



## SKILLED NURSING FACILITY PPS:

### PROPOSED RULE FOR FY 2018 & ADVANCE NOTICE OF PROPOSED RULEMAKING

#### AT A GLANCE

##### **The Issue:**

On May 4, the Centers for Medicare & Medicaid Services (CMS) published two items related to the skilled nursing facility (SNF) prospective payment system (PPS) – its fiscal year (FY) 2018 [proposed rule](#) and an advance notice of proposed rulemaking that seeks public comment on potential major refinements the agency plans to propose in FY 2019.

Under the proposed rule, SNFs would receive a 1.0 percent payment update, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015, which translates into a \$390 million increase over FY 2017 payments. Additionally, CMS proposes to add four outcome measures on resident functional status to the FY 2020 SNF Quality Reporting Program (QRP), and modify the Potentially Preventable 30 Day Post-Discharge Readmissions to be based on two years of claims data rather than one, as originally specified. In accordance with the Improving Medicare Post-Acute Care Transformation Act of 2014, CMS proposes to require the reporting of certain standardized patient assessment data starting in FY 2019; most of this data is already reported by SNFs in the Minimum Data Set. CMS also proposes program details for the SNF Value-Based Purchasing FY 2020 program year, including performance standards and an incentive payment distribution methodology.

In the advanced notice, CMS proposes a new methodology to improve the accuracy of Medicare payments to SNFs. CMS would base payments on patient characteristics instead of service utilization. In addition, the current payment categories known as RUGs would be replaced with a methodology that bases payment on a patient's clinical characteristics in four domains: physical and occupational therapy; speech-language pathology; nursing; and non-therapy ancillaries.

*The proposed rule is summarized in this advisory and a summary of the advance notice of proposed rulemaking that was prepared for the AHA by Health Policy Alternatives Inc. is available [online](#).*

##### **Our Take:**

The payment provisions in the SNF PPS proposed rule are brief and straight forward. However, for hospital-based providers that face significantly negative Medicare margins, the payment update continues to be inadequate. On the QRP proposals, AHA is concerned that the submission of new data elements required in such a short time frame would result in an overly complex and burdensome task for providers. For the SNF VBP program, AHA is troubled with the lack of transparency around the process to determine incentive payment distribution. We urge CMS to provide more information on the results of its modeling and other background on how the agency arrived at decisions for the VBP program.

Given the chronic underpayment of hospital-based SNFs, we are encouraged by the direction of the reforms put forward in the advance notice that appear to benefit hospital-based SNFs. In particular, it appears the new approach would more adequately reimburse providers treating greater proportions of high-complexity/low-therapy patients, such as hospital-based SNFs.

##### **What You Can Do:**

- ✓ Share the attached summary with your senior management team to examine the impact these payment changes would have on your organization for FY 2018.
- ✓ Submit a comment letter on the proposed rule to CMS by June 26 explaining the impact the rule would have on your patients, staff and facility.
- ✓ Participate in the AHA-member call on Friday, May 19 at 2 p.m. ET. [Click here](#) to register in advance.

##### **Further Questions:**

Please contact Rochelle Archuleta, AHA director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org) for questions on payment provisions, and Caitlin Gillooley, associate director of policy, at [cgillooley@aha.org](mailto:cgillooley@aha.org) for quality-related questions.



## **SKILLED NURSING FACILITY PPS:**

### **PROPOSED RULE FOR FY 2018 & ADVANCE NOTICE OF PROPOSED RULEMAKING**

#### **Proposed Rule for FY 2018**

On May 4, the Centers for Medicare & Medicaid Services (CMS) published its [proposed rule](#) for fiscal year (FY) 2018 for the skilled nursing facility (SNF) prospective payment system (PPS). As mandated by Congress, SNF PPS payments in FY 2018 would be updated by 1.0 percent. Due to their unique case-mix profiles, rural hospital-based SNFs would receive an average increase of 0.3 percent, while urban hospital-based SNFs would receive an average increase of 1.2 percent.

#### **Proposed FY 2018 Payment Update**

##### ***Market-basket Update***

Under the proposed rule, SNFs would receive a 1.0 percent payment update, as mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which translates into a \$390 million increase over FY 2017 payments. CMS did not propose a market-basket forecast error adjustment for FY 2018 since the difference between the actual and estimated market basket for FY 2016 did not exceed 0.5 percentage point.

##### ***Revising and Rebasings the SNF Market Basket***

Although the payment update amount for FY 2018 is mandated by MACRA, CMS proposes to revise and rebase the SNF market basket for FY 2018 and beyond. Specifically, the agency would rebase the SNF PPS market basket using FY 2014 cost reports, instead of those from FY 2010, to utilize more current, routine, ancillary and capital-related costs from freestanding SNFs. In addition, the market basket would be revised with updated cost categories and price proxies. CMS proposes to maintain its policy of using data from freestanding SNFs (which represent 93 percent of all SNFs) as opposed to hospital-based SNF data, as hospital-based SNF data require more complex calculations and assumptions about how to handle ancillary costs. The proposed rule also notes that the 2014 Medicare cost reports represent the most recent, complete set of cost report data available. It also explains that CMS is no longer referring to the market basket in “fiscal year” terms since the majority of SNF cost reporting periods began January 1, 2014. Table 9 in the proposed rule compares the major cost categories and

their respective cost weights from FY 2010 and 2014. The full discussion on CMS's methodology to construct the new market basket can be found on pages 21029 through 21039 of the proposed rule.

### ***Case-mix Adjustment***

For FY 2018, no change is proposed to the SNF PPS's resource utilization group version 4 (RUG-IV) case-mix classification system, or to version 3.0 of the Minimum Data Set (MDS), which categorizes patients for payment. However, we note that CMS's separate advance notice of proposed rulemaking seeks public comment on potential SNF PPS revisions in FY 2019, and is discussed at the end of this document. The proposed rule lists the 66 RUG-IV payment categories for urban and rural SNFs for FY 2018, along with corresponding case-mix values, in Tables 4 and 5, respectively.

### ***Area Wage Index***

To establish the SNF PPS wage index for FY 2018, CMS would use the same methodology as prior years, along with hospital wage data from cost reports beginning from FY 2014. The proposed SNF PPS wage index applicable for FY 2018 is available in Table A on the CMS [webpage](#).

### ***Labor-related Share***

CMS proposes a labor-related share of 70.8 percent for FY 2018, an increase compared with the FY 2017 share of 69.1 percent. Tables 6 and 7 in the rule provide the labor and non-labor related shares of the proposed case-mix adjusted RUG-IV payments.

## **OTHER PAYMENT ISSUES & POLICY CLARIFICATIONS**

### ***Administrative Presumption***

As it did for the last three years, CMS reviews its administrative presumption that is applied to SNF patients being assigned a RUG per diem for the days leading up to the first mandatory patient assessment, which occurs on the fifth day of a SNF stay. The agency proposes the following technical changes to align current regulatory text with the guiding statute:

- Remove 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)” from the second sentence of §413.345;
- In §409.30, clarify that the assignment of a designated case-mix classifier would serve to trigger the administrative presumption only when that assignment is itself correct;
- Substitute the “resident classification system” definition for current language in §413.333; and
- Align cross-references to delegating physician tasks in SNFs.

As reviewed in the proposed rule, under this administrative presumption, CMS allows any patient initially classified into one of the upper 52 RUGs (for more

clinically complex patients) to be automatically designated as meeting the SNF level of care definition for the days up to and including the five-day assessment. These 52 RUGs fall in 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; and
- Clinically complex.

Under the administrative presumption, patients are automatically assigned into one of the 52 RUGs to set the per-diem payment rate for the first five days. Beneficiaries in one of the remaining 14 RUGs (for less clinically complex patients) receive an individualized determination, since it is less likely that these patients meet SNF admission criteria.

### **Consolidated Billing**

As it did in its FY 2015 through 2017 rulemaking, CMS reviews the requirement that SNFs submit consolidated medical bills for physical, occupational and speech-language therapy services for covered and non-covered Part A stays. Also, the agency proposes to revise §411.15(p)(3) to specify that CMS views certain exceptionally intensive types of outpatient hospital services as being generally beyond the scope of SNF care plans. In addition, CMS proposes to revise §411.15(p)(3)(iii) and related cross-references to reflect recent revisions in the long-term care facility requirements for participation.

In this rule, the agency again reviews the consolidated billing exclusions that allow separate billing under Part B for selected Part A “high-cost, low-probability” services that fall within these four categories:

- chemotherapy items;
- chemotherapy administration services;
- radioisotope services; and
- customized prosthetic devices.

CMS invites public comment to identify services in any of these four categories that have been subject to medical advances, which, as a result, now warrant an exclusion from SNF consolidated billing.

### **Swing Beds**

As it has in recent years, CMS again clarifies that all rates and wage indexes for the SNF PPS also apply to all non-critical access hospital swing beds. Per the FY 2010 SNF PPS final rule, these rural hospitals must complete a MDS 3.0 swing-

bed assessment. Information on the MDS for swing-bed rural hospitals is available on CMS's [website](#).

## **SNF QUALITY REPORTING PROGRAM (QRP)**

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that CMS establish the SNF QRP. Starting in FY 2018, SNFs that fail to meet all SNF QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments. A detailed summary of the IMPACT Act's requirements can be found in the AHA's October 16, 2014 [Legislative Advisory](#).

CMS adopted the first measures and several other program requirements and processes in the FY 2016 SNF PPS final rule, and additional measures in the FY 2017 final rule. In this rule, CMS proposes changes to the measures required in the SNF QRP and to require the reporting of certain standardized patient assessment data to meet the mandates of the IMPACT Act.

### ***FY 2020 Measurement Proposals***

CMS proposes to replace one measure, add four additional measures, and modify one measure for the FY 2020 SNF QRP. The four added measures are function outcome measures on resident functional status. These measures were finalized for inpatient rehabilitation facilities (IRF) in the FY 2017 IRF PPS, and CMS intends to propose these measures for long-term care hospitals (LTCH) and home health agencies in the future. Detailed specifications for the measures are available on CMS's SNF QRP [website](#).

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. CMS proposes to remove the current pressure ulcer measure in the SNF QRP, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay), and replace it with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. This modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator in addition to Stage 2, 3 and 4 pressure ulcers. This modified measure would satisfy the requirements of the IMPACT Act domain of skin integrity and changes in skin integrity.

In addition, the new measure is calculated differently. The current measure assesses new or worsened pressure ulcers, while the new measure counts all unhealed pressure ulcers minus any pressure ulcers that were present upon admission. The data for this measure would be collected using the SNF MDS 3.0, which is currently submitted by SNFs through the QIES ASAP System. **The AHA is concerned that the new data elements included in the proposed measure would be difficult for providers to capture, as there is no universally accepted definition of injuries like DTIs, and providers would be asked to report on a wholly different data element. We will urge CMS to provide guidance on the correct collection and calculation of the measure results.**

Application of SNF Functional Outcome Measures. These functional outcome measures estimate the following:

- The mean risk-adjusted improvement in self-care score between admission and discharge among SNF residents;
- The mean risk-adjusted improvement in mobility score between admission and discharge among SNF residents;
- The percentage of SNF residents who meet or exceed an expected discharge self-care score; and
- The percentage of residents who meet or exceed an expected discharge mobility score.

The measures would require 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 showering/bathing, dressing the upper body, dressing the lower body, toilet transfer, walking, eating, oral hygiene and bed mobility. The elements are each coded using a six-level rating scale that indicates the resident's level of independence with the activity; higher scores indicate more independence. The measures also would require 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. Data for the proposed quality measures would be collected using the MDS, with the submission through the QIES ASAP system.

The data elements included in the measures were originally developed and tested as part of the PAC-PRD version of the Continuity Assessment Record and Evaluation (CARE) Item Set. The measures underwent additional development through input from a technical expert panel and review by the National Quality Forum's Measure Applications Partnership. The latter group recommended caution in the interpretation of the measure results due to the differences in patients in various post-acute care (PAC) settings and also noted that the MDS already includes several function elements, rendering these measures as duplicative. CMS contends that the risk-adjustment factors would account for patient differences among PAC settings, and that the exact elements required for these measures are not duplicative of work already done in patient assessments in SNFs. In addition, because some of the data elements associated with the proposed measures are already included on the MDS (in Section GG, which is necessary to calculate other quality measures), CMS asserts there would not be additional burden on providers to collect this data. In short, CMS states that these measures could be completed with little additional burden and no duplication of effort.

Certain residents are excluded from the measure; generally, these are residents who are not expected to show any improvement in their functions. Excluded residents are those with certain conditions like progressive neurologic conditions as well as those who were independent on all self-care items at the time of admission.

Potentially Preventable 30-Days Post-Discharge Readmission Measure. CMS proposes to modify this measure by increasing the measurement period from one to two years of claims data.

This modification would expand the number of SNFs with 25 stays or more, which is the minimum number of stays required for public reporting. In addition, the two-year period would align the SNF measure with other potentially preventable readmissions measures used in other settings (i.e., LTCH and IRF), which use two years of data to calculate the measure.

To implement this modification, CMS proposes to update the dates associated with public reporting on this measure. CMS would shift the measure from the calendar year to the fiscal year, beginning with publicly reporting on claims data for discharges in FY 2016 and FY 2017. This would allow these measure data to be publicly available by October 2018.

### ***Proposed Standardized Patient Assessment Data Reporting: FY 2019 and FY 2020***

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. **The reporting of these data is made a requirement of the PAC QRPs, and as a result, failure to comply with the requirements would result in a payment reduction.** Currently, each PAC setting collects different patient assessment data in setting-specific tools. The SNF setting collects this data in the MDS 3.0, whereas LTCHs, IRFs and home health agencies collect different data elements in their own tools—the LTCH CARE Data Set (LCDS), Patient Assessment Instrument (PAI) and Outcome and Assessment Information Set (OASIS), respectively.

The standardized patient assessment data elements must satisfy five domains specified by CMS, which include functional status, cognitive function, special services, medical conditions and comorbidities, and impairments. Some of the items have been tested, either for individual settings or in the PAC Payment Reform Demonstration (PRD) study, and are already implemented in some settings.

FY 2019 Proposals. The IMPACT Act requires SNFs to report standardized patient assessment data starting with the FY 2019 SNF QRP. CMS has determined that the data elements used to calculate the current pressure ulcer measure (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, Short Stay) meet the definition of standardized patient assessment data with respect to the “medical conditions and co-morbidities” domain. Thus, successful reporting of that data for admissions and discharges during the quarter of CY 2017 would satisfy the requirement to report standardized patient assessment data for the FY 2019 SNF QRP.

FY 2020 Proposals. For the FY 2020 SNF QRP, CMS proposes the reporting of several patient assessment data elements with respect to Medicare Part A

admissions and discharges that occur between October 1, 2018 and December 31, 2018. Following this initial reporting year, subsequent years for the SNF QRP would be based on a full calendar year of data reporting. CMS proposes to extend the current administrative requirements for quality data to the patient assessment data, which include:

- Participation;
- Exception and extension;
- Reconsiderations; and
- Data completion thresholds

Most of the required data elements are already included in the MDS 3.0. Many of these items consist of a “principal” element, which is a question regarding whether a patient is receiving a particular service, as well as two or more “sub-elements,” which provide options regarding that service. For example, a principal element might ask if a patient is receiving chemotherapy, and sub-elements will ask what type of chemotherapy the patient is receiving: intravenous, oral or other. In some of the items, more than one of these sub-elements could be selected; in others, the sub-elements are mutually exclusive. While many “principal” items are already in the MDS, CMS would expand these items to include the new “sub-elements.” Below is the list and our analysis of proposed data elements in **Table 1**, including whether they currently exist in the MDS or other PAC tools, whether they were tested in the PAC PRD, and the number of items the measure would include.

**Table 1. AHA Analysis of Proposed Standardized Patient Assessment Data Elements**

Domain	Element	Currently in LCDS?	Currently in other PAC tool?	Tested in PAC PRD?	Number of items
Functional Status	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Yes (CARE Item set)	LCDS IRF-PAI	Yes	1
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	Yes	IRF-PAI	Yes	7
	Confusion Assessment Method (CAM)	Yes	LCDS	Yes	6
	Behavioral Signs and Symptoms	Yes	OASIS-C2	Yes	3
	Patient Health Questionnaire-2	Yes (part of PHQ-9)	OASIS-C2	Yes	2

Special Services, Treatments, and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	Yes (principal only)	No	Yes (sub)	1-4 (1 principal; 3 sub)
	Cancer Treatment: Radiation	Yes	No	No	1
	Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	Yes (principal only)	OASIS-C2	Yes*	1-2 (1 principal; 2 sub either/or)
	Respiratory Treatment: Suctioning (Scheduled, As needed)	Yes (principal only)	No	Yes*	1-2 (1 principal; 2 sub either/or)
	Respiratory Treatment: Tracheostomy Care	Yes	No	Yes*	1
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes (principal only)	LCDS (principal) OASIS-C2	Yes*	1-3 (1 principal; 2 sub)
	Respiratory Treatment: Invasive Mechanical Ventilator	Yes	LCDS	Yes*	1
	Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	Yes (principal only)	OASIS-C2	Yes (sub)	1-4 (1 principal; 3 sub)
	Other Treatment: Transfusions	Yes	OASIS-C2	Yes	1
	Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	Yes (principal only)	LCDS (principal)	Yes (sub)	1-2 (1 principal; 2 sub either/or)
	Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	No	No	Yes*	1-5 (1 principal; 4 sub)
	Nutritional Approach: Parenteral/IV Feeding	Yes	LCDS IRF-PAI OASIS-C2	Yes*	1
	Nutritional Approach: Feeding Tube	Yes	OASIS-C2	Yes*	1
	Nutritional Approach: Mechanically Altered Diet	Yes	IRF-PAI OASIS-C2	Yes*	1
	Nutritional Approach: Therapeutic Diet	Yes	No	Yes*	1

Medical Condition & Comorbidity	Percent of Resident or Patients with Pressure Ulcers that are New or Worsened	Yes	n/a	n/a	1
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Yes	n/a	n/a	1
Impairment	Hearing	Yes	OASIS-C2	Yes	1
	Vision	Yes	OASIS-C2	Yes	1
<b>Range of Patient Assessment Items (i.e. how many boxes to fill per patient)</b>					<b>38-53</b>

\*Item tested in PAC PRD not identical to item proposed; advisors agreed that element deemed feasible in PAC PRD is related or equivalent to proposed data element and thus reasonable for inclusion as a patient assessment data element.

If the proposal is finalized, providers would be asked to complete, at minimum, 38 patient assessment items, with up to 53 items that could be necessary to complete, depending on the patient.

### ***SNF QRP Public Reporting***

CMS proposes to publicly report data in CY 2018 for three assessment-based measures for which data collection began on October 1, 2016. The measures that would be reported include:

- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and Care Plan That Addresses Function;
- Application of Percent of Residents Experiencing One or More Falls with Major Injury; and
- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened.

For these measures, CMS proposes to assign SNFs with fewer than 20 eligible cases during a performance period to a separate, low-volume category; if a SNF is in this category, its performance would not be publicly reported for the measure for that performance period.

In addition, CMS proposes to publicly report data on three claims-based measures:

- Medicare Spending Per Beneficiary (MSPB);
- Discharge to Community; and
- Potentially Preventable 30-Day Post-Discharge Readmissions

These measures were adopted for the SNF QRP in the FY 2017 SNF PPS rule to be based on data from one calendar year; however, this proposed rule would revise the dates for public reporting to transition from the calendar year to the fiscal year. The first two measures, MSPB and Discharge to Community, would be

based on data collected from discharges beginning October 1, 2016 through September 30, 2017, and rates would be displayed based on one fiscal year of data. The third measure, Potentially Preventable Readmissions, would be based on data collected from discharges between October 1, 2015 through September 30, 2017, and rates would be displayed based on two consecutive fiscal years of data.

For these measures, CMS proposes to assign SNFs with fewer than 25 eligible cases (or fewer than 20 for the MSPB measure) during a performance period to a separate, low-volume category; if a SNF is in this category, its performance would not be publicly reported for the measure for that performance period.

### ***Quality Measures under Consideration for Future Years***

CMS invites public comment on the importance, relevance, appropriateness and applicability of quality measures for future years in the SNF QRP as well as the use of survey-based experience of care measures. The measures under consideration include:

- A measure focused on pain that relies on the collection of patient-reported pain data;
- Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine; and
- Patients Who Received an Antipsychotic Medication.

### ***Possible Future Update to Discharge to Community Measure***

CMS invites public comment on the possibility of modifying the Discharge to Community measure in the SNF QRP for future years. The measure assesses successful discharge to the community from a SNF setting with no unplanned re-hospitalizations and no death in the 31 days following discharge. It was finalized in the FY 2017 SNF PPS final rule for inclusion in the FY 2019 SNF QRP.

CMS received public comments recommending the exclusion of baseline nursing facility residents from the measure, as these residents did not live in the community prior to their stay and thus wouldn't necessarily be expected to return "successfully" to the community following discharge. CMS is considering modifying the measure to exclude these patients. **AHA supports this modification.**

In addition, CMS is 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 also would align the measurement period for this measure with that used in the IRF and LTCH settings.

### ***Development of Additional IMPACT Act Measure***

CMS is developing two new measures that would satisfy the IMPACT Act domain of accurately communicating the existence of and providing for the transfer of health information and care preferences when the individual transitions. The

measures under development in Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from other Providers/Settings; and Transfer of Information at Post-Acute Care Discharge, and End of Care to other Providers/Settings.

CMS intends to specify these measures no later than October 1, 2018 and intends to propose the measures for adoption for the FY 2021 SNF QRP with data collection beginning on or about October 1, 2019.

### **SNF VALUE-BASED PURCHASING PROGRAM (VBP)**

The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019. The SNF VBP program applies to freestanding SNFs, SNFs affiliated with acute care facilities and all non-critical access hospital swing-bed rural hospitals. The SNF VBP program must tie a portion of SNF Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs or a “potentially avoidable readmission” measure. A funding pool will be created by reducing each SNF’s Medicare per-diem payments by 2 percent. However, PAMA states that only 50 to 70 percent of the total pool may be distributed back to SNFs as incentive payments, which will be applied as a percentage increase to the Medicare per-diem rate. SNFs scoring at or below the 40<sup>th</sup> percentile of performance are not eligible for any incentive payment, and will receive the full 2 percent reduction.

In this proposed rule, CMS proposes establishment of the performance period and baseline periods for the FY2020 program year, scoring and payment calculation methodologies, public reporting requirements and other policies.

#### ***Transition from All-Cause to Potentially Preventable Readmission Measure***

As a prerequisite to implementing the SNF VBP program, CMS adopted the all-cause, all-condition hospital readmission measure in the FY 2017 SNF PPS final rule. In the FY 2017 SNF PPS final rule, CMS adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs. PAMA requires CMS to use the latter, potentially preventable readmission measure in the SNF VBP program instead of the all-cause all-condition measure “as soon as practicable.” CMS intends to propose a timeline for replacing the all-condition measure with the potentially preventable measure in future rulemaking.

CMS believes that FY 2021 would be the first opportunity to make this replacement, but has not yet determined whether this timeline is feasible. CMS requests public comments on when the replacement should take place, particularly in light of the proposed performance and baseline periods. **AHA believes that the transition to the potentially preventable readmissions measure should be made as soon as possible, as this measure more accurately represents the quality and value of care being provided at SNFs.**

### ***Proposed FY 2020 Performance and Baseline Periods***

CMS proposes to shift from the calendar year to the federal fiscal year for the performance and baseline periods. Currently, CMS uses the 12-month calendar year for the program coupled with an approximately 90-day claims run-out period following the last date of discharge. Due to this run-out period and the time it takes to calculate the measure rates and allow SNFs to review the rates, CMS is concerned that it might be delayed in meeting the notification requirement in PAMA, which requires CMS to notify SNFs of their value-based incentive payment percentages not later than 60 days prior to the fiscal year involved.

Because CMS believes that a 12-month performance and baseline period is necessary to provide a sufficiently reliable and valid data set, CMS proposes to adopt FY 2018 (October 1, 2017 through September 30, 2018) as the performance period for the FY 2020 SNF VBP program. The baseline period would thus be FY 2016 (October 1, 2015 through September 30, 2016). This shift would provide CMS with an additional three months between the end of the performance period and the 60-day notification deadline.

This transition would result in the 2017 fourth quarter (October 1, 2017 through December 31, 2017) performance being counted for both the FY 2019 program year and the FY 2020 program year. While CMS acknowledges this overlap, it believes that it is the best option. However, the agency welcomes feedback on alternatives to this timeline (including a one-time, three-quarter baseline and performance period for the FY 2020 program year that would not include 2017 fourth quarter).

### ***Scoring and Payment Percentage Methodologies***

SNFs have between 0 and 100 points available for their performance scores under the VBP program. Their scores place them in percentiles, which dictate the payment increases they may receive. CMS has developed several formulas to calculate SNF performance scores and payment percentages, and is requesting public comment on these methodologies. Details on the scoring methodology established in the FY 2017 SNF PPS final rule are available in AHA's August 2016 [Regulatory Advisory](#).

Rounding. Currently, CMS rounds SNF performance scores to the nearest whole number. This results in what CMS believes is an "insufficiently precise" outcome, including a significant number of tie scores. Clusters of providers around scores makes it difficult to determine the distribution of performance among all 16,000-plus SNFs in the program. Because of these challenges, CMS proposes to instead round results to the nearest ten-thousandth of a point.

Exchange Function. CMS will use an "exchange function" to translate SNF performance scores into value-based incentive payments. This will entail using a specific type of equation to assign a SNF an incentive payment (the outcome, on the Y-axis) based on their performance (the input, on the X-axis). CMS considered four possible types of functions to make these assignments: linear (which is used in the Hospital VBP and Hospital Readmission Reduction

programs), cube, cube root and logistic. In this consideration, CMS modeled the results using historical SNF performance data to determine which function provided the fairest distribution. In this exercise, CMS found that “the logistic function maximized the number of SNFs with positive payment adjustments ... [and] 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.”

Based on the results from this modeling exercise, CMS proposes to adopt a logistic function for the FY 2019 SNF VBP program and subsequent years. Under this policy, CMS will perform the following steps:

1. Estimate Medicare spending on SNF services for the FY 2019 payment year.
2. Estimate the total amount of reductions to the SNF adjusted federal per diem rates for the year.
3. Calculate the amount realized under the payback percentage.
4. Order SNFs by their performance scores.
5. Assign a value-based incentive payment multiplier to each SNF that corresponds to a point on the logistic exchange function (each point corresponds to a performance score).

The function’s specific form will depend on the distribution of SNF performance scores during the performance period, but the formula that CMS intends to use for the 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. CMS is open to public comments on this proposal, including on whether a linear function with adjustment would alternatively be feasible for the program.

Payback Percentage. As described above, the PAMA requires the Health and Human Services Secretary to reduce the adjusted federal per diem rate for SNF services by 2 percent. These reductions fund the value-based incentive payments for that fiscal year. The PAMA further specifies that the between 50 to 70 percent of the total reduction will be paid back to SNFs via incentive payments. CMS proposes that 60 percent of the total amount of the funds available be paid as value-based incentive payments, as it believes that this is the most appropriate payback to balance other implementation considerations described in the proposed rule. CMS intends to consider proposing to adjust this percentage in future rulemaking after seeing the program’s effects on readmission rates, potential unintended consequences on beneficiaries and SNF profit margins.

### ***Proposed FY 2020 Performance Standards***

In this proposed rule, CMS provides estimates of the numerical values of the achievement threshold and the benchmark for the FY 2020 program year. CMS based these values on the FY 2016 MedPAR files, including a 3-month run-out period. CMS intends to include the final numerical values in the FY 2018 SNF PPS final rule, but if it is unable to complete the necessary calculations in time, the agency will publish these values not later than 60 days prior to the beginning of the performance period for the FY 2020 program year. If this were to occur, CMS would notify SNFs and the public of those final values through a listerv email and a posting on the QualityNet News portion of the SNF VBP website.

Performance standards are based upon the higher of a SNF's achievement on the all-cause readmission rate measure versus a CMS-determined performance standard or its improvement versus its own performance on the measure in the baseline year. For the SNF 30-days All-Cause Readmission measure, CMS estimates the achievement threshold to be 0.80218. If using the improvement score, CMS will determine whether the score is equal to or higher than the benchmark; if it is, the SNF will score 90 points, which is the most possible when using the improvement score. CMS estimates the benchmark to be 0.83721.

### ***SNF VBP Public Reporting***

Confidential Feedback Reports. As described in the FY 2017 SNF PPS final rule, CMS intends to use the QIES system CASPER files to provide quarterly confidential feedback reports to SNFs on their performance in the VBP program. CMS welcomes feedback from SNFs on the contents of these quarterly reports, including what additional elements (if any) might be useful and what patient-level data would be most helpful.

Also in the FY 2017 final rule, CMS adopted a two-phase review and corrections process for quality measure data that will be publicly reported. In this rule, CMS proposes to limit phase two correction requests to a SNF's performance score and ranking, as SNFs would have already had the opportunity to correct their quality measure data in phase one.

CMS also proposes to provide these reports to SNFs at least 60 days prior to the fiscal year involved. SNFs would not be allowed to request corrections to their value-based incentive payment adjustments, but CMS would make confirming corrections to the payment adjustment if a SNF successfully requests a correction to its SNF performance score.

Phase two correction requests would be submitted the same way as in phase one: SNFs must submit requests to the [SNFVBPinquiries@cms.hhs.gov](mailto:SNFVBPinquiries@cms.hhs.gov) mailbox with the SNF's CMS certification number (CCN), SNF name and the correction requested. In this request, SNFs must identify the error for which it is requesting correction and submit documentation or other evidence (if available) supporting the request. CMS further proposes that SNFs must make any correction requests no later than 30 days following the date that CMS posts the SNF's annual performance score report via the QIES system CASPER files.

Public Reporting. CMS proposes to begin publishing SNF performance information under the SNF VBP Program on the *Nursing Home Compare* website not later than October 1, 2017. This information would include the ranking for each program year.

For the FY 2019 program year, CMS proposes to publish the rankings after August 1, 2018, along with provider ID, facility name and address, baseline and performance period risk-standardized readmission rates, achievement score, improvement score and SNF performance score.

### **Other Policies**

Extraordinary Circumstances Exception. Other VBP programs, including the Hospital VBP program, have extraordinary circumstances exceptions policies, which provide administrative relief from program requirements to providers who have suffered from natural disasters or other circumstances beyond the facility's control that may affect the facility's ability to provide high-quality health care. CMS is considering adopting such a policy for the SNF VBP program, and intends to address the topic in future rulemaking. **AHA supports the adoption of an extraordinary circumstances exception policy for the SNF VBP program.**

Facilities with Zero Readmissions. Under the current risk-adjustment and statistical approach used to calculate the readmission measure, facilities with zero readmissions and other outlier values are shifted toward the mean. This means that providers with zero readmissions (particularly smaller SNFs) might have risk-standardized readmission rates of greater than zero. In addition, CMS acknowledges that these providers might receive a negative value-based incentive payment adjustment based on their risk-standardized rates.

CMS may not exclude any SNFs from the payment withhold and from value-based incentive payments per statute, so it is not an option to exclude SNFs with zero readmissions. CMS is considering different policy options to address this topic, and requests public comments on alternative approaches.

## **CMS Requests Feedback from Providers**

### **Request for Feedback on Long-term Care (LTC) Facility Conditions of Participation.**

As a follow-up to its October 2016 final rule on LTC facility conditions of participation, which was the first update to these requirements since 1991, CMS is seeking feedback on ways to improve the cost and burden associated with these new requirements, with a focus on the following areas:

- Grievance Process. LTC facilities must establish a grievance policy to ensure the prompt resolution of grievances and identify a grievance officer. CMS is considering:
  - reducing the streamlining grievance official requirements;
  - allowing greater flexibility in how grievances are addressed;

- reducing the time required for record retention; and
  - determining whether the abuse and neglect reporting requirements may be duplicative of state law.
- Quality Assurance and Performance Improvement (QAPI). LTC facilities must maintain a comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life. CMS is considering:
    - eliminating certain requirements to allow design flexibility; and
    - eliminating the requirements for identifying and correcting problems, and monitoring effectiveness.
  - Discharge Notices. LTC facilities must send discharge notices to the state LTC ombudsman. CMS is considering whether these ombudsmen have the capacity to determine if a discharge was an involuntary discharge.

***Request for Feedback on the Center for Medicare and Medicaid Innovation***

The proposed rule states that the Center for Medicare and Medicaid Innovation (CMMI) is continuing to develop models to test innovation and improvements to the Medicare program and is interested in receiving feedback about innovative concepts to potentially test in the PAC arena, including regulatory and statutory provisions that could be potentially waived to implement any of the models. CMS encourages submission of strategies that will accelerate changes to improve care and reduce costs.

***Request for Suggestions for CMS Flexibilities and Efficiencies***

This section of the rule notes CMS's commitment to delivery system transformation. To facilitate this cause, the agency requests ideas related to: payment system redesign; 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 with the purpose of reducing burdens for hospitals, physicians, and patients. CMS also is interested in ideas on 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. CMS notes it does not plan to respond to the comments it receives but will use these ideas as it considers future policies, and it encourages concise responses with no confidential information.

***Advance Notice on SNF PPS Reforms for FY 2019***

CMS's [advance notice of proposed rulemaking](#) solicits feedback on potential future refinements to the SNF PPS, including the possibility of replacing the

RUGs-based system of payment. An in-depth description of the advance notice was prepared for the AHA by Health Policy Alternatives and is available [online](#).

The advance notice states that the goal for a new approach for the SNF PPS is to improve the accuracy of Medicare payments to SNFs. The new approach was developed over a five-year period by CMS contractor Acumen, through a process in which AHA engaged through several technical expert panels. The advance notice reviews long-standing concerns with the current system, noting two reports by the Government Accountability Office, which found a pattern of increased billing for higher-paying RUGs, over time, although beneficiary characteristics remained largely unchanged; and that “Medicare payments for therapy greatly exceed SNFs costs for therapy.” The notice also cites concern by the Medicare Payment Advisory Commission that “...almost since its inception the SNF PPS has been criticized for encouraging the provision of excessive rehabilitation therapy services...”

The alternative methodology described in the advance notice is materially different than the current SNF PPS design, and is slated for inclusion in the FY 2019 SNF PPS proposed rule. Specifically, rather than continuing to rely on service-based metrics to set payments, the alternative approach is designed to base payments on patient characteristics. For example, while the RUG system bases payments on two components (therapy and nursing), the alternative model uses four: 1) physical and occupational therapy (PT/OT); 2) speech-language pathology; 3) nursing; and 4) non-therapy ancillaries (NTA). Under the new system, each per-diem payment would represent a compilation of the payments calculated for each of these four payment elements. CMS also is exploring the use of variable per diem rates to account for the typical decline in PT/OT and NTA resources during the latter stages of a SNF stay. Finally, for HIV/AIDS patients, SNFs would receive a payment add-on to account for the extra costs associated with treating this population.

## **Next Steps**

**Submitting Comments.** The AHA urges all hospital-based SNFs to submit comments to CMS. Comments on both the proposed rule and advance notice are due June 26 and may be submitted electronically at: [www.regulations.gov](http://www.regulations.gov). The reference for the proposed rule is “CMS-1679-P,” while the reference for the advance notice is “CMS-1686-ANPRM.”

You also may mail written comments to CMS, modifying the “Attention” line in the address to reference the appropriate document.

**Via regular mail:**  
Centers for Medicare & Medicaid  
Services

Department of Health and Human  
Services  
Attention: CMS-1679-P or CMS-  
1686-ANPRM

P.O. Box 8016  
Baltimore, MD 21244-8016

Via overnight or express mail:  
Centers for Medicare & Medicaid  
Services

Department of Health and Human  
Services  
Attention: CMS-1679-P or CMS-  
1686-ANPRM  
Mailstop: C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

For questions regarding the payment provisions in this rule, please contact Rochelle Archuleta, AHA director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org). For questions pertaining to the quality provisions, contact Caitlin Gillooley, AHA associate director of policy, at [cgillooley@aha.org](mailto:cgillooley@aha.org).