent with the length of the 2017–2018 influenza season.

We seek comments on this proposal.

VI. Possible Burden Reduction in the Long-Term Care Requirements

A. Background

On October 4, 2016, we issued a final rule entitled, "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities" (81 FR 68688). This final rule significantly revised the requirements that Long-Term Care (LTC) facilities must meet to participate in the Medicare and Medicaid programs. Prior to the final rule, the LTC requirements had not been comprehensively reviewed and updated since 1991 (56 FR 48826, September 26, 1991), despite substantial changes in service delivery in this setting. The final rule included revisions that reflect advances in the theory and practice of service delivery and safety. In addition, the various revisions sought to achieve broad-based improvements in the quality of health care provided in LTC facilities and in patient safety.

We received mixed reactions from stakeholders in response to our revision of the LTC requirements. Overall, stakeholders supported the regulation's focus towards person-centered care and agreed that reforms to the existing requirements were necessary to ensure high quality care and quality of life in LTC facilities. While supportive of the

goals of the regulation, stakeholders noted that the changes needed to comply with the revised requirements will be costly and burdensome. Given the scope of the revisions, stakeholder requests for more time to comply with the requirements, and the financial impact that the regulation will impose on LTC facilities, we finalized a phased-in implementation of the requirements over a 3 year time period in hopes of reducing some of the burden placed on LTC facilities. Readers may refer to the October 2016 final rule (81 FR 68696) for a detailed discussion regarding the implementation timeframes for the requirements.

B. Areas of Possible Burden Reduction

In a continued effort to further respond to stakeholder concerns, we are currently reviewing the LTC requirements to balance the need to maintain quality of care while reducing procedural burdens on facilities. Specifically, we are reviewing the requirements for obsolete or redundant provisions, areas where processes can be streamlined to reduce burden and cost, or other areas of possible elimination.

As a result of our review, we have identified the following areas of the LTC requirements that we are considering for modification or removal in an effort to reduce the burden and financial impact imposed on LTC facilities:

1. Grievance Process

In the October 2016 final rule, we finalized a proposal at § 483.10(j) to extensively expand the grievance process in LTC facilities and require facilities to establish a grievance policy to ensure the prompt resolution of grievances, and identify a grievance officer to oversee the process. In public comments on the proposed rule, stakeholders supported the enhancement of residents' rights to voice grievances and emphasized the importance and seriousness of resident concerns. However, stakeholders also indicated that the expansion of the requirements for a grievance process will be overly burdensome and costly. Specifically, stakeholders indicated that maintaining evidence related to grievances for 3 years is burdensome and unnecessary. Stakeholders were also concerned regarding the additional costs associated with staffing a grievance official to oversee the grievance process.

We are considering areas where we may reduce the burden of these requirements. For example, we may reduce the financial cost associated with maintaining records by reducing the

amount of time that they must be retained. We may also consider removing prescriptive language in the requirements regarding the specific duties of the grievance official and allow facilities greater flexibility in how they ensure that grievances are fully addressed. We are reviewing these requirements to determine whether any of the abuse and neglect reporting requirements may be duplicative of state law. In instances where these requirements may potentially be duplicative we may be able to remove them entirely and defer to existing law.

2. Quality Assurance and Performance Improvement (QAPI)

In the October 2016 final rule, we finalized a proposal at § 483.75 to require LTC facilities to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life. Several stakeholders have indicated that our requirements are very detailed, too prescriptive, and significantly exceed the QAPI related requirements for other providers.

We are reviewing these requirements to determine if we can be less prescriptive while achieving a balance between specificity and flexibility in recognition of the diversity throughout LTC facilities. For example, in the areas of program design and scope we could propose to eliminate the detailed requirements regarding how the program must be designed and simply require facilities to design a program that is ongoing, comprehensive, and addresses the full range of care and services provided by the facility. Likewise, in the areas of program feedback, monitoring, and analysis we could eliminate the specific requirements for policies regarding exactly how a facility will determine underlying problems impacting systems in the facility, develop corrective actions, and monitor the effectiveness of its performance. We believe that such revisions will allow facilities greater flexibility in tailoring their QAPI program to fit the needs of their individual facility, eliminating unnecessary burden on facilities, while maintaining consistency with the requirements under section 1128I of the Act.

3. Discharge Notices

In the October 2016 final rule, we finalized a proposal at § 483.15(b)(3)(i) to require LTC facilities to send discharge notices to the state LTC Ombudsman. We are re-evaluating this requirement to determine if the process

is achieving intended objectives to reduce inappropriate involuntary discharges. In addition, we are concerned as to whether LTC Ombudsman have the capacity to receive and review these notices. We are soliciting comment as to whether LTC Ombudsman can handle receiving this material and to what extent they will use information once received.

C. Stakeholder Feedback

We are interested in receiving feedback regarding the realistic reduction in burden that these revisions may have on facilities and the possibility of unintended negative consequences that these potential revisions may impose on resident care and outcomes. We are also interested in receiving feedback regarding any additional areas of burden reduction and cost savings in LTC facilities. To the extent we proceed with rulemaking in this area, we will use this feedback and information to inform our policy decisions with regard to these issues. We invite general comment, but are particularly interested in data and analysis regarding associated costs and benefits.

VII. CMMI Solicitation

As the Center for Medicare and Medicaid Innovation (CMMI) continues developing models to test innovation and improvements to the Medicare program, we regularly engage with stakeholders to solicit ideas for models and concepts to test that have potential to improve the quality of care and reduce overall costs. CMMI authority affords us flexibility to test new ways of managing, delivering and paying for care for Medicare services. This flexibility includes utilizing waivers of statutory and regulatory requirements, such as waiving the qualifying 3-day inpatient hospital stay (QHS) requirement for skilled nursing facility (SNF) services, to allow the model participants to achieve the goals of the specific model. We are interested in receiving feedback on innovative concepts to potentially test in the post-acute care arena and key regulatory and statutory provisions that could be potentially waived if we were to implement any of these model tests. We encourage the submission of creative strategies that will accelerate changes to improve care and reduce costs for this important and often vulnerable population of beneficiaries who utilize post-acute services.

VIII. Request for Information on CMS Flexibilities and Efficiencies

CMS is committed to transforming the health care delivery system—and the Medicare program—by putting an additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes. We seek to reduce burdens for hospitals, physicians, and patients, improve the quality of care, decrease costs, and ensure that patients and their providers and physicians are making the best health care choices possible. These are the reasons we are including this Request for Information in this proposed rule.

As we work to maintain flexibility and efficiency throughout the Medicare program, we would like to start a national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. We aim to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible.

We would like to take this opportunity to invite the public to submit their ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas could include payment system redesign, changes to conditions of participation, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences. Responses to this Request for Information could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers. Where practicable, data and specific examples would be helpful. If the proposals involve novel legal questions, analysis regarding CMS' authority is welcome for CMS' consideration. We are particularly interested in ideas for incentivizing organizations and the full range of relevant professionals and paraprofessionals to provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and other substance use

disorders, including reimbursement methodologies, care coordination, systems and services integration, use of paraprofessionals including community paramedics and other strategies. We are requesting commenters to provide clear and concise proposals that include data and specific examples that could be implemented within the law.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise responses. This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense. We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2018 SNF PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential. This Request for Information should not be construed as

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

IX. Collection of Information Requirements

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

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

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

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

A. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding the SNF VBP Program

As discussed in the FY 2016 SNF PPS final rule (80 FR 46473) and the FY 2017 SNF PPS final rule (81 FR 52049 through 52050), we have specified claims-based measures to fulfill the SNF VBP Program's requirements. Because claims-based measures are calculated based on claims figures that are already submitted to the Medicare program for payment purposes, there is no additional respondent burden associated with data collection or submission for either the SNFRM or SNFPPR measures. Thus, there is no additional reporting burden associated with the SNF VBP Program's measures.

2. ICRs Regarding the Potentially Preventable 30-Day Post-Discharge Readmission Measure

We propose to modify the Potentially Preventable 30-Day Post-Discharge Readmission Measure by increasing the

length of the measurement period and updating the confidential feedback and public reporting dates, as described in section V.B.8. Since this is a claims-based measure, no data collection beyond the bills submitted in the normal course of business are required from providers for the calculation of this measure. Therefore, we believe the SNF QRP burden estimate is unaffected by the proposed modifications of this measure. The burden is unaffected since the proposed measure modifications have no impact on any of the reported data fields.

3. ICRs Regarding the Survey Team Composition

This regulation proposes to clarify the composition of a survey team. There is no new or additional burden associated with the proposed clarification.

4. ICRs Exempt From the PRA

As discussed elsewhere in this preamble, this rule proposes to adopt five new measures beginning with the FY 2020 SNF QRP (see section V.B.7. of this proposed rule), which would be calculated using data elements that are currently included in the MDS. The data elements are discrete questions and response codes that collect information on an IRF patient's health status, preferences, goals and general administrative information.

We are also proposing to require SNFs to report certain standardized patient assessment data beginning with the FY 2019 SNF QRP (see section V.B.10. of this proposed rule). We are proposing to define the term "standardized patient assessment data" as patient assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply. The standardized patient assessment data is intended to be shared electronically among PAC providers and will otherwise enable the data to be comparable for various purposes, including the development of cross-setting quality measures and to inform payment models that take into account patient characteristics rather than setting.

Under section 1899B(m) of the Act, the Paperwork Reduction Act does not apply to the specific changes in the collections of information described in this proposed rule.

These changes to the collections of information arise from section 2(a) of the IMPACT Act, which added new section 1899B to the Act. That section requires SNFs to report standardized patient assessment data, data on quality measures, and data on resource use and

other measures. All of this data must, under section 1899B(a)(1)(B) of the Act, be standardized and interoperable to allow for its exchange among PAC providers and other providers and the use by such providers in order to provide access to longitudinal information to facilitate coordinated care and improved Medicare beneficiary outcomes. Section 1899B(a)(1)(C) of the Act requires us to modify the MDS to allow for the submission of quality measure data and standardized patient assessment data to enable its comparison across IRFs and other providers.

The five new measures that we are proposing to adopt are as follows: (1) Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury; (2) Application of the IRF Function Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633); (3) Application of IRF Function Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634); (4) Application of IRF Function Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and (5) Application of IRF Function Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). We are also proposing that data for these new measures will be collected by SNFs and reported to CMS using the Resident Assessment Instrument, Minimum Data Set (MDS).

For the new measure "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury" the items used to calculate the revised measure are already present on the MDS, so the adoption of this measure will not require SNFs to report new data elements. In addition, some data elements related to pressure ulcers have been identified as duplicative and we are proposing to remove them. Taking these proposals together, we estimate that there will be a 1.5 minute reduction in clinical staff time needed to report the pressure ulcer measure data. Based on the data provided in Table 24 of this proposed rule, and estimating 2,886,336 discharges from 15,447 SNFs annually, we also estimate that the total cost of reporting these data would be reduced by \$324 per SNF annually, or \$5,007,793 for all SNFs annually. We believe that the MDS items we are proposing would be completed by registered nurses.

For the four newly proposed functional outcome measures (NQF: #2633, #2634, #2635, and #2636), we note that although some of the data elements needed to calculate these

measures are currently included on the MDS, other data elements would need to be added to the MDS. As a result, we estimate that reporting these measures would require an additional 9 minutes of nursing and therapy staff time to report data on admission and 5.5 minutes of nursing and therapy time to report data on discharge, for an additional total of 14.5 minutes per stay. We estimate that the additional MDS items we are proposing will be completed by Registered Nurses for approximately 7 percent of the time, Occupational Therapists for approximately 41 percent of the time, and Physical Therapists for approximately 52 percent of the time. Individual providers determine the staffing resources necessary. With 2,886,336 discharges from 15,447 SNFs annually, we estimate that the reporting of the four functional outcome measures would impose on SNFs an additional burden of 697,531 total hours (2,886,336 discharges × 14.5 min/60) or 45.16 hours per SNF (697,531 hr/15,447 SNFs). Of the 14.5 minutes per stay, 1 minute of that time is for a Registered Nurse, 3.5 minutes is for an Occupational Therapist, and 4.5 minutes is for a Physical Therapist for a total of 9 minutes are required for admission. For discharge, 2.5 minutes are for an Occupational Therapist, and 3 minutes for a Physical Therapist for a total of 5.5 minutes. For one stay we estimate a cost of \$19.69 or, in aggregate, an annual cost of \$56,829,551. Per SNF, we estimate an annual cost of \$3,679. A summary of these estimates is provided in Table 24.

Section V.B.10 of this rule proposes to adopt 35 standardized patient assessment data elements beginning with the FY 2020 SNF QRP. Thirty-four of the proposed standardized data elements are already reported to CMS on the MDS for admissions, and one is newly proposed for the admission assessment. For the discharge assessment, there are 13 standardized data elements that are already reported to CMS on the MDS for discharge, 11 that are not applicable to the discharge assessment and 11 standardized patient assessment data elements that would be added to the discharge assessment. For those data elements already reported to CMS on the MDS (34 on the admission assessment and 13 on the discharge assessment), there will be no additional burden associated with these data elements. The data elements can be viewed on our 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.

For the remaining twelve new data elements (one on the admission assessment and eleven on the discharge assessment), we estimate that these data elements will take 0.3 minutes of nursing/clinical staff time to report data on admission and 3.3 minutes of nursing/clinical staff time to report data on discharge, for a total of 3.6 minutes. We estimate that the additional data elements we are proposing will be completed by Registered Nurses for approximately 25 percent of the time and Licensed Vocational Nurses for approximately 75 percent of the time. Individual providers determine the staffing resources necessary. Estimating 2,886,336 discharges from 15,447 SNFs annually, this would equate to 173,180

total hours (2,886,336 discharges × 3.6 min/60) or 11.21 hours per SNF annually (173,180 hr/15,447 SNFs).

Of the 3.6 minutes per stay, 0.9 minute is allocated to the Registered Nurse and 2.7 minutes is allocated to the Licensed Vocational Nurse. For one stay we estimate a cost of \$2.98 or, in aggregate, an annual cost of \$8,605,322. Per SNF we estimate an annual cost of \$547.46. A summary of these estimates is provided in Table 24.

In summary, given the 1.5 minute reduction in burden associated with the new pressure ulcer measure and removal of duplicative pressure ulcer data elements, the additional 14.5 additional minutes of burden for the functional outcome measures, and the 3.6 additional minutes of burden for the proposed standardized data elements, the overall cost associated with

proposed changes to the SNF QRP is estimated at an additional \$3,912 per SNF annually, or \$60,427,080 for all SNFs annually. A summary of these estimates is provided in Table 24.

Under section 1899B(m) of the Act, the Paperwork Reduction Act does not apply to the specific changes to the collections of information described in this proposed rule. We are, however, setting out the burden as a courtesy to advise interested parties of the proposed actions' time and costs and for reference refer to section XI.A of this proposed rule of the regulatory impact analysis (RIA). The requirement and burden will be submitted to OMB for review and approval when the modifications to the MDS have achieved standardization and are no longer exempt from the requirements under section 1899B(m) of the Act.

TABLE 24—CALCULATION OF COST

QRP QM	Data elements	Minutes	Aggregate annual hours all SNFs	Hours per SNF annually	Dollars per stay	Aggregate annual cost all SNFs	Annual cost per SNF
Functional Outcome Measures	18	14.5	697,531	45.16	\$19.69	\$56,829,551	\$3,679
Standardized Data Elements	12	3.6	173,180	11.21	2.98	8,605,322	557
Changes in Skin Integrity	(3)	(1.5)	(72,158)	(4.67)	(1.74)	(5,007,793)	(324)
Total	27	17	798,553	52	21	60,427,080	3,912

Number of Skilled Nursing Facilities = 15,447.

Number of Discharges = 2,886,336.

B. Submission of PRA-Related Comments

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

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS-1679-P) and, where applicable, the preamble section, and the ICR section.

See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

X. 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.

XI. 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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic,

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

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs

associated with at least two prior regulations. OMB's implementation guidance, issued on April 5, 2017, explains that "Federal spending regulatory actions that cause only income transfers between taxpayers and program beneficiaries (for example, regulations associated with . . . Medicare spending) are considered 'transfer rules' and are not covered by EO 13771 However . . . such regulatory actions may impose requirements apart from transfers In those cases, the actions would need to be offset to the extent they impose more than de minimis costs. Examples of ancillary requirements that may require offsets include new reporting or recordkeeping requirements." The implications of the rule's costs and cost savings will be further considered in the context of our compliance with Executive Order 13771.

2. Statement of Need

This proposed rule would update the FY 2017 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach on these issues.

3. Overall Impacts

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2017 (81 FR 51970). Based on the above, we estimate that the aggregate impact would be an increase of \$390 million in payments to SNFs in FY 2018, resulting from the SNF market basket update to the payment rates, as required by section 1888(e)(5)(B)(iii) of the Act. 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.

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

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, if not for the enactment of section 411(a) of MACRA (as discussed in section III.B of this proposed rule), we would update the FY 2017 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 2018. As discussed previously, section 1888(e)(5)(B)(iii) of the Act establishes a special rule for FY 2018 requiring the market basket percentage used to update the federal SNF PPS rates to be equal to 1.0 percent. The impact to Medicare is included in the total column of Table 25. In updating the SNF PPS rates for FY 2018, 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 2018. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2018 SNF PPS payment impacts appear in Table 25. Using the most recently available data, in this case FY 2016, we apply the current FY 2017 wage index and labor-related share value to the number of payment days to simulate FY 2017 payments. Then, using the same FY 2016 data, we apply

the proposed FY 2018 wage index and labor-related share value to simulate FY 2018 payments. We tabulate the resulting payments according to the classifications in Table 25 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2017 payments to the simulated FY 2018 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 2018 payments. The update of 1.0 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 1.0 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 25, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes proposed in this rule, providers in the urban Pacific region would experience a 1.5 percent increase in FY 2018 total payments.

TABLE 25—PROJECTED IMPACT TO THE SNF PPS FOR FY 2018

	Number of facilities FY 2018	Update wage data (%)	Total change (%)
Group:			
Total	15,447	0.0	1.0
Urban	10,992	0.1	1.1
Rural	4,455	-0.6	0.4
Hospital-based urban	517	0.2	1.2
Freestanding urban	10,475	0.1	1.1

TABLE 25—PROJECTED IMPACT TO THE SNF PPS FOR FY 2018—Continued

	Number of facilities FY 2018	Update wage data (%)	Total change (%)
Hospital-based rural	575	-0.7	0.3
Freestanding rural	3,880	-0.6	0.4
Urban by region:			
New England	791	0.2	1.2
Middle Atlantic	1,485	0.4	1.4
South Atlantic	1,867	-0.2	0.8
East North Central	2,117	0.0	1.0
East South Central	551	-0.6	0.4
West North Central	919	0.4	1.4
West South Central	1,333	0.1	1.1
Mountain	509	-0.2	0.8
Pacific	1,415	0.5	1.5
Outlying	5	-1.9	-0.9
Rural by region:			
New England	137	1.5	2.6
Middle Atlantic	215	-0.4	0.6
South Atlantic	502	-0.7	0.3
East North Central	934	-1.1	-0.2
East South Central	527	-0.9	0.1
West North Central	1,077	-0.3	0.7
West South Central	737	-0.8	0.2
Mountain	228	-0.4	0.6
Pacific	98	0.2	1.2
Ownership:			
Profit	10,805	0.0	1.0
Non-profit	3,590	0.0	1.0
Government	1,052	-0.3	0.7

Note: The Total column includes the 1.0 percent market basket increase required by section 1888(e)(5)(B)(iii) of the Act. Additionally, we found no SNFs in rural outlying areas.

5. Estimated Impacts for the SNF QRP

Estimated impacts for the SNF QRP are based on analysis discussed in section V.B. of this proposed rule. For the 1.5 minute reduction in burden associated with the new pressure ulcer

measure and the removal of duplicative pressure ulcer data elements, the additional 14.5 additional minutes of burden for the functional outcome measures, and the 3.6 additional minutes of burden for the proposed standardized data elements, the overall

cost associated with proposed changes to the SNF QRP is estimated at an additional \$3,912 per SNF annually, or \$60,427,080 for all SNFs annually. A summary of these estimates is provided in Table 26.

TABLE 26—CALCULATION OF COST PER QUALITY MEASURE

QRP QM	Data elements	Minutes	Aggregate annual hours all SNFs	Hours per SNF annually	Dollars per stay	Aggregate annual cost all SNFs	Annual cost per SNF
Functional Outcome Measures	18	14.5	697,531	45.16	\$19.69	\$56,829,551	\$3,679
Standardized Data Elements	12	3.6	173,180	11.21	2.98	8,605,322	557
Changes in Skin Integrity	(3)	(1.5)	(72,158)	(4.67)	(1.74)	(5,007,793)	(324)
Total	27	17	798,553	52	21	60,427,080	3,912

Number of Skilled Nursing Facilities = 15,447.

Number of Discharges = 2,886,336.

6. Estimated Impacts for the SNF VBP Program

Estimated impacts of the FY 2019 SNF VBP Program are based on historical data that appear in Table 27. We modeled SNFs' performance in the Program using SNFRM data from CY 2013 as the baseline period and CY 2015 as the performance period. Additionally, we modeled a logistic

exchange function with a payback percentage of 60 percent, as discussed further in the preamble to this proposed rule.

As illustrated in Table 27, the effects of the SNF VBP Program vary by specific types of providers and by location. For example, we estimate that rural SNFs perform better on the SNFRM, on average, compared to urban SNFs. Similarly, we estimate that non-

profit SNFs perform better on the SNFRM compared to for-profit SNFs, and that government-owned SNFs perform better still. We also estimate that smaller SNFs (measured by bed size) tend to perform better, on average, compared to larger SNFs. (We note that the risk-standardized readmission rates presented below are *not* inverted; that is, lower rates represent better performance).

These differences in performance on the SNFRM result in differences in value-based incentive payment percentages computed by the Program. For example, we estimate that, at the proposed 60 percent payback percentage, SNFs in urban areas would receive a 1.161 percent incentive

multiplier, on average, in FY 2019, while SNFs in rural areas would receive a slightly higher incentive multiplier of 1.227 percent, on average. Additionally, SNFs in the smallest 25 percent as measured by bed size would receive an incentive multiplier of 1.203 percent, on average, while SNFs in the 2nd quartile

as measured by bed size would receive an incentive multiplier of 1.166 percent, on average. We note that the multipliers that we have listed in Table 27 are applied to SNFs' adjusted Federal per diem rates *after* application of the 2 percent reduction to those rates required by statute.

TABLE 27—ESTIMATED FY 2019 SNF VBP PROGRAM IMPACTS

Category	Criterion	Number of facilities	RSRR (mean)	Mean incentive multiplier (60% payback)	Percent of proposed payback
Group	Total	15,746	0.19061	1.218	100.0
	Urban	11,116	0.18790	1.161	83.5
	Rural	4,630	0.18293	1.227	16.5
Urban by Region	Total	11,116			
	01=Boston	808	0.18734	1.165	5.978
	02=New York	922	0.18848	1.116	10.590
	03=Philadelphia	1,132	0.18611	1.307	10.295
	04=Atlanta	1,890	0.19291	1.025	12.443
	05=Chicago	2,330	0.18728	1.213	16.248
	06=Dallas	1,379	0.19131	0.920	6.126
	07=Kansas City	666	0.18764	1.109	2.815
	08=Denver	323	0.17831	1.644	2.879
	09=San Francisco	1,325	0.18518	1.174	12.107
	10=Seattle	341	0.17634	1.765	3.983
Rural by Region	Total	4,630			
	01=Boston	145	0.17458	1.648	1.009
	02=New York	94	0.17746	1.435	0.409
	03=Philadelphia	287	0.18145	1.231	1.431
	04=Atlanta	918	0.18633	1.011	3.363
	05=Chicago	1,127	0.18156	1.361	4.662
	06=Dallas	814	0.18676	0.926	1.824
	07=Kansas City	801	0.18459	1.291	1.575
	08=Denver	284	0.17596	1.570	0.883
	09=San Francisco	68	0.16620	1.650	0.706
	10=Seattle	92	0.17488	1.569	0.670
Ownership Type	Total	15,746			
	Government	1,096	0.17844	1.240	4.601
	Profit	10,973	0.18864	1.113	71.137
	Non-Profit	3,677	0.18225	1.364	24.260
No. of Beds:	1st Quartile:	3,986	0.17935	1.203	13.393
	2nd Quartile:	3,937	0.18646	1.166	19.738
	3rd Quartile:	3,887	0.19009	1.148	26.388
	4th Quartile:	3,938	0.19000	1.204	40.481

7. Alternatives Considered

As described in this section, we estimate that the aggregate impact for FY 2018 under the SNF PPS would be an increase of \$390 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as required by section 1888(e)(5)(B)(iii) of the Act.

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology.

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

8. Accounting Statement

As required by OMB Circular A-4 (available online at www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf), in Table 28, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule for FY 2018. Table 28 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 15,447 SNFs in our database and the cost for the SNF QRP of implementing the IMPACT Act.

TABLE 28—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2017 SNF PPS FISCAL YEAR TO THE 2018 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	\$390 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.
FY 2018 Cost to Updating the Quality Reporting Program	
Category	Costs
Cost for SNFs to Submit Data for the Quality Reporting Program	\$60 million.

* The net increase of \$390 million in transfer payments is a result of the market basket increase of \$390 million.

9. Conclusion

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2017 (81 FR 51970). Based on the above, we estimate the overall estimated payments for SNFs in FY 2018 are projected to increase by \$390 million, or 1.0 percent, compared with those in FY 2017. We estimate that in FY 2018 under RUG–IV, SNFs in urban and rural areas would experience, on average, a 1.1 percent increase and 0.4 percent increase, respectively, in estimated payments compared with FY 2017. Providers in the rural New England region would experience the largest estimated increase in payments of approximately 2.6 percent. Providers in the urban Outlying region would experience the largest estimated decrease in payments of 0.9 percent.

Additionally, § 488.314 regarding survey team composition implements section 1819(g)(4) of the Act and provides that States may maintain and utilize a specialized team that need not include a registered nurse for the investigation of complaints. Section 1919 of the Act contains the same statutory language as applicable to Nursing Facilities (NFs). The regulations in part 488 were originally established under the authority of the sections 1819 and 1919 of the Act, which were added by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (Pub. L. 100–203, enacted on December 22, 1987) and further amendments to OBRA 87 by subsequent 1988, 1989, and 1990 legislation.

Sections 4204(b) and 4214(d) of OBRA 87 pertain to skilled nursing facilities (SNFs) and nursing facilities (NFs), respectively, and provide for a waiver of PRA requirements for the regulations that implement the OBRA '87 requirements. The provisions of OBRA 87 that exempt agency actions to collect information from states or facilities relevant to survey and enforcement activities from the PRA are not time-limited.

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 97 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 Web site at <http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards>). In addition, approximately 23 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 2017 (81 FR 51970). Based on the above, we estimate that the aggregate impact for FY 2018 would be an increase of \$390 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 25 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 2018 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2017 Report to Congress (available at http://medpac.gov/docs/default-source/reports/mar17_medpac_ch8.pdf), MedPAC states that Medicare covers approximately 11 percent of total patient days in freestanding facilities and 21 percent of facility revenue (March 2017 MedPAC Report to Congress, 202). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 25. As indicated in Table 25, the effect on facilities is projected to be an aggregate positive impact of 1.0 percent for FY 2018. As the overall impact on the industry as a whole, and thus on small entities specifically, is less than the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities for FY 2018.

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 2017 (81 FR 51970)), 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 25, the effect on facilities for FY 2018 is projected to be an aggregate positive impact of 1.0 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small rural hospitals for FY 2018.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2017, that threshold is approximately \$148 million. This proposed rule will impose no mandates on state, local, or tribal governments or on the private sector.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This proposed rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

E. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

F. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all

commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is \$90.16 per hour, including overhead and fringe benefits https://www.bls.gov/oes/2015/may/naics4_621100.htm. Assuming an average reading speed, we estimate that it would take approximately 4 hours for the staff to review half of this proposed rule. For each SNF that reviews the rule, the estimated cost is \$361 (4 hours × \$90.16). Therefore, we estimate that the total cost of reviewing this regulation is \$34,295 (\$361 × 95 reviewers).

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

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 411

Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 488

Administrative practice and procedure, Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS

- 1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

- 2. Section 409.30 is amended by revising the introductory text to read as follows:

§ 409.30 Basic requirements.

Posthospital SNF care, including SNF-type care furnished in a hospital or CAH that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31. A beneficiary in an SNF is also considered to meet the level of care requirements of § 409.31 up to and including the assessment reference date for the 5-day assessment prescribed in § 413.343(b) of this chapter, when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. For the purposes of this section, the assessment reference date is defined in accordance with § 483.315(d) of this chapter, and must occur no later than the eighth day of posthospital SNF care.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

- 3. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

- 4. Section 411.15 is amended by revising paragraph (p)(3)(iii) to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(p) * * *

(3) * * *

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only for those services that CMS designates as being beyond the general scope of SNF comprehensive care plans, as required under § 483.21(b) of this chapter); or

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

■ 5. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302; 42 U.S.C. 1395d(d); 42 U.S.C. 1395f(b); 42 U.S.C. 1395g; 42 U.S.C. 1395l(a), (i), and (n); 42 U.S.C. 1395x(v); 42 U.S.C. 1395hh; 42 U.S.C. 1395rr; 42 U.S.C. 1395tt; 42 U.S.C. 1395ww; sec. 124 of Public Law 106–113, 113 Stat. 1501A–332; sec. 3201 of Public Law 112–96, 126 Stat. 156; sec. 632 of Public Law 112–240, 126 Stat. 2354; sec. 217 of Public Law 113–93, 129 Stat. 1040; sec. 204 of Public Law 113–295, 128 Stat. 4010; and sec. 808 of Public Law 114–27, 129 Stat. 362.

■ 6. The heading for part 413 is revised to read as set forth above.

■ 7. Section 413.333 is amended by revising the definition of “Resident classification system” to read as follows:

§ 413.333 Definitions.

* * * * *

Resident classification system means a system for classifying SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria. For purposes of this subpart, this term refers to the current version of the resident classification system, as set forth in the annual publication of Federal prospective payment rates described in § 413.345.

* * * * *

■ 8. Section 413.337 is amended by adding paragraph (d)(4) to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(d) * * *

(4) *Penalty for failure to report quality data.* For fiscal year 2018 and subsequent fiscal years—

(i) In the case of a SNF that does not meet the requirements in § 413.360, for a fiscal year, the SNF market basket index percentage change for the fiscal year (as specified in paragraph (d)(1)(v) of this section, as modified by any applicable forecast error adjustment under paragraph (d)(2) of this section, reduced by the MFP adjustment specified in paragraph (d)(3) of this section, and as specified for FY 2018 in section 1888(e)(5)(B)(iii) of the Act), is further reduced by 2.0 percentage points.

(ii) The application of the 2.0 percentage point reduction specified in

paragraph (d)(4)(i) of this section to the SNF market basket index percentage change may result in such percentage being less than zero for a fiscal year, and may result in payment rates for that fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Any 2.0 percentage point reduction applied pursuant to paragraph (d)(4)(i) of this section will apply only to the fiscal year involved and will not be taken into account in computing the payment amount for a subsequent fiscal year.

* * * * *

■ 9. Section 413.338 is added to read as follows:

§ 413.338 Skilled Nursing Facility Value-Based Purchasing.

(a) *Definitions.* (1) *Achievement threshold (or achievement performance standard)* means the 25th percentile of SNF performance on the SNF readmission measure during the baseline period for a fiscal year.

(2) *Adjusted Federal per diem rate* means the payment made to SNFs under the skilled nursing facility prospective payment system (as described under section 1888(e)(4)(G) of the Act).

(3) *Applicable percent* means for FY 2019 and subsequent fiscal years, 2.0 percent.

(4) *Baseline period* means the time period used to calculate the achievement threshold, benchmark and improvement threshold that apply for a fiscal year.

(5) *Benchmark* means, for a fiscal year, the arithmetic mean of the top decile of SNF performance on the SNF readmission measure during the baseline period for that fiscal year.

(6) *Logistic exchange function* means the function used to translate a SNF's performance score on the SNF readmission measure into a value-based incentive payment percentage.

(7) *Improvement threshold (or improvement performance standard)* means an individual SNF's performance on the SNF readmission measure during the applicable baseline period.

(8) *Performance period* means the time period during which performance on the SNF readmission measure is calculated for a fiscal year.

(9) *Performance standards* are the levels of performance that SNFs must meet or exceed to earn points under the SNF VBP Program for a fiscal year, and are announced no later than 60 days prior to the start of the performance period that applies to the SNF readmission measure for that fiscal year.

(10) *Ranking* means the ordering of SNFs based on each SNF's performance

score under the SNF VBP Program for a fiscal year.

(11) *SNF readmission measure* means, for a fiscal year, the all-cause all-condition hospital readmission measure (SNFRM) or the all-condition risk-adjusted potentially preventable hospital readmission rate (SNFPPR) specified by CMS for application in the SNF Value-Based Purchasing Program.

(12) *Performance score* means the numeric score ranging from 0 to 100 awarded to each SNF based on its performance under the SNF VBP Program for a fiscal year.

(13) *SNF Value-Based Purchasing (VBP) Program* means the program required under section 1888(h) of the Social Security Act.

(14) *Value-based incentive payment amount* is the portion of a SNF's adjusted Federal per diem rate that is attributable to the SNF VBP Program.

(15) *Value-based incentive payment adjustment factor* is the number that will be multiplied by the adjusted Federal per diem rate for services furnished by a SNF during a fiscal year, based on its performance score for that fiscal year, and after such rate is reduced by the applicable percent.

(b) *Applicability of the SNF VBP Program.* The SNF VBP Program applies to SNFs, including facilities described in section 1888(e)(7)(B).

(c) *Process for reducing the adjusted Federal per diem rate and applying the value-based incentive payment adjustment factor under the SNF VBP Program—*(1) *General.* CMS will make value-based incentive payments to each SNF based on its performance score for a fiscal year under the SNF VBP Program under the requirements and conditions specified in this paragraph.

(2) *Value-based incentive payment amount—*(i) *Available amount.* The total amount available for value-based incentive payments for a fiscal year is equal to 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS.

(ii) *Calculation of the value-based incentive payment amount.* The value-based incentive payment amount is calculated by multiplying the adjusted Federal per diem rate by the value-based incentive payment adjustment factor, after the adjusted Federal per diem rate has been reduced by the applicable percent.

(iii) *Calculation of the value-based incentive payment adjustment factor.* The value-based incentive payment adjustment factor calculated by estimating Medicare spending under the skilled nursing facility prospective payment system to estimate the total

amount available for value-based incentive payments, ordering SNFs by their SNF performance scores, then assigning an adjustment factor value for each performance score subject to the limitations set by the exchange function.

(iv) *Reporting of adjustment to SNF payments.* CMS will inform each SNF of the value-based incentive payment adjustment factor that will be applied to its adjusted Federal per diem rate for services furnished during a fiscal year at least 60 days prior to the start of that fiscal year.

(d) *Performance scoring under the SNF VBP Program.* (1) CMS will award points to SNFs based on their performance on the SNF readmission measure applicable to a fiscal year during the performance period applicable to that fiscal year as follows:

(i) CMS will award from 1 to 99 points for achievement to each SNF whose performance meets or exceeds the achievement threshold but is less than the benchmark.

(ii) CMS will award from 0 to 90 points for improvement to each SNF whose performance exceeds the improvement threshold but is less than the benchmark.

(iii) CMS will award 100 points to a SNF whose performance meets or exceeds the benchmark.

(2) The highest of the SNF's achievement, improvement and benchmark score will be the SNF's performance score for the fiscal year.

(e) *Confidential feedback reports and public reporting.* (1) Beginning October 1, 2016, CMS will provide quarterly confidential feedback reports to SNFs on their performance on the SNF readmission measure. SNFs will have the opportunity to review and submit corrections for this data by March 31st following the date that CMS provides the reports. Any such correction requests must be accompanied by appropriate evidence showing the basis for the correction.

(2) Beginning not later than 60 days prior to each fiscal year, CMS will provide SNF performance score reports to SNFs on their performance under the SNF VBP Program for a fiscal year. SNFs will have the opportunity to review and submit corrections to their SNF performance scores and ranking contained in these reports for 30 days following the date that CMS provides the reports. Any such correction requests must be accompanied by appropriate evidence showing the basis for the correction.

(3) CMS will publicly report the information described in paragraphs (e)(1) and (2) of this section on the Nursing Home Compare Web site.

(f) *Limitations on review.* There is no administrative or judicial review of the following:

(1) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under section 1888(h)(5) of the Act.

(2) The determination of the amount of funding available for value-based incentive payments under section 1888(h)(5)(C)(ii)(III) of the Act and the payment reduction under section 1888(h)(6) of the Act.

(3) The establishment of the performance standards under section 1888(h)(3) of the Act and the performance period.

(4) The methodology developed under section 1888(h)(4) of the Act that is used to calculate SNF performance scores and the calculation of such scores.

(5) The ranking determinations under section 1888(h)(4)(B) of the Act.

■ 10. Section 413.345 is revised to read as follows:

§ 413.345 Publication of Federal prospective payment rates.

CMS publishes information pertaining to each update of the Federal payment rates in the **Federal Register**. This information includes the standardized Federal rates, the resident classification system that provides the basis for case-mix adjustment, and the factors to be applied in making the area wage adjustment. This information is published before May 1 for the fiscal year 1998 and before August 1 for the fiscal years 1999 and after.

■ 11. Section 413.360 is added to subpart J to read as follows:

§ 413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

(a) *Participation start date.* Beginning with the FY 2018 program year, a SNF must begin reporting data in accordance with paragraph (b) of this section 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, which designates the SNF as operating in the Certification and Survey Provider Enhanced Reports (CASPER) system. For purposes of this section, a program year is the fiscal year in which the market basket percentage described in § 413.337(d) is reduced by two percentage points if the SNF does not report data in accordance with paragraph (b) of this section.

(b) *Data submission requirement.* (1) Except as provided in paragraph (c) of this section, and for a program year, SNFs must submit to CMS data on

measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Act, in the form and manner, and at a time, specified by CMS.

(2) CMS will consider a SNF to have complied with paragraph (b)(1) of this section for a program year if the SNF reports: 100 percent of the required data elements on at least 80 percent of the MDS assessments submitted for that program year.

(c) *Exception and extension requests.* (1) A SNF may request and CMS may grant exceptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the SNF.

(2) A SNF may request an exception or extension within 90 days of the date that the extraordinary circumstances occurred by sending an email to SNFQRPreconsiderations@cms.hhs.gov that contains all of the following information:

(i) SNF CMS Certification Number (CCN).

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) SNF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the SNF believes it will be able to again submit SNF QRP data and a justification for the proposed date.

(3) Except as provided in paragraph (c)(4) of this section, CMS will not consider an exception or extension request unless the SNF requesting such exception or extension has complied fully with the requirements in this paragraph (c).

(4) CMS may grant exceptions or extensions to SNFs without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affected the ability of a SNF to submit data in accordance with paragraph (b) of this section.

(d) *Reconsideration.* (1) SNFs that do not meet the requirement in paragraph

(b) of this section for a program year will receive a letter of non-compliance through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES-ASAP) system, as well as through the United States Postal Service. A SNF may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

(2) Reconsideration requests must be submitted to CMS by sending an email to *SNFQRPRReconsiderations@cms.hhs.gov* containing all of the following information:

- (i) SNF CCN.
- (ii) SNF Business Name.
- (iii) SNF Business Address.
- (iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) CMS identified reason(s) for non-compliance stated in the non-compliance letter.

(vi) Reason(s) for requesting reconsideration, including all supporting documentation. CMS will not consider an exception or extension request unless the SNF has complied fully with the requirements in paragraph (d)(2) of this section.

(3) CMS will make a decision on the request for reconsideration and provide notice of the decision to the SNF through the QIES-ASAP system and via letter sent through the United States Postal Service.

(e) *Appeals.* (1) A SNF that is dissatisfied with CMS' decision on a request for reconsideration may file an appeal with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

(2) [Reserved]

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 12. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.20 [Amended]

- 13. In § 424.20—
 - a. Amend paragraph (a)(1)(ii) by removing the phrase “to one of the Resource Utilization Groups designated” and adding in its place the phrase “one of the case-mix classifiers that CMS designates”; and
 - b. Amend paragraph (e)(2)(ii)(B)(2) by removing the reference “§ 483.40(e)” and adding in its place the reference “§ 483.30(e)”.

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 14. The authority citation for part 488 continues to read as follows:

Authority: Secs. 1102, 1128l, 1864, 1865, 1871 and 1875 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302, 1320a-7j, 1395aa, 1395bb, 1395hh) and 1395ll.

■ 15. Section 488.30(a) is amended by revising the definition of “Complaint surveys” to read as follows:

§ 488.30 Revisit user fee for revisit surveys.

(a) * * *
Complaint surveys means those surveys conducted on the basis of a substantial allegation of noncompliance, as defined in § 488.1. The requirements of sections 1819(g)(4) and 1919(g)(4) of the Social Security Act and § 488.332 apply to complaint surveys.

■ 16. Section 488.301 is amended by revising the definition of “Abbreviated standard survey” to read as follows:

§ 488.301 Definitions.

* * * * *
Abbreviated standard survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change of ownership, management, or director of nursing; or other indicators of specific concern. Abbreviated standard surveys conducted to investigate a complaint or

to conduct on-site monitoring to verify compliance with participation requirements are subject to the requirements of § 488.332. Other premises for abbreviated standard surveys would follow the requirements of § 488.314.

* * * * *

- 17. In § 488.308—
 - a. Redesignate paragraphs (e)(2) and (3) as paragraphs (f)(1) and (2);
 - b. Reserve paragraph (e)(2);
 - b. Add a paragraph heading for paragraph (f); and
 - c. Revise newly redesignated paragraph (f)(1) introductory text.

The addition and revision read as follows:

§ 488.308 Survey frequency.

* * * * *

(f) *Investigation of complaints.* (1) The survey agency must review all complaint allegations and conduct a standard or an abbreviated survey to investigate complaints of violations of requirements by SNFs and NFs if its review of the allegation concludes that—

* * * * *

■ 18. Section 488.314 is amended by revising paragraph (a)(1) to read as follows:

§ 488.314 Survey teams.

(a) * * *
(1) Surveys under sections 1819(g)(2) and 1919(g)(2) of the Social Security Act must be conducted by an interdisciplinary team of professionals, which must include a registered nurse.

* * * * *

Dated: April 21, 2017.
Seema Verma,
Administrator, Centers for Medicare & Medicaid Services.

Dated: April 21, 2017.
Thomas E. Price,
Secretary, Department of Health and Human Services.

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