American Hospital Association®

Regulatory Advisory

August 15, 2017

SKILLED NURSING FACILITY PPS:
FINAL RULE FOR FY 2018

AT A GLANCE

The Issue:

On Aug. 4, the Centers for Medicare & Medicaid Services (CMS) published the FY 2018 final rule for the skilled nursing facility (SNF) prospective payment system (PPS). Under the rule, SNFs will receive a 1.0 percent payment update, as mandated by the Medicare Access and CHIP Reauthorization Act, which translates into a $370 million increase over FY 2017 payments. The net updates for hospital-based SNFs are estimated to be 0.3 percent for rural providers and 1.2 percent for urban providers. Additionally, for the SNF Quality Reporting Program, CMS will add four function outcome measures and replace a measure regarding pressure ulcers. CMS has significantly scaled back its proposal to require the reporting of certain standardized patient assessment data as mandated by the Improving Medicare Post-Acute Care Transformation Act. For the SNF Value-Based Purchasing Program, CMS finalized program logistics including performance standards and a methodology to determine payment rate changes for the calendar year 2020 program year.

The rule did not finalize proposals related to CMS's advance notice of proposed rulemaking on potential SNF payment system refinements in FY 2019. The comment period deadline for these issues was extended to Aug. 25.

Our Take:

The payment provisions in the SNF PPS final 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 quality front, the AHA appreciates that CMS has acknowledged our concerns regarding the expanded patient assessment data reporting requirements, as this would have added or modified several items to the already lengthy Minimum Data Set and imposed a significant burden on providers.

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.
- ✓ **Participate in the AHA-member call on Friday**, **Aug. 25, 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 for questions on payment provisions or Caitlin Gillooley, associate director of policy, at cgillooley@aha.org for quality-related questions.

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SKILLED NURSING FACILITY PPS: FINAL RULE FOR FY 2018

On Aug. 4, the Centers for Medicare & Medicaid Services (CMS) published its final 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 will be updated by 1.0 percent. Due to their unique case-mix profiles, rural hospital-based SNFs will receive an average increase of 0.3 percent, while urban hospital-based SNFs will receive an average increase of 1.2 percent.

Final FY 2018 Payment Update

Market-basket Update

Under the final rule, SNFs will receive a 1.0 percent payment update, as mandated by the Medicare Access and CHIP Reauthorization Act (MACRA), which translates into a $370 million increase over FY 2017 payments. CMS will not implement 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 Rebasing the SNF Market Basket

In addition to the statutorily mandated payment update for FY 2018, CMS will revise and rebase the SNF market basket in FY 2018. Specifically, the agency will 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 will be revised with updated cost categories and price proxies. CMS maintains its policy of using data from freestanding SNFs only (which represent 93 percent of all SNFs); as hospital-based SNF data are more complex and require assumptions about how to handle ancillary costs. The rule also notes that the 2014 Medicare cost reports represent the most recent, complete set of cost report data available. In addition, CMS is no longer referring to the market basket in “fiscal year” terms since the majority of SNF cost-reporting periods began Jan. 1, 2014. As shown below, Table 9 from the rule compares the major cost categories and their respective cost weights from FYs 2010 and 2014.

Table 9: Major Cost Categories as Derived From the Medicare Cost Reports

Major Cost Categories	FY 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 in the residual "All Other" cost weight of the FY 2010-based SNF market basket*

The full discussion of CMS's methodology to construct the new market basket begins on page 36548 of the final rule.

Case-mix Adjustment

For FY 2018, no change will be made 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 a potential redesign of the SNF PPS case-mix system and episode length, beginning in FY 2019 – with comments due to the agency by Aug. 25. Tables 4 and 5 in the rule list the 66 RUG-IV total and itemized rates categories for urban and rural SNFs for FY 2018, along with corresponding case-mix values.

Area Wage Index

The SNF PPS wage index for FY 2018 is calculated using the same methodology as prior years, utilizing hospital wage data from cost reports beginning from FY 2014. The final SNF PPS wage index applicable for FY 2018 is available in Table A on the CMS webpage.

Labor-related Share

In alignment with the rebased and revised market basket, the FY 2018 labor-related share increases to 70.8 from the FY 2017 share of 68.8 percent. CMS notes that this increase reflects the higher quantity of labor-related services, as captured in the 2014 claims versus the prior calculations based on 2010 claims. Also contributing to the higher labor-related share is a higher capital-related cost weight in the 2014-based market basket, which are included in the labor-related share because CMS believes 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. Tables 6 and 7 in the rule provide the labor and non-labor related shares of the final case-mix adjusted payments. Table 16 compares the components of the FY 2017 and 2018 labor-related shares.

OTHER PAYMENT ISSUES & POLICY CLARIFICATIONS

Administrative Presumption

As it did for the past 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 also finalized as proposed several 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 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. The

agency also finalized its proposal 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 finalized revisions to §411.15(p)(3)(iii) and related cross-references to reflect recent revisions in the long-term care facility requirements for participation.

As reviewed in the rule, the consolidated billing exclusions allow separate billing under Part B for Part A "high-cost, low-probability" services that fall within these four categories:

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

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 (SNF 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 Oct. 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 finalizes 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 finalizes the proposal 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 will 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 will satisfy the requirements of the IMPACT Act domain of skin integrity and changes in skin integrity. It is not currently endorsed by the National Quality Forum (NQF); CMS claims that it plans to submit the measure for endorsement consideration "as soon as feasible."

The new measure is calculated differently than the current measure. 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 will be collected using the SNF MDS 3.0, which is currently submitted by SNFs through the Quality Improvement and Evaluation Assessment Submission and Processing (QIES ASAP) system. In the final rule, CMS notes that it will provide training and guidance prior to implementation to promote consistency in the interpretation of the measure.

In response to several comments on the FY 2018 SNF PPS proposed rule, CMS clarifies that the definitions they use for pressure ulcers are adapted from the National Pressure Ulcer Advisory Panel (NPUAP). CMS also notes that it does not intend to include this measure in the Five Star Quality Rating System calculations.

Application of IRF 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 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 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 will 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 NQF's Measure Applications Partnership (MAP). The latter group recommended caution in the interpretation of the measure results due to the differences in patients in various post-acute settings and also noted that the MDS already includes several function elements, rendering these measures as duplicative. CMS contends that the risk-adjustment factors will account for patient differences among post-acute 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 actually not be additional burden on providers to collect this data. In short, CMS states that these measures can 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.

These measures are not currently endorsed for SNFs; CMS claims that it plans to submit these four measures for endorsement after one full year of data collection. In response to comments regarding potential confusion about the use of the words "application of IRF" in the measure title, CMS notes that they will reassess the titling for these measures.

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

This modification will likely 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 time period will 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 updates the dates associated with public reporting on this measure. The measure is shifted from the calendar year to the fiscal year, beginning with publicly reporting on claims data for discharges in FYs 2016 and 2017. Thus, these measure data will 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 requires the collection of standardized patient assessment data. **The reporting of these data is made a requirement of the post-acute quality reporting programs, and as a result, failure to comply with the requirements would result in a payment reduction.** Currently, each setting collects different patient assessment data in setting-specific tools. The SNF setting collects this data in the MDS 3.0, whereas long-term care hospitals, inpatient rehabilitation facilities, 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.

According to the IMPACT Act, 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 Requirements. 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 will 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 proposed the reporting of several patient assessment data elements with respect to Medicare admissions and discharges that occur between Oct. 1, 2018 and Dec. 31, 2018. Subsequent years for the SNF QRP would be based on a full calendar year of data reporting. CMS extends the current administrative requirements for quality data to the patient assessment data, which include:

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

In the FY 2018 SNF PPS proposed rule, CMS listed several data elements that would fulfill the requirements of the IMPACT Act. While most of the proposed data elements are already included in the MDS 3.0 in some form, many of these elements would have to be modified or expanded to meet the requirements that the elements be standardized across all post-acute care settings. The AHA and other stakeholders voiced concerns that these changes and additions, required for

implementation in a very short time period, would result in enormous burden on post-acute care providers. In response to these concerns, CMS will not require the implementation of data elements in three of the five categories mandated by the IMPACT Act for FY 2020. These categories are Cognitive Function, Special Services and Treatments, and Impairments.

CMS finalized its proposal to require SNFs to report data on two of the three categories for FY 2020: functional status and Medical Conditions and Comorbidities. However, CMS states that the data elements already required to calculate existing measures (Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function and the newly finalized Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury) are sufficient to meet the standardized patient assessment data requirements for these two categories.

Below is the list and our analysis of proposed data elements in Table 1, including whether they currently exist in the MDS or other post-acute tools, and whether they will be required as part of the reporting of standardized patient assessment data for FY 2020. The data elements that currently exist in the MDS are still required for reporting by SNFs, but will not be tied to the requirements for standardized patient assessment data reporting in FY 2020.

Table 1: AHA Analysis of Finalized Standardized Patient Assessment Data Elements

Domain	Element	Currently in MDS?	Currently in other PAC tool?	Number of items	Required for FY 2020?
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	1	Yes
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	Yes	IRF-PAI	7	No
	Confusion Assessment Method (CAM)	Yes	LCDS	6	No
	Behavioral Signs and Symptoms	Yes	OASIS-C2	3	No
	Patient Health Questionnaire-2	Yes (part of PHQ-9)	OASIS-C2	2	No
Special Services, Treatments, and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	Yes (principal only)	No	1-4 (1 principal; 3 sub)	No
	Cancer Treatment: Radiation	Yes	No	1	No

	Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	Yes (principal only)	OASIS-C2	1-2 (1 principal; 2 sub either/or)	No
	Respiratory Treatment: Suctioning (Scheduled, As needed)	Yes (principal only)	No	1-2 (1 principal; 2 sub either/or)	No
	Respiratory Treatment: Tracheostomy Care	Yes	No	1	No
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes (principal only)	LCDS (principal) OASIS-C2	1-3 (1 principal; 2 sub)	No
	Respiratory Treatment: Invasive Mechanical Ventilator	Yes	LCDS	1	No
	Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	Yes (principal only)	OASIS-C2	1-4 (1 principal; 3 sub)	No
	Other Treatment: Transfusions	Yes	OASIS-C2	1	No
	Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	Yes (principal only)	LCDS (principal)	1-2 (1 principal; 2 sub either/or)	No
	Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	No	No	1-5 (1 principal; 4 sub)	No
	Nutritional Approach: Parenteral/IV Feeding	Yes	LCDS IRF-PAI OASIS-C2	1	No
	Nutritional Approach: Feeding Tube	Yes	OASIS-C2	1	No
	Nutritional Approach: Mechanically Altered Diet	Yes	IRF-PAI OASIS-C2	1	No
	Nutritional Approach: Therapeutic Diet	Yes	No	1	No
Medical Condition & Comorbidity	Percent of Resident or Patients with Pressure Ulcers that are New or Worsened	Yes	n/a	1	No, but required for FY 2019
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Yes	n/a	1	Yes
Impairment	Hearing	Yes	OASIS-C2	1	No
	Vision	Yes	OASIS-C2	1	No
Range of Patient Assessment Items (i.e., how many boxes to fill per patient)				**38-53**	

SNF QRP Public Reporting

CMS will publicly report data in CY 2018 for three assessment-based measures for which data collection began on Oct. 1, 2016. The measures that will 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 will 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 will not be publicly reported for the measure for that performance period.

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

- Medicare Spending Per Beneficiary;
- 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 rule revises the dates for public reporting to transition from the calendar year to the fiscal year. The first two measures, Medicare Spending Per Beneficiary (MSPB) and Discharge to Community, will be based on data collected from discharges beginning Oct. 1, 2016 through Sept. 30, 2017 and rates will be displayed based on one fiscal year of data. The third measure, Potentially Preventable Readmissions, will be based on data collected from discharges between Oct. 1, 2015 through Sept. 30, 2017 and rates will be displayed based on two consecutive fiscal years of data.

For these measures, CMS will 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 will not be public reported for the measure for that performance period.

SNF VALUE-BASED PURCHASING PROGRAM (SNF VBP)

The Protecting Access to Medicare Act (PAMA) 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-CAH 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 pool

of funding will be created by reducing each SNF's Medicare per-diem payments by 2 percent. However, the 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 40th percentile of performance are not eligible for any incentive payment, and will receive the full 2 percent reduction.

In this rule, CMS finalizes the performance baseline periods for the FY 2020 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 requested public comments on when the replacement should take place, particularly in light of the proposed performance and baseline periods. In response to these comments, CMS noted that they intend to submit the potentially preventable readmissions measure to NQF for endorsement as soon as possible, and that prior to future replacement of the current all-condition readmission measure, they will provide SNFs with their performance on the new measure in their quarterly reports. **The AHA believes that the transition to the potentially preventable readmissions measure should be made as soon as possible following NQF endorsement, as this measure more accurately represents the quality and value of care being provided at SNFs.**

FY 2020 Performance and Baseline Periods

CMS will 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 was concerned about delays in meeting the notification requirement in the act (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 adopts FY 2018 (Oct. 1, 2017 through Sept. 30, 2018) as the performance period for the FY 2020 SNF VBP program. The baseline period will thus be FY 2016 (Oct. 1, 2015

through Sept. 30, 2016). This shift will provide CMS with an additional three months between the end of the performance period and the 60-day notification deadline.

This transition results in 2017 Q4 (Oct. 1, 2017 through Dec. 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.

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. 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 will 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 will use 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.

In response to comments, CMS noted that it will consider performing a "dry run" with the proposed methodology and provide confidential feedback reports to SNFs with the results prior to the planned summer 2018 dissemination of FY 2019 payment reports. **The AHA supports the performance of a dry run prior to full implementation.**

Payback Percentage. As described above, the act requires the 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 act further specifies that the between 50 to 70 percent of the total reduction will be paid back to SNFs via incentive payments. CMS finalizes their proposal that 60 percent of the total amount of the funds available be payed as value-based incentive payments, as they believe 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.

In this final rule, CMS clarifies that withheld funds are not authorized to be distributed separately for quality improvement initiatives; instead, these funds are retained in the Medicare Trust Fund and used for other Medicare program purposes authorized by statute.

Proposed FY 2020 Performance Standards

In this 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 three-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 it 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 listserv 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.

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

Phase Two correction requests can be submitted the same way as in Phase One: SNFs must submit requests to the 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 notes 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 will begin publishing SNF performance information under the SNF VBP Program on the *Nursing Home Compare* website no later than Oct. 1, 2017. This information will include the ranking for each program year.

For the FY 2019 program year, CMS will publish the rankings after Aug. 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 value-based purchasing 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 will continue to consider adopting a similar policy for the SNF VBP program and intends to address the topic in future rulemaking. **The AHA supports the adoption of an Extraordinary Circumstances Exception policy for the SNF VBP program.**

Next Steps

On Friday, Aug. 25, 2:00 p.m. ET, the AHA will host a member conference call to discuss this rule. To register for this call, click here. Related materials and a recording of this call will be available at www.aha.org/postacute in the SNF section.

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