FEDERAL REGISTER

Vol. 80 Monday,
No. 75 April 20, 2015

Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 483

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

[CMS–1622–P]

RIN 0938–AS44

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection

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) 2016. In addition, it includes a proposal to specify a SNF all-cause all-condition hospital readmission measure, as well as a proposal to adopt that measure for a new SNF Value-Based Purchasing (VBP) Program and a discussion of SNF VBP Program policies we are considering for future rulemaking to promote higher quality and more efficient health care for Medicare beneficiaries. Additionally, this proposed rule proposes to implement a new quality reporting program for SNFs as specified in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). It also would amend the requirements that a long-term care (LTC) facility must meet to qualify to participate as a skilled nursing facility (SNF) in the Medicare program, or a nursing facility (NF) in the Medicaid program. These requirements implement the provision in the Affordable Care Act regarding the submission of staffing information based on payroll data.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 19, 2015.

ADDRESSES: In commenting, please refer to file code CMS–1622–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Within the search bar, enter the Regulation Identifier Number associated with this regulation, 0938–AS44, and then click on the ''Comment Now'' box

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1622–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–1622–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 (excluding any issues raised in Section V of this proposed rule).

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.

Shannon Kerr, (410) 786–0666, for information related to skilled nursing facility value-based purchasing.

Camillus Ezeike, (410) 786–8614, for information related to skilled nursing facility quality reporting.

Lorelei Chapman, (410) 786–9254, for information related to staffing data collection.

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 2015 SNF PPS final rule (79 FR 45628), 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/SNFPPS/WageIndex.html.*

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

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

Table of Contents

Acronyms

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

AIDS Acquired Immune Deficiency Syndrome
ARD Assessment reference date
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CASPER Certification and Survey Provider Enhanced Reports
CBSA Core-based statistical area
CCN CMS Certification Number
CFR Code of Federal Regulations
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
COT Change of therapy
ECI Employment Cost Index
EHR Electronic health record
EOT End of therapy
EOT–R End of therapy—resumption
ESRD–QIP End-Stage Renal Disease Quality Incentive Program
FAQ Frequently Asked Questions
FFS Fee-for-service
FR Federal Register
FY Fiscal year
GAO Government Accountability Office
HAC Hospital-Acquired Conditions
HACRP Hospital-Acquired Condition Reduction Program
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
ICR Information Collection Requirements
IGI IHS (Information Handling Services) Global Insight, Inc.
IMPACT Improving Medicare Post-Acute Care Transformation Act of 2014
IPPS Inpatient prospective payment system
IRF Inpatient Rehabilitation Facility
LTC Long-term care
LTCH Long-term care hospital
MAP Measures Application Partnership
MDS Minimum data set
MFP Multifactor productivity
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MSA Metropolitan statistical area
NAICS North American Industrial Classification System
NF Nursing facility
NH Nursing Homes
NQF National Quality Forum
OMB Office of Management and Budget
OMRA Other Medicare Required Assessment
PAC Post-acute care
PAMA Protecting Access to Medicare Act of 2014, Pub. L 113–93
PPS Prospective Payment System
PQRS Physician Quality Reporting System
QIES Quality Improvement Evaluation System
QIES ASAP Quality Improvement and Evaluation System Assessment Submission and Processing
QRP Quality Reporting Program

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

I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for FY 2016 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, certain specified information relating to the payment update (see section II.C.). In addition, it proposes to implement a new quality reporting program for SNFs under section 1888(e)(6) of the Act. Furthermore, this proposed rule would establish new regulatory reporting requirements for SNFs and NFs to implement the statutory obligation to submit staffing information based on payroll data under section 1128I(g) of the Act, specify a SNF all-cause all-condition hospital readmission measure under section 1888(g)(1) of the Act and adopt that measure for a new SNF value-based purchasing (VBP) program under section 1888(h) of the Act. The proposed rule also seeks comment on other policies under consideration for a SNF VBP Program, under which value-based incentive payments will be made in a fiscal year to SNFs beginning with payment for services furnished on or after October 1, 2018.

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 2015 (79 FR 45628) which reflects the SNF market basket index, as adjusted by the applicable forecast error correction and by the multifactor productivity adjustment for FY 2016. We also propose to specify a SNF all-cause all-condition hospital readmission measure under section 1888(g) of the Act, as well as adopt that measure for a new SNF Value-Based Purchasing (VBP) Program under section 1888(h) of the Act. We also seek comment on other policies for the SNF VBP Program that we are considering for adoption in future rulemaking to promote higher quality and more efficient health care for Medicare beneficiaries. We are also proposing to implement a new quality reporting program for SNFs under section 1888(e)(6) of the Act, which was added by section 2(c)(4) of the IMPACT Act of 2014 (Pub. L. 113–85).

For payment determinations beginning with FY 2018, we propose to adopt measures meeting three quality domains specified in section 1899B(c)(1) of the Act: Functional status, skin integrity, and incidence of major falls.

In addition, we propose adding new language at 42 CFR part 483 to implement section 1128I(g) of the Act. Specifically, we propose that, beginning on July 1, 2016, LTC facilities that participate in Medicare or Medicaid will be required to electronically submit direct care staffing information (including information for agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format. We invite public comment on CMS' proposed changes to 42 CFR part 483 to ensure compliance with this requirement.

C. Summary of Cost and Benefits

Provision description	Total transfers
Proposed FY 2016 SNF PPS payment rate update.	The overall economic impact of this proposed rule would be an estimated increase of $500 million in aggregate payments to SNFs during FY 2016.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33, enacted on August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a small number of excluded services, such as physician services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_07302013.pdf.*

Section 215(a) of PAMA added section 1888(g) to the Act requiring the Secretary to specify certain quality measures for the skilled nursing facility setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a value-based purchasing program for skilled nursing facilities. Finally, section 2(a) of the IMPACT Act added section 1899B to the Act that, among other things, requires SNFs to report standardized data for measures in specified quality and resource use domains. In addition, the IMPACT Act added section 1888(e)(6) to the Act, which requires the Secretary to implement a quality reporting program for SNFs, which includes a requirement that SNFs report certain data to receive their full payment under the SNF PPS.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and 1888(e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the federal case-mix adjusted rate. The

transition extended through the facility's first three 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 2015 (79 FR 45628, August 5, 2014).

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

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

Along with other revisions discussed later in this preamble, this proposed rule would provide the required annual updates to the per diem payment rates for SNFs for FY 2016.

III. SNF PPS Rate Setting Methodology and FY 2016 Update

A. Federal Base Rates

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

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

B. SNF Market Basket Update

1. SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. We use the SNF market basket index, adjusted in the manner described below, to update the federal rates on an annual basis. In the SNF PPS final rule for FY 2014 (78 FR 47939 through 47946), we revised and rebased the market basket, which included updating the base year from FY 2004 to FY 2010.

For the FY 2016 proposed rule, the FY 2010-based SNF market basket growth rate is estimated to be 2.6 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2015 forecast with historical data through fourth quarter 2014. In section III.B.5. of this proposed rule, we discuss the specific application of this adjustment to the forthcoming annual update of the SNF PPS payment rates.

2. Use of the SNF Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of the previous FY to the midpoint of the current FY. For the federal rates set forth in this proposed rule, we use the percentage change in the SNF market basket index to compute the update factor for FY 2016. This is based on the IGI first quarter 2015 forecast (with historical data through the fourth quarter 2014) of the FY 2016 percentage increase in the FY 2010-based SNF market basket index for routine, ancillary, and capital-related expenses, which is used to compute the update factor in this proposed rule. As discussed in sections III.B.3. and III.B.4. of this proposed rule, this market basket percentage change would be reduced by the applicable forecast error correction (as described in § 413.337(d)(2)) and by the multifactor productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act. Finally, as discussed in section II.B. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full federal rates that started with cost reporting periods beginning in July 1998 has expired.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46057 through 46059), the regulations at § 413.337(d)(2) provide 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 fiscal years. 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 2014 (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 2014 was 1.7 percentage points, resulting in the actual increase being 0.6

percentage point lower than the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index exceeds the 0.5 percentage point threshold and because the estimated amount of change exceeded the actual amount of change, the FY 2016 market basket percentage change of 2.6 percent would be adjusted downward by the forecast error correction of 0.6 percentage point, resulting in a SNF market basket increase of 2.0 percent, before application of the productivity adjustment discussed in this section. Table 1 shows the forecasted and actual market basket amounts for FY 2014.

TABLE 1—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2014

Index	Forecasted FY 2014 increase *	Actual FY 2014 increase **	FY 2014 difference
SNF	2.3	1.7	−0.6

* Published in **Federal Register**; based on second quarter 2013 IGI forecast (2010-based index).

** Based on the first quarter 2015 IGI forecast, with historical data through the fourth quarter 2014 (2010-based index).

4. Multifactor Productivity Adjustment

Section 3401(b) of the Affordable Care Act requires that, in FY 2012 (and in subsequent FYs), the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the Affordable Care Act, sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period, or other annual period) (the MFP adjustment). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business multifactor productivity (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. In section III.F.3. of the FY 2012 SNF PPS final rule (76 FR 48527 through 48529), we identified each of the major MFP component series employed by the BLS to measure MFP as well as provided the corresponding concepts determined to be the best available proxies for the BLS series.

Beginning with the FY 2016 rulemaking cycle, the MFP adjustment is calculated using a revised series developed by IGI to proxy the aggregate capital inputs. Specifically, IGI has replaced the Real Effective Capital Stock used for Full Employment GDP with a forecast of BLS aggregate capital inputs recently developed by IGI using a regression model. This series provides a better fit to the BLS capital inputs as measured by the differences between the actual BLS capital input growth rates and the estimated model growth rates over the historical time period. Therefore, we are using IGI's most recent forecast of the BLS capital inputs series in the MFP calculations beginning with the FY 2016 rulemaking cycle. 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.* Although we discuss the IGI changes to the MFP proxy series in this proposed rule, in the future, when IGI makes changes to the MFP methodology, we will announce them on our Web site rather than in the annual rulemaking.

a. Incorporating the Multifactor Productivity Adjustment Into the Market Basket Update

According to section 1888(e)(5)(A) of the Act, the Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act for a FY being less than such payment rates for the preceding FY. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

For the FY 2016 update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2016, which is 0.6 percent. Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2) of the regulations, the market basket percentage for FY 2016 for the SNF PPS is based on IGI's first quarter 2015 forecast of the SNF market basket update (2.6 percent) as adjusted by the forecast error adjustment (0.6 percentage point), and is estimated to be 2.0 percent. In accordance with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act) and § 413.337(d)(3), this market basket percentage is then reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2016) of 0.6 percent, which is calculated as described above and based on IGI's first quarter 2015 forecast. The resulting MFP-adjusted SNF market basket update is equal to 1.4 percent, or 2.0 percent less 0.6 percentage point.

5. Market Basket Update Factor for FY 2016

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 2016 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, 2014 through September 30, 2015 to the average market basket level for the period of October 1, 2015 through September 30, 2016. This process yields a percentage change in the market basket of 2.6 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust the market basket percentage change by the forecast error from the most recently available FY for which

there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the forecasted FY 2014 SNF market basket percentage change exceeded the actual FY 2014 SNF market basket percentage change (FY 2014 is the most recently available FY for which there is historical data) by more than 0.5 percentage point, the FY 2016 market basket percentage change of 2.6 percent would be adjusted downward by the applicable difference, which for FY 2014 is 0.6 percent.

In addition, for FY 2016, section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage change by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2016) of 0.6 percent, as described in section III.B.4. of this proposed rule. The resulting net SNF market basket update would equal 1.4 percent, or 2.6 percent less the 0.6 percentage point forecast error adjustment, less the 0.6 percentage point MFP adjustment. We propose that if more recent data become available (for example, a more recent estimate of the FY 2010-based SNF market basket and/or MFP adjustment), we would use such data, if appropriate, to determine the FY 2016 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the FY 2016 SNF PPS final rule.

We used the SNF market basket, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2016 from average prices for FY 2015. We would further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 2 and 3 reflect the updated components of the unadjusted federal rates for FY 2016, prior to adjustment for case-mix.

TABLE 2—FY 2016 UNADJUSTED FEDERAL RATE PER DIEM URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$171.46	$129.15	$17.01	$87.50

TABLE 3—FY 2016 UNADJUSTED FEDERAL RATE PER DIEM RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$163.80	$148.91	$18.17	$89.12

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 (MMA, Pub. L. 108–173) amended section 1888(e)(12) of the Act to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS was to remain in effect until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such

residents. The add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at *www.cms.gov/transmittals/downloads/r160cp.pdf.* In the SNF PPS final rule for FY 2010 (74 FR 40288), we did not address the certification of the add-on for SNF residents with AIDS in that final rule's implementation of the case-mix refinements for RUG–IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect. For the limited number of SNF residents that qualify for this add-on, there is a significant increase in payments. For example, using FY 2013 data, we identified fewer than 4,800 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2016, an urban facility with a resident with AIDS in RUG–IV group ''HC2'' would have a case-mix adjusted per diem payment of $428.57 (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 $977.14.

Currently, we use the International Classification of Diseases, 9th revision, Clinical Modification (ICD–9–CM) code 042 to identify those residents for whom it is appropriate to apply the AIDS add-on established by section 511 of the MMA. In this context, we note that the Department published a final rule in the September 5, 2012 **Federal Register** (77 FR 54664) which requires us to stop using ICD–9–CM on September 30, 2014, and begin using the International Classification of Diseases, 10th revision, Clinical Modification (ICD–10–CM), on October 1, 2014. Regarding the above-referenced ICD–9–CM diagnosis code of 042, in the FY 2014 SNF PPS proposed rule (78 FR 26444, May 6, 2013), we proposed to transition to the equivalent ICD–10–CM diagnosis code of B20 upon the overall conversion to ICD–10–CM on October 1, 2014, and we subsequently finalized that proposal in the FY 2014 SNF PPS final rule (78 FR 47951 through 47952).

However, on April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) was enacted. Section 212 of PAMA, titled ''Delay in Transition from ICD–9 to ICD–10 Code Sets,'' provides that the Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations. In the FY 2015 SNF PPS final rule (79 FR 45633), we stated that the Department expected to release an interim final rule in the near future that would include a new compliance date that would require the use of ICD–10 beginning October 1, 2015. In light of this, in the FY 2015 SNF PPS final rule, we stated that the effective date of the change from ICD–9–CM code 042 to ICD–10–CM code B20 for purposes of applying the AIDS add-on is October 1, 2015, and that until that time we would continue to use the ICD–9–CM code 042 for this purpose. On August 4, 2014, the U.S. Department of Health and Human Services released a final rule in the **Federal Register** (79 FR 45128 through 45134) that included a new compliance date that requires the use of ICD–10 beginning October 1, 2015. The August 4, 2014 final rule is available for viewing on the Internet at *http://www.gpo.gov/fdsys/pkg/FR-2014-08-04/pdf/2014-18347.pdf.* That final rule also requires HIPAA covered entities to continue to use ICD–9–CM through September 30, 2015. Thus, as we finalized in the FY 2015 SNF PPS final rule, the effective date of the change from ICD–9–CM code 042 to ICD–10–CM code B20 for the purpose of applying the AIDS add-on enacted by section 511 of the MMA is October 1, 2015.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The payment rates set forth in this proposed rule reflect the use of the RUG–IV case-mix classification system from October 1, 2015, through September 30, 2016. We list the proposed case-mix adjusted RUG–IV payment rates, provided separately for urban and rural SNFs, in Tables 4 and 5 with corresponding case-mix values. We use the revised OMB delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634) to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. These tables 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	$457.80	$241.51	.....	$87.50	$786.81
RUL	2.57	1.87	440.65	241.51	.....	87.50	769.66
RVX	2.61	1.28	447.51	165.31	.....	87.50	700.32
RVL	2.19	1.28	375.50	165.31	.....	87.50	628.31
RHX	2.55	0.85	437.22	109.78	.....	87.50	634.50
RHL	2.15	0.85	368.64	109.78	.....	87.50	565.92
RMX	2.47	0.55	423.51	71.03	.....	87.50	582.04
RML	2.19	0.55	375.50	71.03	.....	87.50	534.03
RLX	2.26	0.28	387.50	36.16	.....	87.50	511.16
RUC	1.56	1.87	267.48	241.51	.....	87.50	596.49
RUB	1.56	1.87	267.48	241.51	.....	87.50	596.49
RUA	0.99	1.87	169.75	241.51	.....	87.50	498.76
RVC	1.51	1.28	258.90	165.31	.....	87.50	511.71
RVB	1.11	1.28	190.32	165.31	.....	87.50	443.13
RVA	1.10	1.28	188.61	165.31	.....	87.50	441.42
RHC	1.45	0.85	248.62	109.78	.....	87.50	445.90
RHB	1.19	0.85	204.04	109.78	.....	87.50	401.32
RHA	0.91	0.85	156.03	109.78	.....	87.50	353.31
RMC	1.36	0.55	233.19	71.03	.....	87.50	391.72
RMB	1.22	0.55	209.18	71.03	.....	87.50	367.71

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 compo-nent	Total rate
RMA	0.84	0.55	144.03	71.03	.....	87.50	302.56
RLB	1.50	0.28	257.19	36.16	.....	87.50	380.85
RLA	0.71	0.28	121.74	36.16	.....	87.50	245.40
ES3	3.58	.....	613.83	.....	17.01	87.50	718.34
ES2	2.67	.....	457.80	.....	17.01	87.50	562.31
ES1	2.32	.....	397.79	.....	17.01	87.50	502.30
HE2	2.22	.....	380.64	.....	17.01	87.50	485.15
HE1	1.74	.....	298.34	.....	17.01	87.50	402.85
HD2	2.04	.....	349.78	.....	17.01	87.50	454.29
HD1	1.60	.....	274.34	.....	17.01	87.50	378.85
HC2	1.89	.....	324.06	.....	17.01	87.50	428.57
HC1	1.48	.....	253.76	.....	17.01	87.50	358.27
HB2	1.86	.....	318.92	.....	17.01	87.50	423.43
HB1	1.46	.....	250.33	.....	17.01	87.50	354.84
LE2	1.96	.....	336.06	.....	17.01	87.50	440.57
LE1	1.54	.....	264.05	.....	17.01	87.50	368.56
LD2	1.86	.....	318.92	.....	17.01	87.50	423.43
LD1	1.46	.....	250.33	.....	17.01	87.50	354.84
LC2	1.56	.....	267.48	.....	17.01	87.50	371.99
LC1	1.22	.....	209.18	.....	17.01	87.50	313.69
LB2	1.45	.....	248.62	.....	17.01	87.50	353.13
LB1	1.14	.....	195.46	.....	17.01	87.50	299.97
CE2	1.68	.....	288.05	.....	17.01	87.50	392.56
CE1	1.50	.....	257.19	.....	17.01	87.50	361.70
CD2	1.56	.....	267.48	.....	17.01	87.50	371.99
CD1	1.38	.....	236.61	.....	17.01	87.50	341.12
CC2	1.29	.....	221.18	.....	17.01	87.50	325.69
CC1	1.15	.....	197.18	.....	17.01	87.50	301.69
CB2	1.15	.....	197.18	.....	17.01	87.50	301.69
CB1	1.02	.....	174.89	.....	17.01	87.50	279.40
CA2	0.88	.....	150.88	.....	17.01	87.50	255.39
CA1	0.78	.....	133.74	.....	17.01	87.50	238.25
BB2	0.97	.....	166.32	.....	17.01	87.50	270.83
BB1	0.90	.....	154.31	.....	17.01	87.50	258.82
BA2	0.70	.....	120.02	.....	17.01	87.50	224.53
BA1	0.64	.....	109.73	.....	17.01	87.50	214.24
PE2	1.50	.....	257.19	.....	17.01	87.50	361.70
PE1	1.40	.....	240.04	.....	17.01	87.50	344.55
PD2	1.38	.....	236.61	.....	17.01	87.50	341.12
PD1	1.28	.....	219.47	.....	17.01	87.50	323.98
PC2	1.10	.....	188.61	.....	17.01	87.50	293.12
PC1	1.02	.....	174.89	.....	17.01	87.50	279.40
PB2	0.84	.....	144.03	.....	17.01	87.50	248.54
PB1	0.78	.....	133.74	.....	17.01	87.50	238.25
PA2	0.59	.....	101.16	.....	17.01	87.50	205.67
PA1	0.54	.....	92.59	.....	17.01	87.50	197.10

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 compo-nent	Total rate
RUX	2.67	1.87	$437.35	$278.46	.....	$89.12	$804.93
RUL	2.57	1.87	420.97	278.46	.....	89.12	788.55
RVX	2.61	1.28	427.52	190.60	.....	89.12	707.24
RVL	2.19	1.28	358.72	190.60	.....	89.12	638.44
RHX	2.55	0.85	417.69	126.57	.....	89.12	633.38
RHL	2.15	0.85	352.17	126.57	.....	89.12	567.86
RMX	2.47	0.55	404.59	81.90	.....	89.12	575.61
RML	2.19	0.55	358.72	81.90	.....	89.12	529.74
RLX	2.26	0.28	370.19	41.69	.....	89.12	501.00
RUC	1.56	1.87	255.53	278.46	.....	89.12	623.11
RUB	1.56	1.87	255.53	278.46	.....	89.12	623.11
RUA	0.99	1.87	162.16	278.46	.....	89.12	529.74
RVC	1.51	1.28	247.34	190.60	.....	89.12	527.06
RVB	1.11	1.28	181.82	190.60	.....	89.12	461.54

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
RVA	1.10	1.28	180.18	190.60	.....	89.12	459.90
RHC	1.45	0.85	237.51	126.57	.....	89.12	453.20
RHB	1.19	0.85	194.92	126.57	.....	89.12	410.61
RHA	0.91	0.85	149.06	126.57	.....	89.12	364.75
RMC	1.36	0.55	222.77	81.90	.....	89.12	393.79
RMB	1.22	0.55	199.84	81.90	.....	89.12	370.86
RMA	0.84	0.55	137.59	81.90	.....	89.12	308.61
RLB	1.50	0.28	245.70	41.69	.....	89.12	376.51
RLA	0.71	0.28	116.30	41.69	.....	89.12	247.11
ES3	3.58	.....	586.40	.....	$18.17	89.12	693.69
ES2	2.67	.....	437.35	.....	18.17	89.12	544.64
ES1	2.32	.....	380.02	.....	18.17	89.12	487.31
HE2	2.22	.....	363.64	.....	18.17	89.12	470.93
HE1	1.74	.....	285.01	.....	18.17	89.12	392.30
HD2	2.04	.....	334.15	.....	18.17	89.12	441.44
HD1	1.60	.....	262.08	.....	18.17	89.12	369.37
HC2	1.89	.....	309.58	.....	18.17	89.12	416.87
HC1	1.48	.....	242.42	.....	18.17	89.12	349.71
HB2	1.86	.....	304.67	.....	18.17	89.12	411.96
HB1	1.46	.....	239.15	.....	18.17	89.12	346.44
LE2	1.96	.....	321.05	.....	18.17	89.12	428.34
LE1	1.54	.....	252.25	.....	18.17	89.12	359.54
LD2	1.86	.....	304.67	.....	18.17	89.12	411.96
LD1	1.46	.....	239.15	.....	18.17	89.12	346.44
LC2	1.56	.....	255.53	.....	18.17	89.12	362.82
LC1	1.22	.....	199.84	.....	18.17	89.12	307.13
LB2	1.45	.....	237.51	.....	18.17	89.12	344.80
LB1	1.14	.....	186.73	.....	18.17	89.12	294.02
CE2	1.68	.....	275.18	.....	18.17	89.12	382.47
CE1	1.50	.....	245.70	.....	18.17	89.12	352.99
CD2	1.56	.....	255.53	.....	18.17	89.12	362.82
CD1	1.38	.....	226.04	.....	18.17	89.12	333.33
CC2	1.29	.....	211.30	.....	18.17	89.12	318.59
CC1	1.15	.....	188.37	.....	18.17	89.12	295.66
CB2	1.15	.....	188.37	.....	18.17	89.12	295.66
CB1	1.02	.....	167.08	.....	18.17	89.12	274.37
CA2	0.88	.....	144.14	.....	18.17	89.12	251.43
CA1	0.78	.....	127.76	.....	18.17	89.12	235.05
BB2	0.97	.....	158.89	.....	18.17	89.12	266.18
BB1	0.90	.....	147.42	.....	18.17	89.12	254.71
BA2	0.70	.....	114.66	.....	18.17	89.12	221.95
BA1	0.64	.....	104.83	.....	18.17	89.12	212.12
PE2	1.50	.....	245.70	.....	18.17	89.12	352.99
PE1	1.40	.....	229.32	.....	18.17	89.12	336.61
PD2	1.38	.....	226.04	.....	18.17	89.12	333.33
PD1	1.28	.....	209.66	.....	18.17	89.12	316.95
PC2	1.10	.....	180.18	.....	18.17	89.12	287.47
PC1	1.02	.....	167.08	.....	18.17	89.12	274.37
PB2	0.84	.....	137.59	.....	18.17	89.12	244.88
PB1	0.78	.....	127.76	.....	18.17	89.12	235.05
PA2	0.59	.....	96.64	.....	18.17	89.12	203.93
PA1	0.54	.....	88.45	.....	18.17	89.12	195.74

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 2016, 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 2016, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2011 and before October 1, 2012 (FY 2012 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection

Act of 2000 (BIPA, Pub. L. 106–554, enacted on December 21, 2000) authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

In addition, we propose to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2016 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 2016, 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 2016, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. The proposed wage index applicable to FY 2016 is set forth in Table A available on the CMS Web site at *http://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 revised FY 2010-based SNF market basket cost weights for the following cost categories: Wages and salaries; employee benefits; the labor-related portion of nonmedical professional fees; administrative and facilities support services; all other—labor-related services; and a proportion of capital-related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2016. 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 2016 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2016 in four steps. First, we compute the FY 2016 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2016 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2016 relative importance for each cost category by multiplying this ratio by the base year (FY 2010) weight. Finally, we add the FY 2016 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, the labor-related portion of non-medical professional fees, administrative and facilities support services, all other: labor-related services, and a portion of capital-related expenses) to produce the FY 2016 labor-related relative importance. Table 6 summarizes the proposed updated labor-related share for FY 2016, compared to the labor-related share that was used for the FY 2015 SNF PPS final rule.

We are proposing for FY 2016 and subsequent fiscal years, to report and apply the SNF PPS labor-related share at a tenth of a percentage point (rather than at a thousandth of a percentage point) consistent with the manner in which we report and apply the market basket update percentage under the SNF PPS and the IPPS and the manner in which we report and apply the IPPS labor-related share. The level of precision specified for the IPPS labor-related share is three decimal places or a tenth of a percentage point (0.696 or 69.6 percent), which we believe provides a reasonable level of precision. We believe it is appropriate to maintain such consistency across all payment systems so that the level of precision specified is both reasonable and similar for all providers. We invite public comments on this proposal.

TABLE 6—LABOR-RELATED RELATIVE IMPORTANCE, FY 2015 AND FY 2016

	Relative importance, labor-related, FY 2015 14:2 forecast [1]	Relative importance, labor-related, FY 2016 15:1 forecast [2]
Wages and salaries	48.816	48.9
Employee benefits	11.365	11.4
Nonmedical Professional fees: labor-related	3.450	3.4
Administrative and facilities support services	0.502	0.5
All Other: Labor-related services	2.276	2.3
Capital-related (.391)	2.771	2.7
Total	69.180	69.2

[1] Published in the **Federal Register**; based on second quarter 2014 IGI forecast.
[2] Based on first quarter 2015 IGI forecast, with historical data through fourth quarter 2014.

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

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

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	786.81	$544.47	$242.34
RUL	769.66	532.60	237.06
RVX	700.32	484.62	215.70
RVL	628.31	434.79	193.52
RHX	634.50	439.07	195.43
RHL	565.92	391.62	174.30
RMX	582.04	402.77	179.27
RML	534.03	369.55	164.48
RLX	511.16	353.72	157.44
RUC	596.49	412.77	183.72
RUB	596.49	412.77	183.72
RUA	498.76	345.14	153.62
RVC	511.71	354.10	157.61
RVB	443.13	306.65	136.48
RVA	441.42	305.46	135.96
RHC	445.90	308.56	137.34
RHB	401.32	277.71	123.61
RHA	353.31	244.49	108.82
RMC	391.72	271.07	120.65
RMB	367.71	254.46	113.25
RMA	302.56	209.37	93.19
RLB	380.85	263.55	117.30
RLA	245.40	169.82	75.58
ES3	718.34	497.09	221.25
ES2	562.31	389.12	173.19
ES1	502.30	347.59	154.71
HE2	485.15	335.72	149.43
HE1	402.85	278.77	124.08
HD2	454.29	314.37	139.92
HD1	378.85	262.16	116.69
HC2	428.57	296.57	132.00
HC1	358.27	247.92	110.35
HB2	423.43	293.01	130.42
HB1	354.84	245.55	109.29
LE2	440.57	304.87	135.70
LE1	368.56	255.04	113.52
LD2	423.43	293.01	130.42
LD1	354.84	245.55	109.29
LC2	371.99	257.42	114.57
LC1	313.69	217.07	96.62
LB2	353.13	244.37	108.76
LB1	299.97	207.58	92.39
CE2	392.56	271.65	120.91
CE1	361.70	250.30	111.40
CD2	371.99	257.42	114.57
CD1	341.12	236.06	105.06
CC2	325.69	225.38	100.31
CC1	301.69	208.77	92.92
CB2	301.69	208.77	92.92
CB1	279.40	193.34	86.06
CA2	255.39	176.73	78.66
CA1	238.25	164.87	73.38
BB2	270.83	187.41	83.42
BB1	258.82	179.10	79.72
BA2	224.53	155.37	69.16
BA1	214.24	148.25	65.99
PE2	361.70	250.30	111.40
PE1	344.55	238.43	106.12
PD2	341.12	236.06	105.06
PD1	323.98	224.19	99.79
PC2	293.12	202.84	90.28
PC1	279.40	193.34	86.06
PB2	248.54	171.99	76.55
PB1	238.25	164.87	73.38
PA2	205.67	142.32	63.35
PA1	197.10	136.39	60.71

TABLE 8—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	804.93	$557.01	$247.92

TABLE 8—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
RUL	788.55	545.68	242.87
RVX	707.24	489.41	217.83
RVL	638.44	441.80	196.64
RHX	633.38	438.30	195.08
RHL	567.86	392.96	174.90
RMX	575.61	398.32	177.29
RML	529.74	366.58	163.16
RLX	501.00	346.69	154.31
RUC	623.11	431.19	191.92
RUB	623.11	431.19	191.92
RUA	529.74	366.58	163.16
RVC	527.06	364.73	162.33
RVB	461.54	319.39	142.15
RVA	459.90	318.25	141.65
RHC	453.20	313.61	139.59
RHB	410.61	284.14	126.47
RHA	364.75	252.41	112.34
RMC	393.79	272.50	121.29
RMB	370.86	256.64	114.22
RMA	308.61	213.56	95.05
RLB	376.51	260.54	115.97
RLA	247.11	171.00	76.11
ES3	693.69	480.03	213.66
ES2	544.64	376.89	167.75
ES1	487.31	337.22	150.09
HE2	470.93	325.88	145.05
HE1	392.30	271.47	120.83
HD2	441.44	305.48	135.96
HD1	369.37	255.60	113.77
HC2	416.87	288.47	128.40
HC1	349.71	242.00	107.71
HB2	411.96	285.08	126.88
HB1	346.44	239.74	106.70
LE2	428.34	296.41	131.93
LE1	359.54	248.80	110.74
LD2	411.96	285.08	126.88
LD1	346.44	239.74	106.70
LC2	362.82	251.07	111.75
LC1	307.13	212.53	94.60
LB2	344.80	238.60	106.20
LB1	294.02	203.46	90.56
CE2	382.47	264.67	117.80
CE1	352.99	244.27	108.72
CD2	362.82	251.07	111.75
CD1	333.33	230.66	102.67
CC2	318.59	220.46	98.13
CC1	295.66	204.60	91.06
CB2	295.66	204.60	91.06
CB1	274.37	189.86	84.51
CA2	251.43	173.99	77.44
CA1	235.05	162.65	72.40
BB2	266.18	184.20	81.98
BB1	254.71	176.26	78.45
BA2	221.95	153.59	68.36
BA1	212.12	146.79	65.33
PE2	352.99	244.27	108.72
PE1	336.61	232.93	103.68
PD2	333.33	230.66	102.67
PD1	316.95	219.33	97.62
PC2	287.47	198.93	88.54
PC1	274.37	189.86	84.51
PB2	244.88	169.46	75.42
PB1	235.05	162.65	72.40
PA2	203.93	141.12	62.81
PA1	195.74	135.45	60.29

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 2016 (federal rates effective October 1, 2014), 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 2015 to the weighted average wage adjustment factor for FY 2016. For this calculation, we use the same FY 2014 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 2016 would be 0.9989.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), available online at *www.whitehouse.gov/omb/bulletins/b03-04.html,* which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas.

In adopting the CBSA geographic designations, we provided for a one-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), since the expiration of this one-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

On February 28, 2013, OMB issued OMB Bulletin No. 13–01, announcing revisions to the delineation of MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation of these areas. A copy of this bulletin is available online at *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.* This bulletin states that it provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246–37252) and Census Bureau data.

While the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the February 28, 2013 bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that became rural, rural counties that became urban, and existing CBSAs that were split apart.

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. Because the 1-year transition period expires at the end of FY 2015, the proposed SNF PPS wage index for FY 2016 is fully based on the revised OMB delineations adopted in FY 2015. As noted above, the proposed wage index applicable to FY 2016 is set forth in Table A available on the CMS Web site at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

E. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ described below, Table 9 shows the adjustments made to the federal per diem rates to compute the provider's actual per diem PPS payment. We derive the Labor and Non-labor columns from Table 7. The wage index used in this example is based on the proposed wage index, which may be found in Table A as referenced above. As illustrated in Table 9, SNF XYZ's total PPS payment would equal $45,462.10.

TABLE 9—ADJUSTED RATE COMPUTATION EXAMPLE
SNF XYZ: LOCATED IN FREDERICK, MD (URBAN CBSA 43524)
WAGE INDEX: 0.9681
[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	$484.62	0.9681	$469.16	$215.70	$684.86	$684.86	14	$9,588.04
ES2	389.12	0.9681	376.71	173.19	549.90	549.90	30	16,497.00
RHA	244.49	0.9681	236.69	108.82	345.51	345.51	16	5,528.16
CC2*	225.38	0.9681	218.19	100.31	318.50	726.18	10	7,261.80
BA2	155.37	0.9681	150.41	69.16	219.57	219.57	30	6,587.10
							100	45,462.10

* 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 section 1888(e)(4)(H)(ii) of the Act and the regulations at § 413.345, we include in each update of the federal payment rates in the **Federal Register** the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in § 409.30. As set forth in the FY 2011 SNF PPS update notice (75 FR 42910), this designation reflects an administrative presumption under the

66-group RUG–IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG–IV groups on the initial five-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the five-day Medicare-required assessment.

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

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. In this proposed rule, we would continue to designate the upper 52 RUG–IV groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG–IV categories:

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

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the beneficiary's assignment to one of the upper 52 RUG–IV groups (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption:

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

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

B. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) 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_07302013.pdf.* In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113, enacted on November 29, 1999) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual high-cost, low probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *www.cms.gov/transmittals/downloads/ab001860.pdf.*

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

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

customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2015). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

C. Payment for SNF-Level Swing-Bed Services

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

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN–SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356–57), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

V. Other Issues

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

1. Background

a. Overview

In recent years, we have undertaken a number of initiatives to promote higher quality and more efficient health care for Medicare beneficiaries. These initiatives, which include demonstration projects, quality reporting programs, and value-based purchasing programs, have been implemented in various health care settings, including physician offices, ambulatory surgical centers (ASCs), hospitals, nursing homes, home health agencies (HHAs), and dialysis facilities. Many of these programs link a portion of Medicare payments to provider reporting or performance on quality measures. The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.

We view value-based purchasing as an important step toward revamping how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovations instead of merely volume.

b. SNF VBP Report to Congress

Section 3006(a) of the Affordable Care Act required the Secretary to develop a plan to implement a value-based purchasing program under the Medicare program for SNFs (as defined in section 1819(a) of the Act) and to submit that plan to Congress. In developing the plan, this section required the Secretary to consider several issues, including the ongoing development, selection, and modification process for measures, the reporting, collection, and validation of quality data, the structure of value-based payment adjustments, methods for public disclosure of SNF performance, and any other issues determined appropriate by the Secretary. The Secretary was also required to consult with relevant affected parties and consider experience with demonstrations relevant to the SNF VBP Program.

HHS submitted the Report to Congress required under section 3006 of the Affordable Care Act in March 2012. The report explains that a significant number of elderly Americans receive care in SNFs/NFs, either as short-term post-acute care or as long-term custodial care, and that quality of care is a significant concern for a subset of SNFs/NFs. The report also states that the SNF PPS does not strongly incentivize SNFs to furnish high quality care to this very fragile patient population. The report concludes that if HHS harnesses the significant and growing purchasing power of Medicare in this sector, it can incentivize SNFs to improve the quality of care for their patients.

In the report, we explained our belief that the implementation of a SNF VBP Program is a central step in revamping Medicare's payments for health care services to reward better value, outcome, and innovations, rather than the volume of care. We also explained our belief that a SNF VBP Program should promote the development and use of robust quality measures, including measures that assess functional status, to promote timely, safe, and high-quality care for Medicare beneficiaries. We noted that the creation of a SNF VBP Program would align with numerous HHS and CMS efforts to improve care coordination, and would be consistent with the National Quality Strategy and its aims of Better Care, Healthy People and Communities, and Affordable Care.

The full report is available on our Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf.*

2. Statutory Basis for the SNF VBP Program

Section 215 of PAMA added sections 1888(g) and (h) to the Act. Section 1888(g)(1) of the Act requires the Secretary to specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure) not later than

October 1, 2015. Section 1888(g)(2) of the Act requires the Secretary to specify an all-condition risk-adjusted potentially preventable hospital readmission rate for SNFs not later than October 1, 2016. Section 1888(g)(3) of the Act directs the Secretary to develop a methodology to achieve high reliability and validity for these measures, especially for SNFs with a low volume of readmissions. Section 1888(g)(4) of the Act makes the pre-rulemaking Measure Applications Partnership process of Section 1890A of the Act optional for these measures. Under section 1888(g)(5) of the Act, the Secretary is directed to provide quarterly confidential feedback reports to SNFs on their performance on the readmission or resource use measure beginning on October 1, 2016. Under section 1888(g)(6) of the Act, not later than October 1, 2017, the Secretary must establish procedures for making performance data on readmission and resource use measures public on *Nursing Home Compare* or a successor Web site. That paragraph also requires that the procedures ensure that a SNF has the opportunity to review and submit corrections to the information that is to be made public for it before that information is made public.

Section 1888(h)(1)(A) of the Act requires the Secretary to establish a SNF value-based purchasing program under which value-based incentive payments are made in a fiscal year to SNFs, and section 1888(h)(1)(B) of the Act requires that the Program apply to payments for services furnished on or after October 1, 2018. Under section 1888(h)(2)(A) of the Act, the Secretary must apply the readmission measure specified under section 1888(g)(1) of the Act for purposes of the Program, and section 1888(h)(1)(B) of the Act requires the Secretary to apply the resource use measure specified under section 1888(g)(2) of the Act instead of the readmission measure specified under section 1888(g)(1) as soon as practicable. Sections 1888(h)(3)(A) and (B) of the Act require the Secretary to establish performance standards for the measure applied under section 1888(h)(2) of the Act for a performance period for a fiscal year and that those performance standards include levels of achievement and improvement. In addition, in calculating the SNF performance score for the measure under the Program, section 1888(h)(3)(B) of the Act requires the Secretary to use the higher of achievement or improvement scores. Further, the performance standards established under section 1888(h)(3) of the Act must, under section 1888(h)(3)(C), be established and announced by the Secretary not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

Section 1888(h)(4) of the Act directs the Secretary to develop a methodology to assess each SNF's total performance based on the performance standards for the applicable measure for each performance period. Under section 1888(h)(4)(B) of the Act, SNF performance scores for the performance period for each fiscal year must be ranked from low to high.

Section 1888(h)(5) of the Act outlines several requirements for value-based incentive payments under the SNF VBP Program. Under section 1888(h)(5)(A) of the Act, the Secretary is directed to increase the adjusted federal per diem rate determined under section 1888(e)(4)(G) for services furnished by a skilled nursing facility by the value-based incentive payment amount determined under section 1888(h)(5)(B). This section also directs that the value-based incentive payment amount be equal to the product of the adjusted federal per diem rate and the value-based incentive payment percentage specified under section 1888(h)(5)(C) of the Act for the SNF for the fiscal year. Section 1888(h)(5)(C) requires the Secretary to specify a value-based incentive payment percentage for a SNF for a fiscal year, which may include a zero percentage. The Secretary is further directed under section 1888(h)(5)(C) to ensure that such percentage is based on the SNF performance score for the performance period for the fiscal year, that the application of all such percentages in a fiscal year results in an appropriate distribution of value-based incentive payments, and that the total amount of value-based incentive payments for all SNFs for a fiscal year be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for the fiscal year under section 1888(h)(6), as estimated by the Secretary.

Section 1888(h)(6) of the Act requires the Secretary to reduce the adjusted federal per diem rate for SNFs otherwise applicable to each SNF for services furnished by that SNF during the applicable fiscal year by the applicable percent, which is defined in paragraph (b) as two percent for FY 2019 and subsequent years. Section 1888(h)(7) of the Act requires the Secretary to inform each SNF of its payment adjustments under the Program not later than 60 days prior to the fiscal year involved, and under section 1888(h)(8) of the Act, the value-based incentive payments calculated for a fiscal year apply only for that fiscal year.

Section 1888(h)(9)(A) of the Act requires the Secretary to publish SNF-specific performance information on the *Nursing Home Compare* Web site or a successor Web site, including SNF performance scores and rankings. Section 1888(h)(9)(B) of the Act requires the Secretary to post aggregate information on the SNF VBP Program, including the range of SNF performance scores and the number of SNFs receiving value-based incentive payments and the range and total amount of those payments.

3. Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510; Measure Steward: CMS)

a. Overview

Reducing hospital readmissions is important for quality of care and patient safety. Readmission to a hospital may be an adverse event for patients and in many cases imposes a financial burden on the health care system. Successful efforts to reduce preventable readmission rates will improve the quality of care furnished to beneficiaries while simultaneously decreasing the cost of that care. Hospitals and other health care providers can work with their communities to lower readmission rates and improve patient care in a number of ways, such as by ensuring that patients are clinically ready to be discharged, reducing infection risk, reconciling medications, improving communication with community providers responsible for post-discharge patient care, improving care transitions, and ensuring that patients understand their care plans upon discharge.

Many studies have demonstrated the effectiveness of these types of in-hospital and post-discharge interventions in reducing the risk of readmission, confirming that hospitals and their partners have the ability to lower readmission rates.[1] [2] [3] These types of efforts during and after a hospitalization have been shown to be effective in reducing readmission rates

[1] Gwadry-Sridhar FH, Flintoft V, Lee DS, Lee H, Guyatt GH: A systematic review and meta-analysis of studies comparing readmission rates and mortality rates in patients with heart failure. Arch Intern Med. 2004;164(21):2315–2320.

[2] McAlister FA, Lawson FM, Teo KK, Armstrong PW.: A systematic review of randomized trials of disease management programs in heart failure. AmJMed. 2001;110(5):378–384.

[3] Krumholz HM, Amatruda J, Smith GL, et al.: Randomized trial of an education and support intervention to prevent readmission of patients with heart failure. J Am Coll Cardiol. 2002;39(1):83–89.

in geriatric populations generally,[4] [5] as well as for multiple specific conditions. Moreover, such interventions can result in cost saving. Financial incentives to reduce readmissions will in turn promote improvement in care transitions and care coordination, as these are important means of reducing preventable readmissions.[6] In its 2007 Report to Congress on Promoting Better Efficiency in Medicare,[7] MedPAC noted the potential benefit to patients of lowering readmissions and suggested payment strategies that would incentivize hospitals to reduce these rates. Readmission rates are important markers of quality of care, particularly of the care of a patient in transition from an acute care setting to a non-acute care setting, and improving readmissions can positively influence patient outcomes and the cost of care.

We are proposing to specify the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) as the skilled nursing facility all-cause, all-condition hospital readmission measure under section 1888(g)(1) of the Act. This measure assesses the risk-standardized rate of all-cause, all-condition, unplanned inpatient hospital readmissions of Medicare fee-for-service (FFS) SNF patients within 30 days of discharge from an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital. This measure is claims-based, requiring no additional data collection or submission burden for SNFs.

We are also proposing to apply this measure for purposes of the SNF VBP Program under section 1888(h)(2)(A) of the Act. We believe that this measure will (1) incentivize SNFs to make quality improvements that result in successful transitions of care for patients discharged from the hospital (IPPS, CAH or psychiatric hospital) setting to a SNF, and subsequently to the community or to another post-acute care setting, (2) reduce unplanned readmission rates of these patients to hospitals; and (3) align the SNF VBP Program with the National Quality Strategy priorities of safer, better coordinated care and lower costs.[8]

We developed this measure based upon the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF #1789) (*http://www.qualityforum.org/QPS/1789*)[9] implemented in the Hospital Inpatient Quality Reporting Program. To the extent methodologically and clinically appropriate, we harmonized the SNFRM with the HWR measure specifications.

b. Measure Calculation

The SNFRM estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for SNF Medicare FFS beneficiaries within 30 days of discharge from their prior proximal acute hospitalization. The SNF admission must have occurred within one day after discharge from the prior proximal hospitalization. The prior proximal hospitalization is defined as an inpatient admission to an IPPS, CAH, or a psychiatric hospital. Because the measure denominator is based on SNF admissions, each Medicare beneficiary may be included in the measure multiple times within a given year if they have more than one SNF stay meeting all measure inclusion criteria including a prior proximal hospitalization.

Patient readmissions included in the measure are identified by examining Medicare claims data for readmissions of SNF Medicare FFS beneficiaries to an IPPS hospital or CAH occurring within 30 days of discharge from the prior proximal hospitalization. If the patient was admitted to the SNF within 1 day of discharge from the prior proximal hospitalization and the hospital readmission occurred within the 30-day risk window, it is counted in the numerator regardless of whether the patient is readmitted directly from the SNF or has been discharged from the SNF. Because patients differ in complexity and morbidity, the measure is risk-adjusted for patient case-mix. The measure also excludes planned readmissions, because these are not considered to be indicative of poor quality of care by the SNF. Details regarding how readmissions are identified are available in our SNFRM Technical Report.[10]

The SNFRM (NQF # 2510) assesses readmission rates while accounting for patient demographics, principal diagnosis in the prior hospitalization, comorbidities, and other patient factors. While estimating the predictive power of patient characteristics, the model also estimates a facility-specific effect common to patients treated at that SNF.

The SNFRM is calculated based on the ratio, for each SNF, of the number of risk-adjusted all-cause, unplanned readmissions to an IPPS hospital or CAH that occurred within 30 days of discharge from the prior proximal hospitalization, including the estimated facility effect, to the estimated number of risk-adjusted predicted unplanned inpatient hospital readmissions for the same patients treated at the average SNF. A ratio above 1.0 indicates a higher than expected readmission rate, or lower level of quality, while a ratio below 1.0 indicates a lower than expected readmission rate, or higher level of quality. This ratio is referred to as the standardized risk ratio or SRR. The SRR is then multiplied by the overall national raw readmission rate for all SNF stays. The resulting rate is the risk-standardized readmission rate (RSRR). The full methodology is detailed in the SNFRM Technical Report.

The patient population includes SNF patients who:

- Had a prior hospital discharge (IPPS, CAH or psychiatric hospital) within one day of their admission to a SNF.
- Had at least 12 months of Medicare Part A, FFS coverage prior to their discharge date from the prior proximal hospitalization.
- Had Medicare Part A, FFS coverage during the 30 days (the 30-day risk window) following their discharge date from the prior proximal hospitalization.

c. Exclusions

Patients whose prior proximal hospitalization was for the medical treatment for cancer are excluded. Analyses of this population during measure development showed them to have a different trajectory of illness and mortality than other patient populations, which is consistent with

[4] Coleman EA, Parry C, Chalmers S, Min SJ.: The care transitions intervention: Results of a randomized controlled trial. Arch Intern Med. 2006;166:1822–8.

[5] Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, Schwartz JS.: Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. JAMA. 1999;281:613–20. 186

[6] Coleman EA.: 2005. Background Paper on Transitional Care Performance Measurement. Appendix I. In: Institute of Medicine, Performance Measurement: Accelerating Improvement. Washington, DC: National Academy Press.

[7] Medicare Payment Advisory Commission (MedPAC). Report to Congress: Promoting Greater Efficiency in Medicare; 2007. Available at *http://www.medpac.gov/documents/Jun07_EntireReport.pdf*. Accessed January 10, 2011.

[8] Wilson, N. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2014). National quality strategy: Overview.

[9] Adopted for the Hospital IQR Program in the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53521 through 53528).

[10] Available on the Nursing Home Quality Initiative Web site at *https://www.cms.gov/Medicare/Quality-nitiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/*.

findings in studies in other patient populations.[11]

SNF stays excluded from the measure are:

- SNF stays where the patient had one or more intervening post-acute care (PAC) admissions (inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or another SNF) which occurred either between the prior proximal hospital discharge and SNF admission (from which the patient was readmitted) or after the SNF discharge but before the readmission, within the 30-day risk window.
- SNF stays with a gap of greater than 1 day between discharge from the prior proximal hospitalization and the SNF admission.
- SNF stays in which the patient was discharged from the SNF against medical advice (AMA).
- SNF stays in which the principal diagnosis for the prior proximal hospitalization was for rehabilitation care; fitting of prostheses and for the adjustment of devices.
- SNF stays in which the prior proximal hospitalization was for pregnancy.
- SNF stays in which data were missing on any variable used in the SNFRM construction.

Readmissions within the 30-day risk window that are usually considered planned due to the nature of the procedures and principal diagnoses of the readmission are also excluded from the measure. In addition to the list of planned procedures is a list of diagnoses (provided in the SNFRM Technical Report), which, if found as the principal diagnosis on the readmission claim, would indicate that the usually planned procedure occurred during an unplanned acute readmission. In addition to the HWR Planned Readmission Algorithm, the SNFRM incorporates procedures that are considered planned in post-acute care settings as identified in consultation with technical expert panels. Full details on the planned readmissions criteria used, including the additional procedures considered planned for post-acute care may be found in the SNFRM Technical Report. Details regarding the TEP proceedings can be found in the SNFRM TEP Report.

d. Eligible Readmissions

An eligible SNF admission is considered to be in the 30-day risk window from the date of discharge from the proximal acute hospitalization until: (1) The 30-day period ends; or (2) the patient is readmitted to an IPPS hospital or CAH. If the readmission is unplanned, it is counted as a readmission in the numerator of the measure. If the readmission is planned, the readmission is not counted in the numerator of the measure. The occurrence of a planned readmission ends further tracking for readmissions in the 30-day risk window.

e. Risk Adjustment

Readmission rates are risk-adjusted for patient case-mix characteristics, independent of quality. The risk adjustment modeling estimates the effects of patient characteristics, comorbidities, and select health status variables on the probability of readmission. More specifically, the risk-adjustment model for SNFs accounts for demographic characteristics (age and sex), principal diagnosis during the prior proximal hospitalization, comorbidities based on the secondary medical diagnoses listed on the patient's prior proximal hospital claim and diagnoses from prior hospitalizations that occurred in the previous 365 days, length of stay during the patient's prior proximal hospitalization, length of stay in the intensive care unit (ICU), body system specific surgical indicators, end-stage renal disease status, whether the patient was disabled, and the number of prior hospitalizations in the previous 365 days.

f. Measurement Period

The SNFRM utilizes 1 year of data to calculate the measure rate. Given that there are more than 2 million Medicare FFS SNF admissions per year in more than 15,000 SNFs, 1 year of data is sufficient to calculate this measure with a model in which the risk adjusters have sufficient sample size to have good precision. The relevant reliability testing may be found in the SNFRM Technical Report.

g. Stakeholder/MAP Input

Our measure development contractor convened a technical expert panel (TEP) which provided input on the technical specifications of this quality measure. The TEP was supportive of the design of this measure. We also solicited stakeholder feedback on the development of this measure through a public comment process from July 15th to 29th, 2013. In December 2014, the NQF endorsed the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (NQF #2510).

We also considered input from the Measures Application Partnership (MAP) when selecting measures under the CMS SNF VBP Program. The MAP is composed of multi-stakeholder groups convened by the NQF, our current contractor under section 1890(a) of the Act. The MAP has noted the need for care transition measures in PAC/Long term care (LTC) performance measurement programs and stated that setting-specific admission and readmission measures under consideration would address this need.[12] We included the SNFRM on the December 1, 2014 List of Measures under Consideration (MUC List), and the MAP supported the measure. A spreadsheet of MAP's 2015 Final Recommendations is available at NQF's Web site at *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=78711.*

We invite public comment on our proposal to adopt the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) for use in the SNF VBP Program.

h. Feedback Reports to SNFs

Section 1888(g)(5) of the Act requires that beginning October 1, 2016, SNFs be provided quarterly confidential feedback reports on their performance on measures specified under sections 1888(g)(1) or (2) of the Act.

We intend to address this topic in future rulemaking. However, we request public comment on the best means by which to communicate these reports to SNFs. For example, we could consider providing confidential, downloadable feedback reports to SNFs through a secure portal, such as QualityNet. We also seek comment on the level of detail that would be most helpful to SNFs in understanding their performance on the new quality measures.

4. Performance Standards

a. Background

Section 1888(h)(3) of the Act requires the Secretary to establish performance standards for the SNF VBP Program. The performance standards must include levels of achievement and improvement, and must be established and announced not later than 60 days prior to the beginning of the performance period for the fiscal year involved. To assist us in developing our proposals to establish performance standards for the SNF VBP program, we reviewed a number of innovative health care programs and demonstration

[11] National Quality Forum. ''Patient Outcomes: All-Cause Readmissions Expedited Review 2011''. July 2012. pp12.

[12] National Quality Forum. *Measure Applications Partnership Pre-Rulemaking Report: 2013 Recommendations of Measures Under Consideration by HHS: February 2013.* Available at *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72738.*

projects, both public and private, to discover if any could serve as a prototype for the SNF VBP program. One methodology of important note that provides us an analogous framework for implementation of performance standards is the Performance Assessment Model, implemented for our Hospital VBP program. We also reviewed the Hospital Acquired Conditions Reduction Program, as well as the Hospital Readmissions Reduction Program and the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). We seek comment on several potential approaches for calculating performance standards under the SNF VBP Program.

i. Hospital Value-Based Purchasing Program

Under the Hospital VBP Program, a hospital's Total Performance Score is determined by aggregating and weighting domain scores, which are calculated based on hospital performance on measures within each domain. The domain scores are then weighted to calculate a TPS that ranges between 0 and 100 points. At this time, we do not anticipate proposing to adopt quality measurement domains akin to other CMS quality programs under the SNF VBP Program due to fact that this program is based on only one measure.

To calculate HVBP measure scores, hospital performance on specified quality measures is compared to performance standards established by the Secretary. These performance standards include levels of achievement and improvement and enable us to award between 0 and 10 points to each hospital based on its performance on each measure during the performance period. An achievement threshold, generally defined as the median of all hospital performance on most measures during a specified baseline period, is the minimum level of performance required to receive achievement points. The benchmark, generally defined as the mean of the top decile of all hospital performance on a measure during the baseline period, is the performance level required for receiving the maximum number of points on a given measure. The Program also establishes an improvement threshold for each measure, set at each individual hospital's performance on the measure during the baseline period, to award points for improvement over time.

We believe that the Hospital VBP Program's performance standards methodology is a well-understood methodology under which health care providers and suppliers can be rewarded both for providing high-quality care and for improving their performance over time. The statutory authority for the Hospital VBP Program is structured similarly to the statutory authority for the SNF VBP Program, and we are considering adoption of a similar methodology for establishing performance standards under the SNF VBP Program. We also seek to align our pay-for-performance and quality reporting programs as much as possible. Specifically, we could consider adopting performance standards based on all SNF performance during the baseline period on the measure specified under section 1888(g)(1) or (2) of the Act in the form of the achievement threshold—median of all SNF performance during a baseline period—and the benchmark—mean of the top decile of all SNF performance during a baseline period. We could then consider awarding points along a continuum relative to those performance levels.

ii. Hospital-Acquired Conditions Reduction Program

We also considered whether we should adopt any components of the scoring methodology that we have finalized for the HAC Reduction Program under the SNF VBP Program. The HAC Reduction Program requires the Secretary to reduce eligible hospitals' Medicare payments to 99 percent of what would otherwise have been paid for discharges when hospitals rank in the worst performing quartile for risk-adjusted HAC quality measures. These quality measures comprise efforts to promote quality of care by reducing the number of HACs in the acute inpatient hospital setting.

We determine a hospital's Total HAC Score by first assigning each hospital a score of between 1 and 10 for each measure based on the hospital's relative performance ranking in 10 groups (or deciles) for that measure. Second, the measure score is used to calculate the domain score. We discuss other details of the HAC Reduction Program's scoring methodology in further detail below.

Although the HACRP statutory authority is not structured the same as the SNF VBP statutory authority, we view the HACRP's use of decile-based performance standards as one conceptual possibility for constructing performance standards under the SNF VBP Program. Specifically, we could consider setting performance standards based on SNFs' ranked performance on the measures specified under sections 1888(g)(1) or (2) of the Act during the performance period. We could divide SNFs' performance on the measures into deciles and award between 1 and 10 points to all SNFs within each decile. While this type of performance standards calculation would measure and reward achievement, we are concerned that it would not incorporate improvement, and we seek comment on the best means by which we could include improvement in this type of calculation.

iii. Hospital Readmissions Reduction Program (HRRP)

We also considered aspects of the Hospital Readmissions Reduction Program (HRRP) for adaptation under the SNF VBP Program. HRRP reduces Medicare payments to hospitals with a higher number of readmissions for applicable conditions over a specified time period.

Hospital readmissions are defined as Medicare patients that are readmitted to the same or another hospital within 30 days of a discharge from the same or another hospital, which includes short-term inpatient acute care hospitals. The initial hospital inpatient admission (the discharge from which starts the 30-day potential penalty clock) is termed the index admission. The hospital inpatient readmission (which can be used to determine application of a penalty if the readmission occurs within 30 days of the index inpatient admission stay) can be for any cause, that is, it does not have to be for the same cause as the index admission.

Using historical data, we determine whether eligible IPPS hospitals have readmission rates that are higher than expected, given the hospital's case mix, while accounting for the patient risk factors, including age, and chronic medical conditions identified from inpatient and outpatient claims for the 12 months prior to the hospitalization. A hospital's excess readmission ratio for each condition is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. If the hospital's actual readmission rate, based on the hospital's actual performance, for the year is greater than its CMS-expected readmission rate, the hospital incurs a penalty up to the maximum cap. If a hospital performs better than an average hospital that admitted similar patients, the hospital will not be subjected to a payment reduction. If a hospital performs worse than average (below a 1.000 score), the poorer performance triggers a payment reduction. For FY 2013, the reduction was capped at 1 percent, for FY 2014 at 2 percent, and at 3 percent for FY 2015 and for subsequent years.

We view the Hospital Readmissions Reduction Program as a potential model for the SNF VBP Program because that program does not weight scores based on domains. That is, under the HRRP, hospitals' risk-adjusted readmissions ratios form the basis for Medicare payment adjustments. Under SNF VBP (and as discussed further in this section), the Program's statute requires us to select only one measure to form the basis for the SNF Performance Score. We believe that this conceptual similarity stands distinct from certain other CMS quality programs that incorporate quality measurement domains and domain weighting into the scoring calculations. However, the HRRP sets an effective performance standard based on the average readmissions adjustment factor of 1.000. We seek comment on whether or not we should adopt a similar form of performance standard under the SNF VBP Program. This performance standard could take the form of the median or mean performance on the specified quality measure during the performance period. However, we believe we would also need to consider more granular delineations in SNF scoring to ensure an appropriate distribution of value-based incentive payments under the Program, and we seek comment on what additional policies we should consider adopting in this topic area.

iv. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is authorized by section 1881(h) of the Act. The program promotes patient health by providing a financial incentive for renal dialysis facilities to deliver high-quality care to their patients.

Section 1881(h)(3)(A)(i) of the Act requires the Secretary to develop a methodology for assessing the total performance of each provider and facility based on performance standards. For each clinical measure adopted under the ESRD QIP, we assess performance on both achievement and improvement. For the achievement score, facility performance on a measure during a performance period is compared against national facility performance on that measure during a specified baseline period. To calculate the improvement score, we compare a facility's performance during the performance period to its performance during a specified baseline period. In determining a clinical measure score for each measure, we take the higher of the improvement or achievement score.

For each reporting measure, we assess performance based on whether the facility completed the reporting for that measure as specified. If a facility reports data according to the specifications we have adopted, then the facility earns the maximum number of points on the measure. If the facility partially reports data according to the specifications we have adopted, the hospital earns some points on the measure, but less than the maximum.

We believe that the ESRD QIP performance standards methodology is a well-understood methodology under which health care providers and suppliers can be rewarded both for providing high-quality care and for improving their performance over time. The scoring methodology rewards achievement and improvement, and is generally aligned with other pay-for-performance and quality reporting programs. Like the Hospital VBP Program statutory language, the ESRD QIP statutory language is structured similar to the SNF VBP Program statutory language, and we are considering adoption of a similar methodology for calculating performance standards under the SNF VBP Program. Specifically, we could consider adopting performance standards based on all SNF performance during the baseline period on the measure specified under sections 1888(g)(1) or (2) of the Act in the forms of the achievement threshold—median of all SNF performance—and the benchmark—mean of the top decile of all SNF performance. We could then consider awarding points for those performance levels.

b. Measuring Improvement

We are considering several methodologies for improvement scoring under the SNF VBP Program, and we welcome public comments on these options or others that we should consider as we develop our SNF VBP Program policies for future rulemaking.

Section 1888(h)(4)(B) of the Act specifically requires us to construct a ranking of SNF performance scores. While we view such a ranking system as fairly straightforward when based on achievement scoring—for example, ranking SNFs based on their performance on a measure during the performance period could be achieved by ordering SNF performance rates on the measure specified for the Program year—we are considering several approaches for including improvement in the SNF scoring methodology because we are limited to one measure for each SNF Program year. These approaches include:

- Improvement points, awarded using a similar methodology as the one we use to award improvement points in the Hospital VBP Program.
- Measure rate increases, in which a SNF's performance rate on a measure would be increased as a result of its improvement over time.
- Ranking increases, in which a SNF's ranking relative to other SNFs would be increased as a result of improvement.
- Performance score increases, in which a SNF's performance score would be increased as a result of improvement.

We discuss each of these options in further detail below.

i. Improvement Points

The Hospital VBP Program calculates both achievement and improvement points for participating hospitals with sufficient data on each measure adopted under the Program, and the score a hospital receives on a measure is the higher of the achievement and improvement score. We could consider adopting a similar methodology under the SNF VBP Program, in which points would be calculated for SNFs for both achievement (in comparison to all SNFs during the performance period) and for improvement (in comparison to that individual SNF's performance during the baseline period). Points awarded could be, similar to the HVBP Program, between 0 and 10 points, or we could consider awarding points on a broader range, such as from 0 to 50, or 0 to 100.

We believe that adapting the Hospital VBP Program's performance standards methodology presents certain advantages, in that it is well understood by the public and reflects a fair means to fulfill the statutory requirement at section 1888(h)(3)(B) of the Act to include both achievement and improvement. However, since there is only one measure in the SNF VBP Program, such a policy could result in significant differences in SNF value-based incentive payments between SNFs with relatively small differences in measured performance. We seek comment on whether or not we should adopt improvement points in a similar form to that which we have adopted for the Hospital VBP Program.

ii. Measure Rate Increases

Given the limited number of measures that we may select for the SNF VBP Program, we are considering whether we should include improvement in the program by way of increasing a SNF's performance rate on the Program's measure by a certain amount. Such a measure rate increase could take several forms, and could rely on any number of

qualifying criteria. For example, an increase of 10 percent of measured performance could be awarded to any SNF's measure rate that rises between the baseline and performance periods. We could also consider limiting this increase to SNFs whose improvement on the Program's measure placed them in the top 50 percent of improving SNFs between the baseline and performance period. Additionally, we could consider incorporating a penalty into the scoring methodology if a SNF's performance on the measure selected under the Program should decline significantly, and we seek comment on whether or not we should consider such a policy.

However, we are concerned about the methodological implications to quality measurement of awarding increases in measured performance rates to recognize improvement. We understand that quality measures are developed with robust considerations for the clinical topic covered, the recommended care provided, and in many cases, for the health of the underlying patient population, and we seek comment on whether such an adjustment would be methodologically sound.

iii. Ranking Increases

Another possibility for rewarding improvement is to adopt certain elements of the Hospital VBP Program's scoring methodology—that is, 0 to 10 points for measured performance—and increase a SNF's relative placement as a result of improvement. Under this type of scenario, SNF performance would be rank-ordered, and each SNF would be placed in a cohort numbered from 0 to 10, which would correspond to the points that would be awarded to that SNF for achievement along a 0 to 10 point scale of SNF performance scores based on their measured performance. Once SNF performance has been ranked from 0 to 10, we could consider increasing SNFs' ranking, and basing value-based incentive payments under the program on the resulting adjusted ranking. For example, a SNF whose performance on a measure resulted in a score of 3 on the 0 to 10 point scale, but whose performance improved, could have its score increased to 4. We could also consider limiting this increase to only those SNFs whose improvement places them in the top 50 percent of improving SNFs between the baseline and performance period.

However, we are concerned that this type of ranking may not provide us with enough granularity to meaningfully differentiate performance between groups of SNFs, and may result in substantial differences in value-based incentive payments between SNFs with relatively small differences in measured performance. We are also concerned about comparability once this type of ranking increase has been performed, because comparing two SNFs that both ended at a given point on the 0 to 10 scale may not be meaningful if one of them reached that point via improvement. Because we are limited in the number of measures that we may adopt, we believe that we may need to consider adopting a scoring methodology that allows additional granularity to capture improvement appropriately. We seek comment on this issue.

iv. Performance Score Increases

This option is a variation on the HVBP improvement points scenario described further above. Under this option, we would construct SNF performance scores based on measured performance during the performance period, and would award an increased performance score to SNFs whose measured performance rose between the baseline and performance periods. This option could take the form of a percentage-based increase—such as a 25 percent increase to a SNF performance score if the SNF improved over time—and could also be limited to top improvers, as described above in reference to other options.

This option would not result in direct adjustments to quality measure rates. We would instead be adjusting the SNF performance score, and given the broad authority that the SNF VBP statute provides us in calculating the SNF performance score, we believe this option be to operationally feasible. However, we remain concerned about the challenges associated with comparability between SNFs with different performance rates on the measure but the same SNF performance score. We specifically seek comment on how, if at all, we should differentiate SNFs' performance scores when based on achievement or improvement to address this issue.

5. FY 2019 Performance Period and Baseline Period Considerations

a. Performance Period

We intend to specify a performance period for a payment year with an end date as close as feasibly possible to the payment year's start date. We strive to link performance furnished by SNFs as closely as possible to the payment year to ensure clear connections between quality measurement and value-based payment. We also strive to measure performance using a sufficiently reliable population of patients that broadly represent the total care provided by SNFs. As such, we anticipate that our annual performance period end date must provide sufficient time for SNFs to submit claims for the patients included in our measure population. In other programs, such as HRRP and the Hospital Inpatient Quality Reporting Program (HIQR), this time lag between care delivered to patients who are included in the readmission measures and application of a payment consequence linked to reporting or performance on those measures has historically been close to one year. We also recognize that other factors contribute to this time lag, including the processing time we need to calculate measure rates using multiple sources of claims needed for statistical modeling, time for providers to review their measure rates and included patients, and processing time we need to determine whether a payment adjustment needs to be made to a provider's reimbursement rate under the applicable PPS based on its reporting or performance on measures.

For the FY 2019 SNF VBP Program's performance period, we are also considering the necessary timeline we need to complete measure scoring to announce the net result of the Program's adjustments to Medicare payments not later than 60 days prior to the fiscal year, in accordance with section 1888(h)(7) of the Act. We are also considering the number of SNF stays typically covered by Medicare each year. As discussed previously, Medicare typically covers more than two million Medicare Part A stays per year in more than 15,000 SNFs, and we therefore believe that one year of SNFRM data is sufficient to ensure that the measure rates are statistically reliable.

We intend to propose a performance period for the FY 2019 SNF VBP Program in future rulemaking. However, we seek public comment on the most appropriate performance period length.

b. Baseline Period

As described previously, in other Medicare quality programs such as the Hospital Value-Based Purchasing Program and the End-Stage Renal Disease Quality Incentive Program, we generally adopt a baseline period that occurs prior to the performance period for a fiscal year to measure improvement and establish performance standards.

We view the SNF VBP Program as necessitating a similarly-adopted baseline period for each fiscal year to measure improvement (as required by section 1888(h)(3)(B) of the Act) and to

enable us to calculate performance standards that we must establish and announce prior to the performance period (as required by section 1888(h)(3)(A) of the Act). As with the Hospital VBP Program, we intend to adopt baseline periods that are as close as possible in duration as the performance period specified for a fiscal year. However, we may occasionally need to adopt a baseline period that is shorter than the performance period to meet operational timelines. We also intend to adopt baseline periods that are seasonally aligned with the performance periods to avoid any effects on quality measurement that may result from tracking SNF performance during different times of the calendar year.

We intend to propose a baseline period for purposes of calculating performance standards and measuring improvement in future rulemaking. We seek public comment on the most appropriate baseline period for the FY 2019 Program, including what considerations we should take into account when developing this policy for future rulemaking.

6. SNF Performance Scoring

a. Considerations

As with our performance standards policy considerations described above, we considered how other Medicare quality programs score eligible facilities. Specifically, we considered how the Hospital Value-Based Purchasing Program and the Hospital-Acquired Conditions Reduction Program score eligible hospitals. We discussed the Hospital Readmissions Reduction Program's scoring above in relation to performance standards.

i. Hospital Value-Based Purchasing

A Hospital VBP domain score is calculated by combining the measure scores within that domain, weighting each measure equally. The domain score reflects the number of points the hospital has earned based on its performance on the measures within that domain for which it is eligible to receive a score. After summing the weighted domain scores, the TPS is translated using a linear exchange function into the percentage multiplier to be applied to each Medicare discharge claim submitted by the hospital during the applicable fiscal year. (We discuss the Exchange Function in further detail below).

Unlike the Hospital VBP Program, the SNF VBP program focuses on a single readmission measure, one that will be replaced by a single resource use measure as soon as is practicable. As described above, we do not anticipate adopting quality measure domains akin to other CMS quality programs under the SNF VBP Program. We therefore seek comment on how, if at all, we should adapt the HVBP Program's scoring methodology to accommodate both the smaller number of measures and the ranking required under the SNF VBP Program.

ii. Hospital-Acquired Conditions Reduction Program

The Hospital-Acquired Conditions (HAC) Reduction Program scores measures that have been categorized into domains, in a manner that is similar to the HVBP Program's domain structure. For Domain 1, the points awarded to the single assigned measure yield the Domain 1 score, since Domain 1 only contains one measure. For Domain 2, the points awarded for the domain measures are averaged to yield a Domain 2 score. A hospital's Total HAC Score is determined by the sum of weighted Domain 1 and Domain 2 scores. Higher scores indicate worse performance relative to the performance of all other eligible hospitals. Hospitals with a Total HAC Score above the 75th percentile of the Total HAC Score distribution are subject to a payment reduction.

Unlike the Hospital VBP program, referenced above, there is no requirement in the HAC Reduction Program that measures or performance standards must incorporate improvement and achievement scores. As with the HVBP Program above, we seek public comments on the extent to which, if at all, we should adopt components of the HAC Reduction Program's scoring methodology for purposes of the SNF VBP Program. We specifically seek comment on whether or not we should set an absolute level of performance that must be reached to receive a positive SNF value-based incentive payment.

iii. Other Considerations

We intend to consider several additional factors when developing the performance scoring methodology. We believe that it is important to ensure that the performance scoring methodology is straightforward and transparent to SNFs, patients, and other stakeholders. SNFs must be able to clearly understand performance scoring methods and performance expectations to maximize their quality improvement efforts. The public must understand the scoring methodology to make the best use of the publicly reported information when choosing a SNF. We also believe that scoring methodologies for all Medicare value-based purchasing programs should be aligned as appropriate given their specific statutory requirements. This alignment will facilitate the public's understanding of quality information disseminated in these programs and foster more informed consumer decision making about health care. We believe that differences in performance scores must reflect true differences in performance. To ensure that these beliefs are appropriately reflected in the SNF VBP Program, we intend to assess the quantitative characteristics of the measures specified under sections 1888(g)(1) and (2) of the Act, including the current state of measure development, to ensure an appropriate distribution of value-based incentive payments as required by the SNF VBP statute.

We seek public comment on what other considerations we should take into account when developing our proposed scoring methodology for the SNF VBP Program in future rulemaking.

b. Notification Procedures

As described above, we intend to address the topic of quarterly feedback reports to SNFs related to measures specified under sections 1888(g)(1) and (2) of the Act in future rulemaking. We also intend to address how to notify SNFs of the adjustments to their PPS payments based on their performance scores and ranking under the SNF VBP Program, in accordance with the requirement in section 1888(h)(7) of the Act, in future rulemaking.

However, we seek public comment on the best means by which to so notify SNFs.

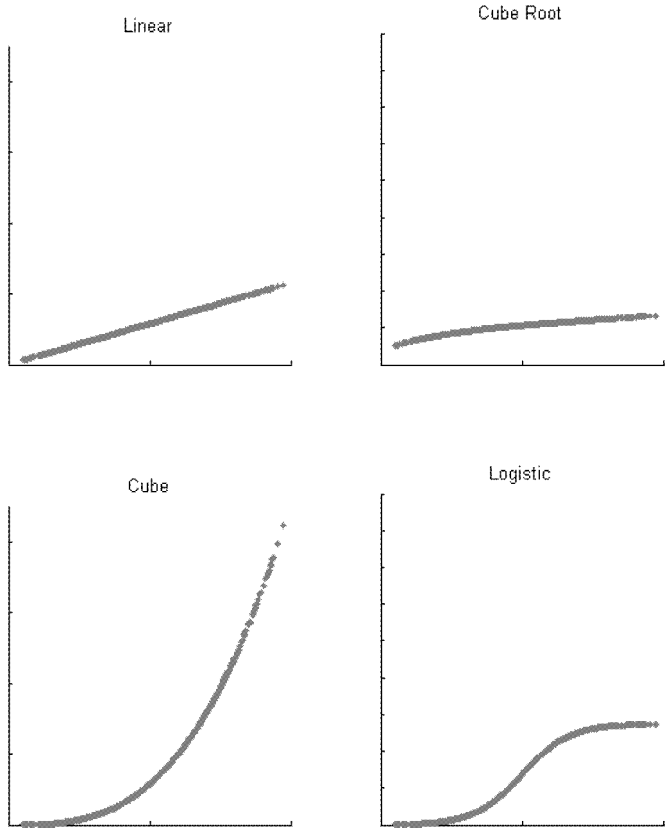
c. Exchange Function

As described above in reference to the Hospital VBP Program's scoring methodology, we use a linear exchange function to translate a hospital's Total Performance Score under that Program into the percentage multiplier to be applied to each Medicare discharge claim submitted by the hospital during the applicable fiscal year. We refer readers to the Hospital Inpatient VBP Program Final Rule (76 FR 26531 through 26534) for detailed discussion of the Hospital VBP Program's Exchange Function, as well as responses to public comments on this issue.

We believe we could consider adopting a similar exchange function methodology to translate SNF performance scores into value-based incentive payments under the SNF VBP Program, and we seek comment on whether or not we should do so. However, as we did for the Hospital

VBP Program, we believe we would need to consider the appropriate form and slope of the exchange function to determine how best to reward high performance and encourage SNFs to improve the quality of care provided to Medicare beneficiaries. As illustrated in figure 1, we could consider the following four mathematical exchange function options: Straight line (linear); concave curve (cube root function); convex curve (cube function); and S-shape (logistic function), and we seek comment on what form of the exchange function we should consider implementing if we adopt such a function under the SNF VBP Program.

Figure 1. Exchange Function Options.



We also seek comment on what considerations we should take into account when determining the appropriate form of the exchange function under the SNF VBP Program. We intend to consider how such options would distribute the value-based incentive payments among SNFs, the potential differences between the value-based incentive payment amounts for SNFs that perform poorly and SNFs that perform very well, the different marginal incentives created by the different exchange function slopes, and the relative importance of having the exchange function be as simple and straightforward as possible. We request public comments on what additional considerations, if any, we should take into account.

7. SNF Value-Based Incentive Payments

Sections 1888(h)(5) and (6) of the Act outline several requirements for value-based incentive payments under the SNF VBP Program, including the value-based incentive payment percentage that must be determined for each SNF and the funding available for value-based incentive payments.

We intend to address this topic in future rulemaking.

8. SNF VBP Public Reporting

a. SNF-Specific Performance Information

Section 1888(h)(9)(A) of the Act requires the Secretary to post information on the performance of individual SNFs under the SNF VBP Program on the *Nursing Home Compare* Web site or its successor. This information is to include the SNF performance score for the facility for the applicable fiscal year and the SNF's ranking for the performance period for such fiscal year.

We intend to address this topic in future rulemaking. However, we seek public comment on how we should display this SNF-specific performance information, whether or not we should allow SNFs an opportunity to review and correct the SNF-specific performance information that we will post on *Nursing Home Compare,* and how such a review and correction process should operate.

b. Aggregate Performance Information

Section 1888(h)(9)(B) of the Act requires the Secretary to post aggregate information on the SNF VBP Program on the *Nursing Home Compare* Web site, or a successor Web site, to include the range of SNF performance scores and the number of SNFs that received value-based incentive payments and the range and total amount of such value-based incentive payments.

We intend to address this topic in future rulemaking. However, we seek public comment on the most appropriate form for posting this

aggregate information to make such information easily understandable for the public.

B. Advancing Health Information Exchange

HHS has a number of initiatives designed to encourage and support the adoption of health information technology and to promote nationwide health information exchange to improve health care. As discussed in the August 2013 Statement ''Principles and Strategies for Accelerating Health Information Exchange'' (available at *http://www.healthit.gov/sites/default/files/acceleratinghieprinciples_strategy.pdf*), HHS believes that all individuals, their families, their healthcare and social service providers, and payers should have consistent and timely access to health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the individual's care. Health IT that facilitates the secure, efficient and effective sharing and use of health-related information when and where it is needed is an important tool for settings across the continuum of care, including SNFs and NFs. While these facilities are not eligible for the Medicare and Medicaid EHR Incentive Programs, effective adoption and use of health information exchange and health IT tools will be essential as these settings seek to improve quality and lower costs through initiatives such as value-based purchasing.

The Office of the National Coordinator for Health Information Technology (ONC) has released a document entitled ''Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0 (draft Roadmap) (available at *http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf*) which describes barriers to interoperability across the current health IT landscape, the desired future state that the industry believes will be necessary to enable a learning health system, and a suggested path for moving from the current state to the desired future state. In the near term, the draft Roadmap focuses on actions that will enable a majority of individuals and providers across the care continuum to send, receive, find and use a common set of electronic clinical information at the nationwide level by the end of 2017. The Roadmap's goals also align with the IMPACT Act of 2014 which requires assessment data to be standardized and interoperable to allow for exchange of the data. Moreover, the vision described in the draft Roadmap significantly expands the types of electronic health information, information sources and information users well beyond clinical information derived from electronic health records (EHRs). This shared strategy is intended to reflect important actions that both public and private sector stakeholders can take to enable nationwide interoperability of electronic health information such as: (1) Establishing a coordinated governance framework and process for nationwide health IT interoperability; (2) improving technical standards and implementation guidance for sharing and using a common clinical data set; (3) enhancing incentives for sharing electronic health information according to common technical standards, starting with a common clinical data set; and (4) clarifying privacy and security requirements that enable interoperability.

In addition, ONC has released the draft version of the 2015 Interoperability Standards Advisory (available at *http://www.healthit.gov/standards-advisory*), which provides a list of the best available standards and implementation specifications to enable priority health information exchange functions. Providers, payers, and vendors are encouraged to take these ''best available standards'' into account as they implement interoperable health information exchange across the continuum of care, including care settings such as behavioral health, long-term and post-acute care, and home and community-based service providers.

We encourage stakeholders to utilize health information exchange and certified health IT to effectively and efficiently help providers improve internal care delivery practices, support management of care across the continuum, enable the reporting of electronically specified clinical quality measures (eCQMs), and improve efficiencies and reduce unnecessary costs. As adoption of certified health IT increases and interoperability standards continue to mature, HHS will seek to reinforce standards through relevant policies and programs.

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

1. Background and Statutory Authority

We seek to promote higher quality and more efficient health care for Medicare beneficiaries, and our efforts are furthered by quality reporting programs coupled with public reporting of that information. Such quality reporting programs already exist for various settings such as the Hospital Inpatient Quality Reporting (HIQR) Program, the Hospital Outpatient Quality Reporting (HOQR) Program, the Physician Quality Reporting System, the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), the Home Health Quality Reporting Program (HHQRP), and the Hospice Quality Reporting Program (HQRP). We have also implemented quality reporting programs for home health agencies (HHAs) that are based on conditions of participation, and an End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and a Hospital Value-Based Purchasing (HVBP) Program that link payment to performance.

SNFs are providers that meet conditions of participation for Medicare. Some SNFs are also certified under Medicaid as nursing facilities, and these types of long-term care facilities furnish services to both Medicare beneficiaries and Medicaid enrollees. SNFs provide short-term skilled nursing services, including but not limited to rehabilitative therapy, physical therapy, occupational therapy, and speech-language pathology services. Such services are provided to beneficiaries who are recovering from surgical procedures, such as hip and knee replacements, or from medical conditions, such as stroke and pneumonia. SNF services are provided when needed to maintain or improve a beneficiary's current condition, or to prevent a condition from worsening. The care provided in a SNF (as a free-standing facility or part of a hospital), is aimed at enabling the beneficiary to maintain or improve his/her health and to function independently. SNF care is a benefit under Medicare Part A and such care is covered for up to 100 days in a benefit period if all coverage requirements are met.[13] In 2014, 2.6 million covered stays occurred within 15,421 SNFs.

Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for fiscal years (FYs) beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the timeframes specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF

[13] Section 1812(a)(2) and (b)(2) of the Social Security Act; 42 CFR 409.61; *http://www.medicare.gov/Pubs/pdf/10153.pdf.*

submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the timeframes specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points.

The IMPACT Act adds section 1899B to the Act that imposes new data reporting requirements for certain PAC providers, including SNFs. Sections 1899B(c)(1) and 1899B(d)(1) of the Act collectively require that the Secretary specify quality measures and resource use and other measures with respect to certain domains not later than the specified application date that applies to each measure domain and PAC provider setting. Section 1899B(a)(2)(E) of the Act delineates the specified application dates for each measure domain and PAC provider. The IMPACT Act also added section 1886(e)(6) to the Act, to require the Secretary to reduce the otherwise applicable PPS payment to a SNF that does not report the new data in a form and manner, and at a time, specified by the Secretary. For SNFs, new section 1886(e)(6)(A)(i) of the Act would require the Secretary to reduce the payment update for any SNF that does not satisfactorily submit the new required data.

Under the SNF QRP, we are proposing that the general timeline and sequencing of measure implementation would occur as follows: Specification of measures; proposal and finalization of measures through notice-and-comment rulemaking; SNF submission of data on the adopted measures; analysis and processing of the submitted data; notification to SNFs regarding their quality reporting compliance with respect to a particular fiscal year; consideration of any reconsideration requests; and imposition of a payment reduction in a particular fiscal year for failure to satisfactorily submit data with respect to that fiscal year. We are also proposing that any payment reductions that are taken with respect to a fiscal would year begin approximately one year after the end of the data submission period for that fiscal year and approximately two years after we first adopt the measure.

This timeline, which is followed in the other quality reporting programs, reflects operational and other practical constraints, including the time needed to specify and adopt valid and reliable measures, collect the data, and determine whether a SNF has complied with our quality reporting requirements. It also takes into consideration our desire to give SNFs enough notice of new data reporting obligations so that they are prepared to timely start reporting the data. Therefore, we intend to follow the same timing and sequence of events for measures specified under section 1899B(c)(1) and (d)(1) of the Act that we currently follow for the other quality reporting programs. We intend to specify each of these measures no later than the specified application dates set forth in section 1899B(a)(2)(E) of the Act and propose to adopt them consistent with the requirements in the Act and Administrative Procedure Act. To the extent that we finalize a proposal to adopt a measure for the SNF QRP that satisfies an IMPACT Act measure domain, we intend to require SNFs to report data on the measure for the fiscal year that begins 2 years after the specified application date for that measure. Likewise, we intend to require SNFs to begin reporting any other data specifically required under the IMPACT Act for the fiscal year that begins 2 years after we adopt requirements that would govern the submission of that data.

As provided at section 1888(e)(6)(A)(ii) of the Act, depending on the market basket percentage for a particular year, the 2 percentage point reduction under section 1888(e)(6)(A)(i) of the Act may result in this percentage, after application of the productivity adjustment under section 1888(e)(5)(B)(ii) of the Act, being less than 0.0 percent for a FY and may result in payment rates under the SNF PPS being less than payment rates for the preceding FY. In addition, as set forth at section 1888(e)(6)(A)(iii) of the Act, any reduction based on failure to comply with the SNF QRP reporting requirements applies only to the particular FY involved, and any such reduction must not be taken into account in computing the SNF PPS payment rates for subsequent FYs.

For purposes of meeting the reporting requirements under the SNF QRP, section 1888(e)(6)(B)(ii) of the Act states that SNFs (or other facilities described in section 1888(e)(7)(B) of the Act, other than a CAH) may submit the 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. Currently, the resident assessment instrument is titled the MDS 3.0. To the extent data required for submission under subclause (II) or (III) of section 1888(e)(6)(B)(i) of the Act duplicates other data required to be submitted under clause (i)(I), section 1888(e)(6)(B)(iii) provides that the submission of data under subclause (II) or (III) is to be in lieu of the submission of such data under clause (I), unless the Secretary makes a determination that such duplication is necessary to avoid delay in the implementation of section 1899B of the Act taking into account the different specified application dates under section 1899B(a)(2)(E) of the Act.

In addition to requiring a quality reporting program for SNFs under new section 1888(e)(6), the IMPACT Act requires feedback to SNFs and public reporting of their performance. More specifically, section 1899B(f)(1) of the Act requires the Secretary to provide confidential feedback reports to SNFs on their performance on the quality measures and resource use and other measures specified under that section. The Secretary must make such confidential feedback reports available to SNFs beginning one year after the specified application date that applies to the measures in that section and, to the extent feasible, no less frequently than on a quarterly basis, except in the case of measures reported on an annual basis, as to which the confidential feedback reports may be made available annually.

Section 1899B(g)(1) of the Act requires the Secretary to provide for the public reporting of SNF performance on the quality measures specified under section 1899B(c)(1) of the Act and the resource use and other measures specified under section 1899B(d)(1) of the Act by establishing procedures for making the performance data available to the public. Such procedures must ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act, that SNFs have the opportunity to review and submit corrections to the data and other information before it is made public as required by section 1899B(g)(2) of the Act. Section 1899B(g)(3) of the Act requires that the data and information is made publicly available beginning no later than two years after the specified application date applicable to such a measure and SNFs. Finally, section 1899B(g)(4)(B) of the Act requires that such procedures must provide that the data and information described in section 1899B(g)(1) of the Act with respect to quality and resource use measures be made publicly available consistent with sections 1819(i) and 1919(i) of the Act.

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

We strive to promote high quality and efficiency in the delivery of health care to the beneficiaries we serve. Performance improvement leading to the highest quality health care requires continuous evaluation to identify and address performance gaps and reduce the unintended consequences that may arise in treating a large, vulnerable, and aging population. Quality reporting programs, coupled with public reporting of quality information, are critical to the advancement of health care quality improvement efforts.

Valid, reliable, relevant quality measures are fundamental to the effectiveness of our quality reporting programs. Therefore, selection of quality measures is a priority for CMS in all of its quality reporting programs.

We are proposing to adopt for the SNF QRP three measures that we are specifying under section 1899(B)(c)(1) of the Act for purposes of meeting the following three domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; and incidence of major falls. These measures align with the CMS Quality Strategy,[14] which incorporates the three broad aims of the National Quality Strategy: [15]

- *Better Care:* Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- *Healthy People, Healthy Communities:* Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- *Affordable Care:* Reduce the cost of quality healthcare for individuals, families, employers, and government.

In deciding to propose these measures, we also took into account national priorities, including those established by the National Priorities Partnership (*http://www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx*), and the HHS Strategic Plan (*http://www.hhs.gov/secretary/about/priorities/priorities.html*).

These measures also incorporate common standards and definitions that can be used across post-acute care settings to allow for the exchange of data among post-acute care providers, to provide access to longitudinal information for such providers to facilitate coordinated and improved outcomes, and to enable comparison of such assessment data across all such providers as required by section 1899B(a) of the Act.

We initiated an Ad Hoc MAP process to obtain input on the measures that we are proposing to adopt in this proposed rule. On February 5th, 2015, we made publicly available a list of Measures Under Consideration (called the ''List of Ad Hoc Measures Under Consideration for the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014'') (MUC list) as part of an Ad Hoc Measures Application Partnership (MAP) convened by the National Quality Forum (NQF). The MAP Post-Acute Care/Long-Term Care Workgroup convened on February 9, 2015 to ''review the measures technical properties as they are adapted for use in new settings and whether the new settings impact the measures' adherence to the NQF Scientific Acceptability criterion.'' [16] The NQF published the MUC list on our behalf for public comment from February 11, 2015 through February 19, 2015 on its Web site. The MAP Coordinating Committee convened on February 27, 2015 to discuss the public comments received, and those public comments are listed here *http://public.qualityforum.org/MAP/MAP%20Coordinating%20Committee/MAP_CC%20Feb%2027_Discussion_Guide.html#agenda.*

The MAP issued a pre-rulemaking report on March 6, 2015 Pre-Rulemaking Report, which is available for download at *http://www.qualityforum.org/Project_Pages/MAP_Post-Acute_CareLong-Term_Care_Workgroup.aspx.* The MAP's input for each of the proposed measures is discussed in this section.

Section 1899B(j) of the Act requires that we allow for stakeholder input as part of the pre-rulemaking process. Therefore, we sought stakeholder input on the measures we are proposing to adopt in this proposed rule as follows: We convened a technical expert panel that included stakeholder experts and patient representatives on February 3, 2015; we sought public input during the February 2015 ad hoc MAP process; and we implemented a public mail box for the submission of comments in January 2015, *PACQualityInitiative@cms.hhs.gov* which is located on our post-acute care quality initiatives Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html.* In addition, we held a National Stakeholder Special Open Door Forum on February 25, 2015 for the purpose of seeking input on these measures. Lastly, we held two separate listening sessions on February 10 and March 24, 2015, respectively.

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

For the SNF QRP, for the purpose of streamlining the rulemaking process, we are proposing that when we adopt a measure for the SNF QRP for a payment determination, this measure would be automatically retained for all subsequent payment determinations unless we propose to remove, suspend, or replace the measure.

Section 1899B(h)(1) of the Act provides that the Secretary may remove, suspend or add a quality measure or resource use or other measure specified under section 1899B(c)(1) or (d)(1) of the Act so long as the Secretary publishes a justification for the action in the **Federal Register** with a notice and comment period. Consistent with the policies of other quality reporting programs including the HIQR Program, the HOQR Program, LTCH QRP, and the IRF QRP, we are proposing that quality measures would be considered for removal if: (1) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made in which case the measure may be removed or suspended; (2) performance or improvement on a measure does not result in better resident outcomes; (3) a measure does not align with current clinical guidelines or practice; (4) a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available; (5) a measure that is more proximal in time to desired resident outcomes for the particular topic is available; (6) a measure that is more strongly associated with desired resident outcomes for the particular topic is available; or (7) collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

We also note that under section 1899B(h)(2) of the Act, in the case of a quality measure or resource use or other measure for which there is a reason to

[14] *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html*

[15] *http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm*

[16] . Ad-hoc Review: Expansion of Settings. (n.d.). Retrieved March 5, 2015, from *http://www.qualityforum.org/Projects/a-b/Ad_Hoc_Reviews/CMS/Ad_Hoc_Reviews-CMS.aspx*

believe that the continued collection raises possible safety concerns or would cause other unintended consequences, the Secretary may promptly suspend or remove the measure and publish the justification for the suspension or removal in the **Federal Register** during the next rulemaking cycle.

For any measure that meets this criteria (that is, a measure that raises safety concerns), we will take immediate action to remove the measure from SNF QRP, and, in addition to publishing a justification in the next rulemaking cycle, will immediately notify SNFs and the public through the usual communication channels, including listening session, memos, email notification, and web postings. We are inviting public comment on these proposals and policies.

4. Proposed Process for Adoption of Changes to SNF QRP Program Measures

Quality measures selected for the SNF QRP must be endorsed by the NQF unless they meet the statutory criteria for exception. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other healthcare stakeholder organizations. The NQF was established to standardize healthcare quality measurement and reporting through its consensus development process (*http://www.qualityforum.org/About_NQF/Mission_and_Vision.aspx*). The NQF undertakes review of: (a) New quality measures and national consensus standards for measuring and publicly reporting on performance, (b) regular maintenance processes for endorsed quality measures, (c) measures with time-limited endorsement for consideration of full endorsement, and (d) ad hoc review of endorsed quality measures, practices, consensus standards, or events with adequate justification to substantiate the review (*http://www.qualityforum.org/Measuring_Performance/Ad_Hoc_Reviews/Ad_Hoc_Review.aspx*).

The NQF solicits information from measure stewards for annual reviews and in order to review measures for continued endorsement in a specific 3-year cycle. In this measure maintenance process, the measure steward is responsible for updating and maintaining the currency and relevance of the measure and for confirming existing specifications to the NQF on an annual basis. As part of the ad hoc review process, the ad hoc review requester and the measure steward are responsible for submitting evidence for review by a NQF Technical Expert panel which, in turn, provides input to the Consensus Standards Approval Committee which then makes a decision on endorsement status and/or specification changes for the measure, practice, or event.

The NQF regularly maintains its endorsed measures through annual and triennial reviews, which may result in the NQF making updates to the measures. We believe that it is important to have in place a subregulatory process to incorporate nonsubstantive updates made by the NQF into the measure specifications as we have adopted for the Hospital IQR Program so that these measures remain up-to-date. We also recognize that some changes the NQF might make to its endorsed measures are substantive in nature and might not be appropriate for adoption using a subregulatory process.

Therefore, in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53504 through 53505), we finalized a policy under which we use a subregulatory process to make nonsubstantive updates to measures used for the Hospital IQR Program. For what constitutes substantive versus nonsubstantive changes, we expect to make this determination on a case-by-case basis. Examples of nonsubstantive changes to measures might include updated diagnosis or procedure codes, medication updates for categories of medications, broadening of age ranges, and exclusions for a measure (such as the addition of a hospice exclusion to the 30-day mortality measures). We believe that nonsubstantive changes may include updates to NQF-endorsed measures based upon changes to guidelines upon which the measures are based.

Therefore, we propose to use rulemaking to adopt substantive updates made to measures as we have for the Hospital IQR Program. Examples of changes that we might consider to be substantive would be those in which the changes are so significant that the measure is no longer the same measure, or when a standard of performance assessed by a measure becomes more stringent (for example, changes in acceptable timing of medication, procedure/process, or test administration). Another example of a substantive change would be where the NQF has extended its endorsement of a previously endorsed measure to a new setting, such as extending a measure from the inpatient setting to hospice. These policies regarding what is considered substantive versus nonsubstantive would apply to all measures in the SNF QRP. We also note that the NQF process incorporates an opportunity for public comment and engagement in the measure maintenance process.

We believe this policy adequately balances our need to incorporate updates to the SNF QRP measures in the most expeditious manner possible while preserving the public's ability to comment on updates that so fundamentally change an endorsed measure that it is no longer the same measure that we originally adopted.

We are inviting public comment on this proposal.

5. Proposed New Quality Measures for FY 2018 and Subsequent Payment Determinations

For the FY 2018 SNF QRP and subsequent years, we are proposing to adopt three post-acute care (PAC) cross-setting quality measures. These measures address the following domains: (1) Skin integrity and changes in skin integrity; (2) incidence of major falls; and (3) functional status, cognitive function, and changes in function and cognitive function, which are all required under section 1899B(c)(1) of the Act. The proposed quality measure addressing skin integrity and changes in skin integrity is the NQF-endorsed measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) (*http://www.qualityforum.org/QPS/0678*). The proposed quality measure addressing the incidence of major falls is an application of the NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) (*http://www.qualityforum.org/QPS/0674*). Finally, the proposed quality measure addressing functional status, cognitive function, and changes in function and cognitive function is an application of the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under NQF review) (*http://www.qualityforum.org/QPS/2631*).

The proposed quality measures addressing the domains of incidence of major falls and functional status, as well as cognitive function, and changes in function and cognitive function, are not currently NQF-endorsed for the SNF population. We reviewed the NQF's endorsed measures and were unable to identify any NQF-endorsed cross-setting quality measures that focused on these domains. We are also unaware of any other cross-setting quality measures that have been endorsed or adopted by another consensus organization.

a. Quality Measure Addressing the Domain of Skin Integrity and Changes in Skin Integrity: Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

We are proposing to adopt for the SNF QRP, beginning with the FY 2018 payment determination, NQF #0678, Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) as a cross-setting quality measure that satisfies the skin integrity and changes in skin integrity domain. This measure assesses the percentage of short-stay residents or patients in SNFs, IRFs, and LTCHs with Stage 2 through 4 pressure ulcers that are new or worsened since a prior assessment.

Pressure ulcers are a serious medical condition that result in pain, decreased quality of life, and increased mortality in aging populations.[17] [18] [19] [20] Pressure ulcers typically are the result of prolonged periods of uninterrupted pressure on the skin, soft tissue, muscle, and bone.[21] [22] [23] Elderly individuals in SNFs are prone to a wide range of medical conditions that increase their risk of developing pressure ulcers. These include impaired mobility or sensation, malnutrition or undernutrition, obesity, stroke, diabetes, dementia, cognitive impairments, circulatory diseases, dehydration, the use of wheelchairs, medical devices, and a history of pressure ulcers or a pressure ulcer at admission.[24] [25] [26] [27] [28] [29] [30] [31] [32] [33] [34]

Section 1899B(a)(1)(B) of the Act requires that the data submitted on quality measures under section 1899B(c)(1) of the Act be standardized and interoperable across PAC settings, and section 1899B(c)(2)(A) of the Act requires that the measures be reported through the use of a PAC assessment instrument. These requirements are in line with the NQF Steering Committee report, which stated that to understand the impact of pressure ulcers across settings, quality measures addressing prevention, incidence, and prevalence of pressure ulcers must be harmonized and aligned. This measure has been implemented in nursing homes for resident population with stays of less than 100 days under CMS's Nursing Home Quality Initiative. We also adopted the measure for use in the LTCH QRP (76 FR 51753 through 51756) beginning with the FY 2014 payment determination, and for use in the IRF QRP (76 FR 24254) beginning with the FY 2014 payment determination. We have not, to date, adopted the measure for the home health setting. More information on the NQF endorsed measure, the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay), is available at *http://www.qualityforum.org/QPS/0678.*

A TEP convened by our measure development contractor provided input on the technical specifications of this quality measure, including the feasibility of implementing the measure across PAC settings. The TEP supported the measure's implementation across PAC settings and was also supportive of our efforts to standardize the measure for cross-setting development. The MAP also supported the use of NQF #0678, Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) in the SNF QRP as a cross-setting quality measure.

We are proposing that the data for this quality measure would be collected using the MDS 3.0, currently submitted by SNFs through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. We believe that this data collection method will minimize the reporting burden on SNFs because SNFs are already required to submit MDS data for payment purposes. For more information on SNF submission using the QIES ASAP system, readers are referred to *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.*

The data items that we would use to calculate the proposed quality measure include: M0800A (Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS assessment) or Last Admission/Entry or Reentry, Stage 2), M0800B (Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS assessment) or Last Admission/Entry or Reentry, Stage 3), and M0800C (Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS assessment) or Last Admission/Entry or Reentry, Stage 4). This measure would be calculated at two points in time, at admission and discharge (see Proposed Form, Manner, and Timing of Quality Data Submission). The specifications and data items for the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay), are available in the MDS 3.0 Quality Measures User's Manual available on our Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.*

We invite public comment on our proposal to adopt NQF #0678 Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) for the SNF QRP for the FY 2018

[17] Casey, G. (2013). ''Pressure ulcers reflect quality of nursing care.'' Nurs N Z 19(10): 20–24.

[18] Gorzoni, M. L. and S. L. Pires (2011). ''Deaths in nursing homes.'' Rev Assoc Med Bras 57(3): 327–331.

[19] 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.

[20] White-Chu, E. F., et al. (2011). ''Pressure ulcers in long-term care.'' Clin Geriatr Med 27(2): 241–258.

[21] 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.

[22] Institute for Healthcare Improvement (IHI). Relieve the pressure and reduce harm. May 21, 2007. Available from *http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/ImprovementStories/FSRelievethePressureandReduceHarm.htm*

[23] Russo CA, Steiner C, Spector W. Hospitalizations related to pressure ulcers among adults 18 years and older, 2006 (Healthcare Cost and Utilization Project Statistical Brief No. 64). December 2008. Available from *http://www.hcupus.ahrq.gov/reports/statbriefs/sb64.pdf.*

[24] Agency for Healthcare Research and Quality (AHRQ). Agency news and notes: pressure ulcers are increasing among hospital patients. January 2009. Available from *http://www.ahrq.gov/research/jan09/0109RA22.htm.=*

[25] 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.

[26] Cai, S., et al. (2013). ''Obesity and pressure ulcers among nursing home residents.'' Med Care 51(6): 478–486.

[27] Casey, G. (2013). ''Pressure ulcers reflect quality of nursing care.'' Nurs N Z 19(10): 20–24.

[28] Hurd D, Moore T, Radley D, Williams C. Pressure ulcer prevalence and incidence across post-acute care settings. Home Health Quality Measures & Data Analysis Project, Report of Findings, prepared for CMS/OCSQ, Baltimore, MD, under Contract No. 500–2005–000181 TO 0002. 2010.

[29] MacLean DS. Preventing & managing pressure sores. Caring for the Ages. March 2003;4(3):34–7. Available from *http://www.amda.com/publications/caring/march2003/policies.cfm.*

[30] Michel, J. M., et al. (2012). ''As of 2012, what are the key predictive risk factors for pressure ulcers? Developing French guidelines for clinical practice.'' Ann Phys Rehabil Med 55(7): 454–465

[31] National Pressure Ulcer Advisory Panel (NPUAP) Board of Directors; Cuddigan J, Berlowitz DR, Ayello EA (Eds). Pressure ulcers in America: Prevalence, incidence, and implications for the future. An executive summary of the National Pressure Ulcer Advisory Panel Monograph. Adv Skin Wound Care. 2001;14(4):208–15

[32] Park-Lee E, Caffrey C. Pressure ulcers among nursing home residents: United States, 2004 (NCHS Data Brief No. 14). Hyattsville, MD: National Center for Health Statistics, 2009. Available from *http://www.cdc.gov/nchs/data/databriefs/db14.htm*

[33] Reddy, M. (2011). ''Pressure ulcers.'' Clin Evid (Online) 2011.

[34] Teno, J. M., et al. (2012). ''Feeding tubes and the prevention or healing of pressure ulcers.'' Arch Intern Med 172(9): 697–701.

payment determination and subsequent years.

As part of our ongoing measure development efforts, we are considering a future update to the numerator of the quality measure NQF #0678, Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay). This update would require PAC providers to report the development of unstageable pressure ulcers and suspected deep tissue injuries (sDTIs). Under this potential change we are considering, the numerator of the quality measure would be updated to include unstageable pressure ulcers, including sDTIs that are new/developed in the facility, as well as Stage 1 or 2 pressure ulcers that become unstageable due to slough or eschar (indicating progression to a stage 3 or 4 pressure ulcer) after admission. SNFs are already required to complete the unstageable pressure ulcer items on the MDS 3.0. As such, this update would require a change in the way the measure is calculated but would not increase the data collection burden for SNFs.

A TEP convened by our measure development contractor strongly recommended that CMS update the specifications for the measure to include these pressure ulcers in the numerator, although it acknowledged that unstageable pressure ulcers and sDTIs cannot and should not be assigned a numeric stage. The TEP also recommended that a Stage 1 or 2 pressure ulcer that becomes unstageable due to slough or eschar should be considered worsened because the presence of slough or eschar indicates a full thickness (equivalent to Stage 3 or 4) wound.[35] [36] These recommendations were supported by technical and clinical advisors and the National Pressure Ulcer Advisory Panel.[37] Additionally, exploratory data analysis conducted by our measure development contractor suggests that the addition of unstageable pressure ulcers, including sDTIs, will increase the observed incidence of new or worsened pressure ulcers at the facility level and may improve the ability of the quality measure to discriminate between poor- and high-performing facilities.

We invite public comment to inform our consideration of the inclusion of unstageable pressure ulcers and sDTIs in the numerator of the quality measure NQF #0678 Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) as part of our future measure development efforts.

b. Quality Measure Addressing the Domain of the Incidence of Major Falls: An Application of the Measure Percent of Residents Experiencing One or More Falls With Major Injury (Long Stay) (NQF #0674)

We are proposing to adopt beginning with the FY 2018 SNF QRP an application to the SNF setting of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) measure that satisfies the incidence of major falls domain. This outcome measure reports the percentage of residents who have experienced falls with major injury over a 3-month period. This measure was developed by CMS and is NQF-endorsed for long-stay residents of nursing facilities.

Research indicates that fall-related injuries are the most common cause of accidental death in people aged 65 and older, responsible for approximately 41 percent of accidental deaths annually.[38] Rates increase to 70 percent of accidental deaths among individuals aged 75 and older.[39] In addition to death, falls can lead to fracture, soft tissue or head injury, fear of falling, anxiety, and depression.[40] Research also indicates that approximately 75 percent of nursing facility residents fall at least once a year. This is twice the rate of their counterparts in the community.[41] Further, it is estimated that 10 percent to 25 percent of nursing facility resident falls result in fractures and/or hospitalization.[42]

Falls also represent a significant cost burden to the entire health care system, with injurious falls accounting for 6 percent of medical expenses among those age 65 and older.[43] In their 2006 work, Sorensen et al. estimate the costs associated with falls of varying severity among nursing home residents. Their work suggests that acute care costs incurred for falls among nursing home residents range from $979 for a typical case with a simple fracture to $14,716 for a typical case with multiple injuries.[44] A similar study of hospitalizations of nursing home residents due to serious fall-related injuries (intracranial bleed, hip fracture, other fracture) found an average cost of $23,723.[45] Among the SNF population, the average 6-month cost of a resident with a hip fracture was estimated at $11,719 in 1996 U.S. dollars.[46]

According to Morse, 78 percent of falls are anticipated physiologic falls, which are falls among individuals who scored high on a risk assessment scale, meaning their risk could have been identified in advance of the fall.[47] To date, studies have identified a number of risk factors for falls.[48] [49] [50] [51] [52] [53] [54] [55] [56]

[35] 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: *http://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*

[36] 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: *http://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.*

[37] 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: *http://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.*

[38] Currie LM. Fall and injury prevention. Annu Rev Nurs Res. 2006;24:39–74.

[39] Fuller GF. Falls in the elderly. Am Fam Physician. Apr 1 2000;61(7):2159–2168, 2173–2154.

[40] Premier Inc. Causes of Falls. 2013. Available: *https://www.premierinc.com/quality-safety/toolsservices/safety/topics/falls/causes_of_falls.jsp.*

[41] Rubenstein LZ, Josephson KR, Robbins AS. Falls in the nursing home. Ann Intern Med. 1994 Sep 15; 121(6):442–51.

[42] Vu MQ, Weintraub N, Rubenstein LZ. Falls in the nursing home: are they preventable? J Am Med Dir Assoc. 2004 Nov-Dec; 5(6):401–6. Review.

[43] Tinetti ME, Williams CS. The effect of falls and fall injuries on functioning in community-dwelling older persons. J Gerontol A Biol Sci Med Sci. 1998 Mar;53(2):M112–9.

[44] Sorensen SV, de Lissovoy G, Kunaprayoon D, Resnick B, Rupnow MF, Studenski S. A taxonomy and economic consequence of nursing home falls. Drugs Aging. 2006;23(3):251–62.

[45] Quigley PA, Campbell RR, Bulat T, Olney RL, Buerhaus P, Needleman J. Incidence and cost of serious fall-related injuries in nursing homes. Clin Nurs Res. Feb 2012;21(1):10–23.

[46] Kramer AM, Steiner JF, Schlenker RE, et al. Outcomes and costs after hip fracture and stroke: a comparison of rehabilitation settings. JAMA. 1997;277(5):396–404.

[47] Ibid. Ibid.Morse, J. M. (1996). Preventing patient falls. Sage.

[48] Rothschild JM, Bates DW, Leape LL. Preventable medical injuries in older patients. Arch Intern Med. 2000 Oct 9; 160(18):2717–28.

[49] Morris JN, Moore T, Jones R, et al. Validation of long-term and post-acute care quality indicators. CMS Contract No: 500–95–0062/T.O. #4. Cambridge, MA: Abt Associates, Inc., June 2003.

[50] Avidan AY, Fries BE, James ML, Szafara KL, Wright GT, Chervin RD. Insomnia and hypnotic use, recorded in the minimum data set, as predictors of falls and hip fractures in Michigan nursing homes. J Am Geriatr Soc. 2005 Jun; 53(6):955–62.

[51] Fonad E, Wahlin TB, Winblad B, Emami A, Sandmark H. Falls and fall risk among nursing

The identification of such risk factors suggests the potential for health care facilities to reduce and prevent the incidence of falls.

The Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) quality measure is NQF-endorsed and has been successfully implemented in nursing facilities for long-stay residents since 2011. In addition, the quality measure is currently publicly reported on CMS' Nursing Home Compare Web site at *http://www.medicare.gov/nursinghomecompare/search.html.* Further, an application of the quality measure was adopted for use in the LTCH QRP in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50290).

Although NQF #0674 is not currently endorsed for the SNF setting, we reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed cross-setting quality measures for that setting that are focused on falls with major injury. We are aware of one NQF-endorsed measure, Falls with Injury (NQF #0202), which is a measure designed for adult acute inpatient and rehabilitation patients capturing ''all documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter, reported as injury falls per 100 days.'' [57] NQF #0202 is not appropriate to meet the IMPACT Act domain as it includes minor injury in the numerator definition. Additionally, including all falls could result in providers limiting the freedom of activity for individuals at higher risk for falls. We are unaware of any other cross-setting quality measures for falls with major injury that have been endorsed or adopted by another consensus organization for the SNF setting. Therefore, we are proposing to adopt this measure under the Secretary's authority to specify non-NQF-endorsed measures under section 1899B.

A TEP convened by our measure development contractor provided input on the technical specifications of this quality measure, including the feasibility of implementing the measure across PAC settings. The TEP was supportive of the implementation of this measure across PAC settings and was also supportive of our efforts to standardize this measure for cross-setting development. The MAP conditionally supported the use of an application of NQF #0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) in the SNF QRP as a cross-setting quality measure. More information about the MAP's recommendations for this measure is available in the report entitled MAP Off-Cycle Deliberations 2015: Measures under Considerations to Implement Provisions of the IMPACT Act, which can be found at *http://www.qualityforum.org/Project_Pages/MAP_Post-Acute_CareLong-Term_Care_Workgroup.aspx.*

More information on the NQF endorsed measure, the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) is available at *http://www.qualityforum.org/QPS/0674.*

We are proposing that data for this quality measure will be collected using the MDS 3.0, currently submitted by SNFs through the QIES ASAP system for the reason noted previously.

The data items that we would use to calculate this proposed quality measure include: J1800 (Any Falls Since Admission/Entry (OBRA or Scheduled PPS) or Reentry or Prior Assessment, whichever is more recent), and J1900 (Number of Falls Since Admission/Entry (OBRA or Scheduled PPS) or Reentry or Prior Assessment, whichever is more recent). This measure would be calculated at the time of discharge (see Proposed Form, Manner, and Timing of Quality Data Submission). The specifications for the application of the measure, the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay), for the SNF population are available on our SNF QRP measures and technical Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.*

We refer readers to the Form, Manner, and Timing of Quality Data Submission section of this proposed rule for more information on the proposed data collection and submission timeline for this proposed quality measure.

We invite public comment on our proposal to adopt an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) measure for the SNF QRP beginning with the FY 2018 payment determination.

c. Quality Measure Addressing the Domain of Functional Status, Cognitive Function, and Changes in Function and Cognitive Function: 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; Under NQF Review)

We are proposing to adopt beginning with the FY 2018 SNF QRP an application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under NQF review) as a cross-setting quality measure that satisfies the functional status, cognitive function, and changes in functional status and cognitive function domain. This quality measure reports the percent of patients or residents with both an admission and a discharge functional assessment and an activity (self-care or mobility) a goal that addresses function.

The National Committee on Vital and Health Statistics' Subcommittee on Health,[58] noted that ''information on functional status is becoming increasingly essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life span of the effects of people's health conditions on their ability to do basic activities and participate in life situations in other words, their functional status.'' This is supported by research showing that patient and resident functioning is associated with important outcomes such as discharge destination and length of stay in inpatient settings,[59] as well as the risk of nursing home placement and hospitalization of older adults living in the community.[60]

home residents. J Clin Nurs. 2008 Jan; 17(1):126–34.

[52] Currie LM. Fall and injury prevention. Annu Rev Nurs Res. 2006;24:39–74.

[53] Ellis AA, Trent RB. Do the risks and consequences of hospitalized fall injuries among older adults in California vary by type of fall? J Gerontol A Biol Sci Med Sci. Nov 2001;56(11):M686–692.

[54] Chen XL, Liu YH, Chan DK, Shen Q, Van Nguyen H. Chin Med J (Engl). Characteristics associated with falls among the elderly within aged care wards in a tertiary hospital: a retrospective. 2010 Jul;123(13):1668–72.

[55] Frisina PG, Guellnitz R, Alverzo J. A time series analysis of falls and injury in the inpatient rehabilitation setting. Rehabil Nurs. 2010 JulAug;35(4):141–6, 166.

[56] Lee JE, Stokic DS. Risk factors for falls during inpatient rehabilitant Am J Phys Med Rehabil. 2008 May;87(5):341–50; quiz 351, 422.

[57] American Nurses Association (2014, April 9). Falls with injury. Retrieved from *http://www.qualityforum.org/QPS/0202.*

[58] Subcommittee on Health National Committee on Vital and Health Statistics, ''Classifying and Reporting Functional Status'' (2001).

[59] Reistetter TA, Graham JE, Granger CV, Deutsch A, Ottenbacher KJ. Utility of Functional Status for Classifying Community Versus Institutional Discharges after Inpatient Rehabilitation for Stroke. *Archives of Physical Medicine and Rehabilitation,* 2010; 91:345–350.

[60] Miller EA, Weissert WG. Predicting Elderly People's Risk for Nursing Home Placement, Hospitalization, Functional Impairment, and

Continued

The majority of individuals who receive PAC services, including care provided by SNFs, HHAs, IRFs, and LTCHs, have functional limitations and many of these individuals are at risk for further decline in function due to limited mobility and ambulation.[61] The patient and resident populations treated by SNFs, HHAs, IRFs, and LTCHs vary in terms of their functional abilities at the time of the PAC admission and their goals of care. For IRF patients and many SNF residents, treatment goals may include fostering the person's ability to manage his or her daily activities so that he or she can complete self-care and/or mobility activities as independently as possible, and if feasible, return to a safe, active, and productive life in a community-based setting. For home health patients, achieving independence within the home environment and promoting community mobility may be the goal of care. For other home care patients, the goal of care may be to slow the rate of functional decline in order to allow the person to remain at home and avoid institutionalization.[62] Lastly, in addition to having complex medical care needs for an extended period of time, LTCH patients often have limitations in functioning because of the nature of their conditions, as well as deconditioning due to prolonged bed rest and treatment requirements (for example, ventilator use). The clinical practice guideline *Assessment of Physical Function* [63] recommends that clinicians document functional status at baseline and over time to validate capacity, decline, or progress. Therefore, assessment of functional status at admission and discharge and establishing a functional goal for discharge as part of the care plan is an important aspect of patient or resident care in all of these PAC settings.

Given the variation in patient or resident populations across the PAC settings, the functional activities that are typically assessed by clinicians for each type of PAC provider may vary. For example, rolling left and right in bed is an example of a functional activity that may be most relevant for low-functioning patients or residents who are chronically critically ill. However, certain functional activities such as eating, oral hygiene, lying to sitting on the side of the bed, toilet transfers, and walking or wheelchair mobility are important activities for patients or residents in each PAC setting.

Although, functional assessment data are currently collected by all four PAC providers and in NFs, this data collection has employed different assessment instruments, scales, and item definitions. The data cover similar topics, but are not standardized across PAC settings. The different sets of functional assessment items coupled with different rating scales makes communication about patient and resident functioning challenging when patients and residents transition from one type of setting to another. Collection of standardized functional assessment data across SNFs, HHAs, IRFs, and LTCHs using common data items would establish a common language for patient and resident functioning, which may facilitate communication and care coordination as patients and residents transition from one type of provider to another. The collection of standardized functional status data may also help improve patient and resident functioning during an episode of care by ensuring that basic daily activities are assessed for all PAC residents at the start and end of care and that at least one functional goal is established.

The functional assessment items included in the proposed functional status quality measure were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the Continuity Assessment Record and Evaluation (CARE) Item Set, which was designed to standardize the assessment of a person's status, including functional status, across acute and post-acute settings (SNFs, HHAs, IRFs, and LTCHs). The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or discharge in order to determine patient's or resident's needs, evaluate patient or resident progress, and prepare patients, residents, and their families for a transition to home or to another setting.

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.'' [64] Reliability and validity testing were conducted as part of CMS's 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'' [65] 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.'' [66] These reports are available on our 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.*

The functional status quality measure we are proposing to adopt beginning with the FY 2018 SNF QRP is a process quality measure that is an application of the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function'' (NQF #2631; under NQF review). This quality measure reports the percent of patients or residents with both an admission and a discharge functional assessment and a treatment goal that addresses function.

This process measure requires the collection of admission and discharge functional status data by clinicians using standardized clinical assessment items, or data elements, which assess specific functional activities, that is, self-care and mobility activities. The self-care and mobility function activities are coded using a 6-level rating scale that indicates the resident's level of independence with the activity at both admission and discharge. A higher score indicates more independence.

For this quality measure, there must be documentation at the time of admission that at least one activity performance (function) goal is recorded for at least one of the standardized self-care or mobility function items using the 6-level rating scale. This indicates that an activity goal(s) has been established. Following this initial assessment, the clinical best practice would be to ensure that the resident's

Mortality: A Synthesis. Medical Care Research and Review, 57; 3: 259–297.

[61] Kortebein P, Ferrando A, Lombebeida J, Wolfe R, Evans WJ. Effect of 10 days of bed rest on skeletal muscle in health adults. JAMA; 297(16):1772–4.

[62] Ellenbecker CH, Samia L, Cushman MJ, Alster K. Patient safety and quality in home health care. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Vol 1.

[63] Kresevic DM. Assessment of physical function. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 89–103.

[64] 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).

[65] Ibid.

[66] Ibid.

care plan reflected and included a plan to achieve such an activity goal(s). At the time of discharge, goal setting and establishment of a care plan to achieve the goal, is reassessed using the same 6-level rating scale, enabling the ability to evaluate success in achieving the resident's activity performance goals.

To the extent that a resident has an unplanned discharge, for example, for the purpose of being admitted to an acute care facility, the collection of discharge functional status data might not be feasible. Therefore, for patients or residents with unplanned discharges, admission functional status data and at least one treatment goal must be reported, but discharge functional status data are not required to be reported.

A TEP convened by the measure development contractor for CMS provided input on the technical specifications of this quality measure, including the feasibility of implementing the measure across PAC settings. The TEP was supportive of the implementation of this measure across PAC settings and was also supportive of our efforts to standardize this measure for cross-setting use. Additionally, the MAP conditionally supported the use of an application of the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under NQF review) for use in the SNF QRP as a cross-setting measure. The MAP noted that this functional status measure addresses an IMPACT Act domain and a MAP PAC/LTC core concept. The MAP conditionally supported this measure pending NQF-endorsement and resolution of concerns about the use of two different functional status scales for quality reporting and payment purposes. Finally, the MAP reiterated its support for adding measures addressing function, noting the group's special interest in this PAC/LTC core concept. More information about the MAP's recommendations for this measure is available in the report entitled MAP Off-Cycle Deliberations 2015: Measures under Considerations to Implement Provisions of the IMPACT Act, which can be found at *http://www.qualityforum.org/Project_Pages/MAP_Post-Acute_CareLong-Term_Care_Workgroup.aspx.*

The proposed measure is derived from the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function quality measure, and we intend to submit the proposed measure to NQF for endorsement. The specifications are available for review at the SNF QRP measures and technical Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.*

We reviewed the NQF's endorsed measures and were unable to identify any NQF-endorsed cross-setting quality measures focused on assessment of function for PAC patients and residents. We are also unaware of any other cross-setting quality measures for functional assessment that have been endorsed or adopted by another consensus organization. Therefore, we are proposing to adopt this function measure for use in the SNF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures.

We are proposing that data for the proposed quality measure would be collected through the MDS 3.0, which SNFs currently submit through the QIES ASAP system. We refer readers to section V.C.7. of this proposed rule for more information on the proposed data collection and submission timeline for this proposed quality measure.

The calculation algorithm of the proposed measure is: (1) For each SNF stay, records of residents discharged during the 12-month target time period are identified and counted. This count is the denominator; (2) The records of residents with complete stays are identified and the number of these resident stays with complete admission functional assessment data and at least one self-care or mobility activity goal and complete discharge functional assessment data is counted; (3) The records of residents with incomplete stays are identified, and the number of these resident records with complete admission functional status data and at least one self-care or mobility goal is counted; (4) The counts from step 2 (complete SNF stays) and step 3 (incomplete SNF stays) are summed. The sum is the numerator count; and (5) the numerator count is divided by the denominator count to calculate this quality measure. This measure would be calculated at two points in time, at admission and discharge.

For purposes of assessment data collection, we propose to add new functional status items to the MDS 3.0. The items would assess specific self-care and mobility activities, and would be based on functional items included in the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set. The items have been developed and tested for reliability and validity in SNFs, HHAs, IRFs, and LTCHs. More information pertaining to item testing is available on our 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.*

The proposed function items that we would add to the MDS for purposes of the calculation of this proposed quality measure do not duplicate existing items currently collected in that assessment instrument for other purposes. The currently used MDS function items evaluate a resident's greatest dependence on three or more occasions, whereas the proposed functional items would evaluate an individual's usual performance at the time of admission and at the time of discharge for goal setting purposes. Additionally, there are several key differences between the existing and new proposed function items that may result in variation in the resident assessment results including: (1) The data collection and associated data collection instructions; (2) the rating scales used to score a resident's level of independence; and (3) the item definitions. A description of these differences is provided with the measure specifications on our SNF QRP measures and technical Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.*

Because of the differences between the current function assessment items (section G of the MDS 3.0) and the proposed function assessment items that we would collect for purposes of calculating the proposed measure, we would require that SNFs submit data on both sets of items. Data collection for the new proposed function items do not substitute for the data collection under the current Section G.

We invite public comments on our proposal to adopt beginning with the FY 2018 SNF QRP an application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a care Plan that Addresses Function (NQF #2631; under review).

6. SNF QRP Quality Measures Under Consideration for Future Years

TABLE 10—SNF QRP QUALITY MEASURES AND CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

Impact Act Domain	Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.
Measures	(NQF #2510): *Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM).*
	(NQF #2512; NQF #2502): Application of the LTCH/IRF All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs/IRFs.
Impact Act Domain	Resource Use, including total estimated Medicare spending per beneficiary.
Measure	Application of the Payment Standardized Medicare Spending Per Beneficiary (MSPB).
Impact Act Domain	Discharge to community.
Measure	Percentage residents/patients at discharge assessment, who are discharged to a higher level of care or to the community. Measure assesses if the patient/resident went to the community and whether they stayed there. Ideally, this measure would be paired with the 30-day all-cause readmission measure.

We invite comment on the measure domains and associated measures and measure concepts listed in Table 10. In addition, in alignment with the requirements of the IMPACT Act to develop quality measures and standardize data for comparative purposes, we believe that evaluating outcomes across the post-acute settings using standardized data is an important priority. Therefore, in addition to proposing a process-based measure for the domain in the IMPACT Act of ''Functional status, cognitive function, and changes in function and cognitive function'', which is included in this year's proposed rule, we also intend to develop outcomes-based quality measures, including functional status and other quality outcome measures to further satisfy this domain. These measures will be proposed in future rulemaking in order to assess functional change for each care setting as well as across care settings.

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

a. Participation/Timing for New SNFs

Beginning with the submission of data required for the FY 2018 payment determination, we propose that a new SNF would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. For example, for FY 2018 payment determinations, if a SNF received its CCN on August 28, 2016, and 30 days are added (for example, August 28 + 30 days = September 27), the SNF would be required to submit data for residents who are admitted beginning on October 1, 2016.

We invite public comment on this proposed timing for new SNFs to begin reporting quality data under the SNF QRP.

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

As discussed previously, we are proposing that SNFs would submit data on the proposed functional status, skin integrity, and incidence of major falls measures by completing items on the MDS and then submitting the MDS to CMS through the Quality Improvement and Evaluation System (QIES), Assessment Submission and Processing System (ASAP) system. We seek comment on this proposed method of data collection.

Currently, there is no discharge assessment required when a resident is discharged from the SNF Medicare Part A coverage stay but does not leave the facility, and we are aware that this affects nearly 30 percent of all SNF residents. To collect the data at the time these beneficiaries are discharged from the SNF Part A coverage stay, we propose to add an item set in addition to the 5-Day PPS Assessment. Further, to collect the data elements required to calculate the function quality measure (an 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; under NQF review]) at the time of a residents admission, we also propose to add the necessary items to the 5-day PPS Assessment.

A list of the data items that we are proposing to add to the SNF PPS Part A Discharge and the 5-Day PPS Assessments is available on our Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.* We recognize that there may be instances where SNFs want to combine the SNF PPS Part A Discharge Assessment with other required assessments, as happens with other PPS and OBRA assessments, or scenarios in which the end of the Part A coverage stay occurs at the same time as a scheduled PPS assessment. Therefore, we invite comment on any situations where assessments may be combined or interact, which should be considered in implementing the SNF PPS Part A Discharge Assessment with a view toward addressing any issues that we may identify through the public comment process as requiring additional clarification.

For the FY 2018 payment determination, we are proposing that SNFs submit data on the three proposed quality measures for residents who are admitted to the SNF on and after October 1, 2016 and discharged from the SNF up to and including December 31, 2016, using the data submission schedule that we are proposing in this section.

We are proposing to collect a single quarter of data for FY 2018 to remain consistent with the usual October release schedule for the MDS, to give SNFs a sufficient amount of time to update their systems so that they can comply with the new data reporting requirements, and to give CMS a sufficient amount of time to determine compliance for the FY 2018 program. The proposed use of one quarter of data for the initial year of quality reporting is consistent with the approach we used to implement a number of other quality reporting programs, including the LTCH, IRF, and Hospice QRPs.

We also propose that following the close of the reporting quarter, October 1, 2016 through December 31, 2016 for the FY 2018 payment determination, SNFs would have an additional 5½ months to correct and/or submit their quality data. Consistent with the IRF QRP, we propose that the final deadline for submitting data for the FY 2018 payment determination would be May 15, 2017. We further propose that for the FY 2019 payment determination, we would collect data from the 2nd through 4th quarters of FY 2017 (that is, data for residents who are admitted from January 1st and discharged up to and including September 30th) to determine whether a SNF has met its quality reporting requirements with respect to that fiscal year. Beginning with the FY

2020 payment determination, we propose to move to a full year of fiscal year data collection. We intend to propose the FY 2019 payment determination quality reporting data submission deadlines in future rulemaking.

TABLE 11—PROPOSED MEASURES, DATA COLLECTION SOURCE, DATA COLLECTION PERIOD AND DATA SUBMISSION DEADLINES AFFECTING THE FY 2018 PAYMENT DETERMINATION

Quality measure	Data collection source	Proposed data collection period	Proposed data submission deadline for FY 2018 payment determination
NQF #0678: Percent of Patients or Residents with Pressure Ulcers that are New or Worsened.	MDS	10/01/16–12/31/16	May 15, 2017.
NQF #0674: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).	MDS	10/01/16–12/31/16	May 15, 2017.
NQF #2631*: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function.	MDS	10/01/16–12/31/16	May 15, 2017.

* Status: under review at NQF, please see: *http://www.qualityforum.org/ProjectMeasures.aspx?projectID=73867*, see NQF #2631.

We seek public comment on these proposals.

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

We are proposing that, beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the proposed quality measures on at least eighty percent of the MDS assessments that they submit. We are proposing that a SNF has reported all of the data necessary to calculate the measures if the data actually can be used for purposes of calculating the quality measures, as opposed to, for example, the use of a dash [-], to indicate that the SNF was unable to perform a pressure ulcer assessment.

We believe that because SNFs have long been required to submit MDS assessments for other purposes, SNFs should easily be able to meet this proposed requirement for the SNF QRP. Our proposal to set reporting thresholds is consistent with policies we have adopted for the Long-Term Care Hospital (79 FR 50314), Inpatient-Rehabilitation Hospital (79 FR 45923) and Home Health (79 FR 66079) Quality Reporting Programs.

Although we are proposing to adopt an 80 percent threshold initially, we intend to propose to raise the threshold level for subsequent program years through future rulemaking.

We are also proposing that for the FY 2018 SNF QRP, any SNF that does not meet the proposed requirement that 80 percent of all MDS assessments submitted contain 100 percent of all data items necessary to calculate the SNF QRP measures would be subject to a reduction of 2 percentage points to its FY 2018 market basket percentage.

We invite comment on the proposed SNF QRP data completion requirements.

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

To ensure the reliability and accuracy of the data submitted under the SNF QRP, we intend to propose to adopt policies and processes for validating the data submitted under the SNF QRP in future rulemaking. At this time, we are seeking comment on what elements we should consider including in such a process.

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

Our experience with other quality reporting programs has shown that there are times when providers are unable to submit quality data due to extraordinary circumstances beyond their control (for example, natural, or man-made disasters). Other extenuating circumstances are reviewed on a case-by-case basis. We have defined a ''disaster'' as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation. Natural disasters could include events such as hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis. Man-made disasters could include such events as terrorist attacks, bombings, floods caused by man-made actions, civil disorders, and explosions. A disaster may be widespread and impact multiple structures or be isolated and impact a single site only.

In certain instances of either natural or man-made disasters, a SNF may have the ability to conduct a full resident assessment, and record and save the associated data either during or before the occurrence of the extraordinary event. In this case, the extraordinary event has not caused the facility's data files to be destroyed, but it could hinder the SNF's ability to meet the quality reporting program's data submission deadlines. In this scenario, the SNF would potentially have the ability to report the data at a later date, after the emergency has passed. In such cases, a temporary extension of the deadlines for reporting might be appropriate.

In other circumstances of natural or man-made disaster, a SNF may not have had the ability to conduct a full resident assessment, or to record and save the associated data before the occurrence of the extraordinary event. In such a scenario, the facility may not have complete data to submit to CMS. We believe that it may be appropriate, in these situations, to grant a full exception to the reporting requirements for a specific period of time.

We do not wish to penalize SNFs in these circumstances or to unduly increase their burden during these times. Therefore, we are proposing a process for SNFs to request and for us to grant exceptions and extensions with respect to the quality data reporting requirements of the SNF QRP for one or more quarters, beginning with the FY 2018 payment determination, when there are certain extraordinary circumstances beyond the control of the SNF. When an exception or extension is granted, we would not reduce the SNF's PPS payment for failure to comply with the requirements of the SNF QRP.

We are proposing that if a SNF seeks to request an exception or extension

with respect to the SNF QRP, the SNF should request an exception or extension within 90 days of the date that the extraordinary circumstances occurred. The SNF may request an exception or extension for one or more quarters by submitting a written request to CMS that contains the information noted below, via email to the SNF Exception and Extension mailbox at *SNFQRPReconsiderations@cms.hhs.gov.* Requests sent to CMS through any other channel will not be considered as valid requests for an exception or extension from the SNF QRP's reporting requirements for any payment determination.

We note that the subject of the email must read ''SNF QRP Exception or Extension Request'' and the email must contain the following information:

- SNF CCN;
- SNF name;
- CEO or CEO-designated personnel contact information including name, telephone number, email address, and mailing address (the address must be a physical address, not a post office box);
- SNF's reason for requesting an exception or extension;
- Evidence of the impact of extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the SNF believes it will be able to again submit SNF QRP data and a justification for the proposed date.

We are proposing that exception and extension requests be signed by the SNF's CEO or CEO designated personnel, and that if the CEO designates an individual to sign the request, the CEO-designated individual has the appropriate authority to submit such a request on behalf of the SNF. Following receipt of the email, we will: (1) Provide a written acknowledgement, using the contact information provided in the email, to the CEO or CEO-designated contact notifying them that the request has been received; and (2) provide a formal response to the CEO or any CEO-designated SNF personnel, using the contact information provided in the email, indicating our decision.

This proposal does not preclude us from granting exceptions or extensions to SNFs that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. If we make the determination to grant an exception or extension to all SNFs in a region or locale, we are proposing to communicate this decision through routine communication channels to SNFs and vendors, including, but not limited to, issuing memos, emails, and notices on our SNF QRP Web site once it is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

We are also proposing that we may grant an exception or extension to SNFs if we determine that a systemic problem with one of our data collection systems directly affected the ability of the SNF to submit data. Because we do not anticipate that these types of systemic errors will happen often, we do not anticipate granting an exception or extension on this basis frequently.

If a SNF is granted an exception, we will not require that the SNF submit any measure data for the period of time specified in the exception request decision. If we grant an extension to a SNF, the SNF will still remain responsible for submitting quality data collected during the timeframe in question, although we will specify a revised deadline by which the SNF must submit this quality data.

We also propose that any exception or extension requests submitted for purposes of the SNF QRP will apply to that program only, and not to any other program we administer for SNFs such as survey and certification. MDS requirements, including electronic submission, during Declared Public Health Emergencies can be found at FAQs K–5, K–6 and K–9 on the following link: *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/downloads/AllHazardsFAQs.pdf.*

We intend to provide additional information pertaining to exceptions and extensions for the SNF QRP, including any additional guidance, on the SNF QRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

We invite public comment on these proposals for seeking and being granted exceptions and extensions to the quality reporting requirements.

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

At the conclusion of the required quality data reporting and submission period, we will review the data received from each SNF during that reporting period to determine if the SNF met the quality data reporting requirements. SNFs that are found to be noncompliant with the reporting requirements for the applicable fiscal year will receive a 2 percentage point reduction to their market basket percentage update for that fiscal year.

We are aware that some of our other quality reporting programs, such as the HIQR Program, the LTCHQR Program, and the IRF QRP include an opportunity for the providers to request a reconsideration of our initial non-compliance determination. Therefore, to be consistent with other established quality reporting programs and to provide an opportunity for SNFs to seek reconsideration of our initial non-compliance decision, we are proposing a process that will enable a SNF to request reconsideration of our initial non-compliance decision in the event that it believes that it was incorrectly identified as being non-compliant with the SNF QRP reporting requirements for a particular fiscal year.

For the FY 2018 payment determination, and that of subsequent years, we are proposing that a SNF would receive a notification of noncompliance if we determine that the SNF did not submit data in accordance with the data reporting requirements with respect to the applicable FY. The purpose of this notification is to put the SNF on notice of the following: (1) That the SNF has been identified as being non-compliant with the SNF QRP's reporting requirements for the applicable fiscal year; (2) that the SNF will be scheduled to receive a reduction in the amount of two percentage points to its market basket percentage update for the applicable fiscal year; (3) that the SNF may file a request for reconsideration if it believes that the finding of noncompliance is erroneous, has submitted a request for an extension or exception that has not yet been decided, or has been granted an extension or exception; and (4) that the SNF must follow a defined process on how to file a request for reconsideration, which will be described in the notification. We would only consider requests for reconsideration after an SNF has been found to be noncompliant.

Notifications of noncompliance and any subsequent notifications from CMS would be sent via a traceable delivery method, such as certified U.S. mail or registered U.S. mail, or through other practicable notification processes, such as a report from CMS to the provider as a Certification and Survey Provider Enhanced Reports (CASPER) report, that will provide information pertaining to their compliance with the reporting requirements for the given reporting cycle. To obtain the CASPER report, providers should access the CASPER

Reporting Application. Information on how to access the CASPER Reporting Application is available on the Quality Improvement Evaluation System (QIES) Technical Support Office Web site (direct link), *https://web.qiesnet.org/qiestosuccess/*. Once access is established providers can select ''CASPER Reports'' link. The ''CASPER Reports'' link will connect a SNF to the QIES National System Login page for CASPER Reporting.

We seek comments on the most preferable delivery method for the notice of non-compliance, such as U.S. Mail, email, CASPER, etc.

We propose to disseminate communications regarding the availability of compliance reports in the CASPER reports through routine channels to SNFs and vendors, including, but not limited to issuing memos, emails, Medicare Learning Network (MLN) announcements, and notices on our SNF QRP Web site once it is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

A SNF would have 30 days from the date of the initial notification of noncompliance to submit to us a request for reconsideration. This proposed time frame allows us to balance our desire to ensure that SNFs have the opportunity to request reconsideration with our need to complete the process and provide SNFs with our reconsideration decision in a timely manner. We are proposing that a SNF may withdraw its request at any time and may file an updated request within the proposed 30-day deadline. We are also proposing that, in very limited circumstances, we may grant a request by a SNF to extend the proposed deadline for reconsideration requests. It would be the responsibility of a SNF to request an extension and demonstrate that extenuating circumstances existed that prevented the filing of the reconsideration request by the proposed deadline.

We also are proposing that as part of the SNF's request for reconsideration, the SNF would be required to submit all supporting documentation and evidence demonstrating full compliance with all SNF QRP reporting requirements for the applicable fiscal year, that the SNF has requested an extension or exception for which a decision has not yet been made, that the SNF has been granted an extension or exception, or has experienced an extenuating circumstance as defined in section V.C.10 of this rule but failed to file a timely request of exception. We propose that we would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request.

The documentation and evidence may include copies of any communications that demonstrate the SNF's compliance with the SNF QRP, as well as any other records that support the SNF's rationale for seeking reconsideration, but should not include any protected health information (PHI). We intend to provide a sample list of acceptable supporting documentation and evidence, as well as instructions for SNFs on how to retrieve copies of the data submitted to CMS for the appropriate program year in the future on our SNF QRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

We are proposing that a SNF wishing to request a reconsideration of our initial noncompliance determination would be required to do so by submitting an email to the following email address: *SNFQRPReconsiderations@cms.hhs.gov.* Any request for reconsideration submitted to us by a SNF would be required to follow the guidelines outlined on our SNF QRP Web site once it is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

All emails must contain a subject line that reads ''SNF QRP Reconsideration Request.'' Electronic email submission is the only form of reconsideration request submission that will be accepted by us. Any reconsideration requests communicated through another channel including, but not limited to, U.S. Postal Service or phone, will not be considered as a valid reconsideration request.

We are proposing that a reconsideration request include the following information:

- SNF CMS Certification Number (CCN);
- SNF Business Name;
- SNF Business Address;
- The CEO contact information including name, email address, telephone number and physical mailing address; or

The CEO-designated representative contact information including name, title, email address, telephone number and physical mailing address; and

- CMS identified reason(s) for non-compliance from the non-compliance notification; and
- The reason(s) for requesting reconsideration.

The request for reconsideration must be accompanied by supporting documentation demonstrating compliance. Following receipt of a request for reconsideration, we will provide an email acknowledgment, using the contact information provided in the reconsideration request, to the CEO or CEO-designated representative that the request has been received. Once we have reached a decision regarding the reconsideration request, an email will be sent to the SNF CEO or CEO-designated representative, using the contact information provided in the reconsideration request, notifying the SNF of our decision.

We also propose that the notifications of our decision regarding reconsideration requests may be made available through the use of CASPER reports or through a traceable delivery method, such as certified U.S. mail or registered U.S. mail. If the SNF is dissatisfied with the decision rendered at the reconsideration level, the SNF may appeal the decision to the PRRB under 42 CFR 405.1835. We believe this proposed process is more efficient and less costly for CMS and for SNFs because it decreases the number of PRRB appeals by resolving issues earlier in the process. Additional information about the reconsideration process including details for submitting a reconsideration request will be posted in the future to our SNF QRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html.*

We invite public comment on the proposed procedures for reconsideration and appeals.

12. Public Display of Quality Measure Data for the SNF QRP

Section 1899B(g)(1) of the Act requires the Secretary to provide for the public reporting of SNF provider performance on the quality measures specified under subsection (c)(1) and the resource use and other measures specified under subsection (d)(1) by establishing procedures for making available to the public data and information on the performance of individual SNFs with respect to the measures. Under section 1899B(g)(2) of the Act, such procedures must be consistent with those under section 1886(b)(3)(B)(viii)(VII) of the Act and also allow SNFs the opportunity to review and submit corrections to the data and other information before it is made public. Section 1899B(g)(3) of the

Act requires that the data and information be made publicly available not later than 2 years after the specified application date applicable to such a measure and provider. Finally, section 1899B(g)(4)(B) of the Act requires such procedures be consistent with Sections 1819(i) and 1919(i) of the Act. We intend to propose details related to the public display of quality measures in the future.

13. Mechanism for Providing Feedback Reports to SNFs

Section 1899B(f) of the Act requires the Secretary to provide confidential feedback reports to post-acute care providers on their performance with respect to the measures specified under subsections (c)(1) and (d)(1), beginning 1 year after the specified application date that applies to such measures and PAC providers. We intend to provide detailed procedures to SNFs on how to obtain their confidential feedback reports on the SNF QRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html.*

D. Staffing Data Collection

1. Background and Statutory Authority

Section 1819(d)(1)(A) of the Act for SNFs and section 1919(d)(1)(A) of the Act for NFs each state that, in general, a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act give the Secretary authority to issue rules, for SNFs and NFs respectively, relating to the health, safety and well-being of residents and relating to the physical facilities thereof.

Section 6106 of the Affordable Care Act of 2010 (Pub. L. 111–148, March 23, 2010) added a new section 1128I to the Act to promote greater accountability for LTC facilities (defined under section 1128I(a) of the Act as skilled nursing facilities and nursing facilities). Section 1128I(g) pertains to the submission of staffing data by LTC facilities, and specifies that the Secretary, after consulting with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives and other parties the Secretary deems appropriate, shall require a facility to electronically submit to the Secretary direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by the Secretary in consultation with such programs, groups, and parties. The statute further requires that the specifications established by the Secretary specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel), include resident census data and information on resident case mix, be reported on a regular schedule, and include information on employee turnover and tenure and on the hours of care provided by each category of certified employees per resident per day. Section 1128I(g) of the Act establishes that the Secretary may require submission of information for specific categories, such as nursing staff, before other categories of certified employees, and requires that information for agency and contract staff be kept separate from information on employee staffing.

2. Consultation on Specifications

We have adopted a two-pronged strategy to comply with section 1128I(g) of the Act's consultation requirement. First, through this notice of proposed rulemaking, we are soliciting input from all interested parties, including, without limitation, state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives. Second, we are engaged in ongoing consultation with the statutorily identified entities regarding the sub-regulatory reporting specifications that we will establish. For example, in 2012, we conducted a 6-month pilot in which facilities submitted staffing information electronically based on payroll data, and which allowed participants and other stakeholders to provide feedback on the computerized system we are considering using to collect data. Following the pilot, we continue to receive feedback on the collection and reporting of staffing information from stakeholders in anticipation of establishing the specifications for the required submission by all facilities. Over the next few months, we intend to increase the level of engagement with stakeholders, including industry associations, consumer advocacy groups, and long-term care facilities, to solicit their input on these specifications in advance of the proposed mandatory submission date. We anticipate activities to solicit feedback will include Open Door Forums, general question and answer sessions, and a voluntary submission period whereby facilities can submit staffing information on a voluntary basis to become familiar with the system and to provide feedback to CMS on systems issues in advance of the mandatory submission date. Through this proposed rule, we invite public comment on our proposed methods for consultation on the submission specifications.

3. Provisions of the Proposed Rule

We propose to modify current regulations applicable to LTC facilities that participate in Medicare and Medicaid to implement the new statutory requirement in section 1128I(g) of the Act. Specifically, we propose to amend the requirements for the administration of a LTC facility at § 483.75 by adding a new paragraph (u), Mandatory submission of staffing information based on payroll data in a uniform format.

The proposed regulation would require facilities to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, beginning on July 1, 2016.

a. Submission Requirements

We are proposing to add a new § 483.75(u)(1) to establish the categories of information a facility must submit. This provision would implement the requirements in sections 1128I(g)(1), (2) and (4) of the Act, which require that a facility's submission of staffing information specify the category of work a certified employee performs, include resident census data and information on resident case mix, and include information on employee turnover and tenure and on the hours of care provided by each category of certified employees per resident per day. In keeping with Congress's clear intent, CMS is interpreting the statutory terms ''Certified employee'' and ''employee'' in section 1128Ig(1) and (4) of the Act to include contract and agency staff as well as direct employees.

The proposed rule also adopts certain approaches to minimize industry burden and duplication and to provide clarity for long-term care facilities that we believe are consistent with the intent, and meet the requirements, of the statute. For example, this rule does not propose to require the collection of resident case mix information as specified at section 1128I(g)(2) of the

Act because we already collect such information under § 483.20, per which LTC facilities are required to conduct resident assessments by completing the Minimum Data Set (MDS) and submit the MDS data electronically to CMS. Because the MDS data is used to calculate a facility's resident case mix, long-term care facilities are already required to meet this statutory requirement.

Additionally, for purposes of implementing the statutory reporting requirements in section 1128I(g)(4) of the Act, we proposed text for the new § 483.75(u)(1)(iii) to specify that the staffing information a facility would need to submit must include each individual's start date, end date (if applicable) and hours worked. Although the statute does not specifically require reporting each individual's start and end dates, we believe that requiring submission of these data elements is necessary to satisfy section 1128I(g)(4) of the Act's requirement that facilities submit information on turnover and retention.

Finally, although the proposed text for the new § 483.75(u)(1)(iii) would require facilities to submit each individual's hours worked, we note that section 1128I(g)(4) of the Act requires LTC facilities to report on the hours of care provided by each category of certified employees per resident per day. We believe the obligation to submit information on ''hours of care'' is satisfied by requiring facilities to submit hours worked by staff. In contrast with the statutory reference to ''direct care staffing information,'' which we believe is intended to establish that information must be submitted for the categories of individuals who render direct care, we believe Congress's intent in referring to ''hours of care'' was to require submission of information regarding the hours worked by individuals in those categories of staff providing direct care services. One of the primary objectives of the statute is for facilities to submit staffing information that is based on payroll and other verifiable and auditable data. We believe that most payroll or employee time and attendance systems capture the hours worked by individuals, and do not typically distinguish between hours spent doing different tasks (unless the tasks require different levels of pay). If we were to assume that ''hours or care'' was a subset of the hours worked by individuals, we would not be able to verify or audit the data submitted. As such, we believe that requiring facilities to report data on hours worked will yield the information Congress intended regarding ''hours of care provided.''

b. Distinguishing Employees From Agency and Contract Staff

Under section 1128I(g) of the Act's requirement that information for agency and contract staff be kept separate from information on employee staffing, we are proposing to add a new § 483.75(u)(2) to establish that, when reporting direct care staffing information for an individual, a facility must specify whether the individual is an employee of the facility or is engaged by the facility as contract or agency staff. We believe the statute's intent is to require LTC facilities to submit staffing information in a manner that can enable us to distinguish those staff that are employed by the facility from those that are engaged by the facility under a contract or through an agency. We do not believe the statute requires such data to be submitted at separate times or through separate systems, which would merely engender unnecessary costs and burden, so we intend to collect all facility staffing information at the same time and through the same system, employing a mechanism by which LTC facilities will clearly specify whether staff members are employees of the facility, or engaged under contract or through an agency.

c. Data Format

We are proposing to add a new § 483.75(u)(3) to establish that a facility must submit direct care staffing information in the format specified by CMS. This provision would implement the requirement in section 1128I(g) of the Act that facilities submit direct care staffing information in a uniform format. As noted, we are consulting with stakeholders on potential format specifications. The data that we propose be required to be submitted are similar to those already submitted by LTC facilities to CMS on the forms CMS–671 and CMS–672 (we intend for this proposed new information collection to eventually supplant the data collections via the CMS–671 and CMS–672). In advance of the proposed July 1, 2016 implementation date, we will publicize the established format specifications and will offer training to help facilities and other interested parties (for example, payroll vendors) prepare to meet the requirement.

d. Submission Schedule

Section 1128I(g)(3) of the Act requires that facilities submit direct care staffing information on a regular reporting schedule. LTC facilities now submit staffing information to CMS about once a year. Because staffing levels may change throughout the course of a year (based on, among other things, a facility's census and residents' needs), to have a more continuous and accurate reflection of facility staffing, we believe it is preferable for facilities to submit staffing information quarterly. Therefore, the proposed new § 483.75(u)(4) would establish that a facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

4. Compliance and Enforcement

This proposed new § 483.75(u) would implement the provisions of section 1128I(g) of the Act as requirements a LTC facility must meet to qualify to participate as a SNF in the Medicare program or a NF in the Medicaid program. As such, we plan to enforce the requirements under this new regulation through 42 CFR part 488. Should a facility fail to meet the reporting requirements of, or report inaccurate information under, the proposed § 483.75(u), CMS or the state may impose one or more remedies available to address noncompliance with the requirements for LTC facilities.

5. Conclusion

This proposed rule would implement the new requirements regarding the submission of staffing information based on payroll and other verifiable and auditable data by establishing that such submissions are requirements that a LTC facility must meet to qualify to participate as a SNF in the Medicare program or a NF in the Medicaid program. While section 1128I(g) of the Act does not make explicit that submission of staffing information based on these data is a condition of participation for Medicare or Medicaid, we believe that it is implicitly authorized by the terms of section 6106 of the Affordable Care Act. Moreover, it is explicitly permitted by the general rulemaking authority of sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act, which permit the Secretary to issue rules relating to the health, safety and well-being of residents. It is critical for both CMS and consumers to have access to accurate LTC staffing information to evaluate the quality of care rendered by such facilities. Several studies have looked at the relationship between staffing and the quality of care delivered by long term care facilities, and it is clear that staffing has an impact on the quality of care received by residents. This new collection and reporting of staffing data should enable us to have greater insight on the relationship between staffing and quality, and can be

used to inform future programs or policies.

VI. Collection of Information Requirements

As indicated below, this rule only proposes information collection requirements that are exempt from the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*).

Specifically, section V.D. of this preamble proposes to add § 483.75(u) to implement the provisions of section 1128I(g) of the Act as requirements a LTC facility must meet in order to qualify to participate as a SNF in the Medicare program or a NF in the Medicaid program. As such, nursing homes would be required to electronically submit direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data. This requirement is exempt from the Paperwork Reduction Act (PRA) in accordance with the 1987 Omnibus Budget Reconciliation Act (OBRA) for SNF and NF information collection activities (Pub. L. 100–203, section 4204(b) and section 4214(d)). Under sections 4204(b) and 4214(d) of OBRA 1987, requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA).

Section V.C.5. of this preamble proposes the following three new quality measures for the SNF QRP beginning with the FY 2018 program year: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), and an application of the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under NQF review).

While the reporting of quality measures is an information collection, the requirement is exempt from the PRA in accordance with the IMPACT Act 2014. More specifically, section 1899B(m) and section 1899B(a)(2)(B) of the Act, exempt modifications that are intended to achieve the standardization of patient assessment data.

With regard to quality reporting during extraordinary circumstances, section V.C.10. of this rule proposes that SNFs may request an exception or extension from the FY 2018 payment determination and that of subsequent payment determinations. The request must be submitted by email within 90 days from the date that the extraordinary circumstances occurred.

While the preparation and submission of the request is an information collection, the requirement is exempt from the PRA in accordance with the IMPACT Act 2014. More specifically, section 1899B(m) of the Act and the sections referenced in section 1899B(a)(2)(B) of the Act, as added by the IMPACT Act 2014, exempt modifications that are intended to achieve the standardization of patient assessment data.

In section V.C.7.b. of this preamble we propose to require the collection of data—by means of a SNF PPS Part A Discharge Assessment—at the time of transition from a SNF PPS Part A stay; specifically, when the resident has not physically been discharged from the facility. Under this section we also propose to add data items to the scheduled Medicare required PPS Admission/Entry Assessment (5-day).

While the reporting of quality measures is an information collection, the requirements are exempt from the PRA in accordance with the IMPACT Act 2014. More specifically, section 1899B(m) of the Act and the sections referenced in subsection 1899B(a)(2)(B) of the Act, as added by the IMPACT Act 2014, exempt modifications that are intended to achieve the standardization of patient assessment data.

As discussed in section V.C.11. of this preamble, this rule proposes a process that will enable SNFs to request reconsideration of our initial non-compliance decision if the SNF believes that it was incorrectly identified as not having met its reporting requirements for the applicable fiscal year. Because the reconsideration and appeals requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA.

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

VII. Response to Comments

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

VIII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

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

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

2. Statement of Need

This proposed rule would update the SNF prospective payment rates for FY 2015 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 fiscal year, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach.

3. Overall Impacts

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2015 (79 FR 45628). Based on the above, we estimate that the aggregate impact would be an increase of $500

million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the applicable forecast error adjustment and by the MFP adjustment. The impact analysis of this proposed rule represents the projected effects of the changes in the SNF PPS from FY 2015 to FY 2016. Although the best data available are utilized, there is no attempt to predict behavioral responses to these changes, or to make adjustments for future changes in such variables as days or case-mix.

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

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we update the FY 2015 payment rates by a factor equal to the market basket index percentage change adjusted by the FY 2014 forecast error and the MFP adjustment to determine the payment rates for FY 2016. As discussed previously, for FY 2012 and each subsequent FY, as required by section 1888(e)(5)(B) of the Act as amended by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by the MFP adjustment. The special AIDS add-on established by section 511 of the MMA remains in effect until such date as the Secretary certifies that there is an appropriate adjustment in the case mix. We have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are fewer than 4,800 beneficiaries who qualify for the add-on payment for residents with AIDS. The impact to Medicare is included in the total column of Table 12. In updating the SNF PPS rates for FY 2016, 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 2016. Accordingly, the analysis that follows only describes the impact of this single year. In accordance with the requirements of the Act, we will publish a notice or rule for each subsequent FY that will provide for an update to the SNF PPS payment rates and include an associated impact analysis.

In accordance with sections 1888(g) and (h)(2)(A) of the Act, we are proposing to specify a Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) and adopt that measure for the SNF VBP Program. Because this proposed measure is claims-based, its adoption under the SNF VBP Program would not result in any increased costs to SNFs.

However, we do not yet have preliminary data with which we could project economic impacts associated with the measure. We intend to make additional proposals for the SNF VBP Program in future rulemaking, and we will assess the impacts of the SNFRM and any associated SNF VBP Program proposals at that time.

We believe that the burden associated with the SNF QRP is the time and effort associated with data collection and reporting. In this proposed rule, we propose three quality measures to meet the requirements of section 1888(e)(6)(B)(II) of the Act.

Our burden calculations take into account all ''new'' items required on the MDS 3.0 to support data collection and reporting for these three proposed measures. New items will be included on the following assessments: SNF PPS 5-Day, Swing Bed PPS 5-Day, OMRA—Start of Therapy Discharge, OMRA—Other Discharge, OBRA Discharge, Swing Bed OMRA—Start of Therapy Discharge, Swing Bed OMRA—Other Discharge, and Swing Bed Discharge on the MDS 3.0. The SNF QRP also requires the addition of a SNF PPS Part A Discharge Assessment which will also include new items. New items include data elements required to identify whether pressure ulcers were present on admission, to inform future development of the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), as well as changes in function and occurrence of falls with major injury. To the extent applicable, we will use standardized items to collect data for the three measures. For a copy of the data collection instrument, please visit: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.*

We estimate a total additional burden of $27.47 per Medicare-covered SNF stay, based on the most recent data available, in this case FY 2014, that 15,421 SNFs had a total of 2,599,656 Medicare-covered stays for fee-for-service beneficiaries. This would equate to 1,012,566.13 total added hours or 66 hours per SNF annually.

We believe that the additional MDS items we are proposing will be completed by Registered Nurses (RN), Occupational Therapists (OT), and/or Physical Therapists (PT), depending on the item. We identified the staff type per item based on past LTCH and IRF burden calculations in conjunction with expert opinion. Our assumptions for staff type was based on the categories generally necessary to perform assessment: Registered Nurse (RN), Occupational Therapy (OT), and Physical Therapy (PT). Individual providers determine the staffing resources necessary, therefore, we averaged the national average for these labor types and established a composite cost estimate. We obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2013 National Occupational Employment and Wage Estimates (*http://www.bls.gov/oes/current/oes_nat.htm*), and to account for overhead and fringe benefits, we have doubled the mean hourly wage. The mean hourly wage for an RN is $33.13, doubled to $66.26 to account for overhead and fringe benefits. The mean hourly wage for an OT is $37.45, doubled to $74.90 to account for overhead and fringe benefits. The mean hourly wage for a PT is $39.51, doubled to $79.02 to account for overhead and fringe benefits.

To calculate the added burden, we first identified the total number of new items to be added into assessment instruments. We assume that each new item accounts for 0.5 minutes of nursing facility staff time. This assumption is consistent with burden calculations in past IRF and LTCH federal regulations. For each staff type, we then multiply the added burden in minutes with the number of times we believe that each item will be completed annually. To identify the number of times an item would be completed annually, we noted the number of total SNF FFS Medicare-covered stays in FY 2014, the most recent data available to us. We assume that if an item was added to all discharge assessments that that item would be completed at least one time per SNF FFS Medicare-covered stay. For example, the time it takes to complete an item added to all discharge

assessments (0.5 minutes) would be multiplied by the number of SNF FFS Medicare-covered stays in FY 2014 to identify the total added burden in minutes associated with that item. Items added only to the SNF PPS Part A Discharge were weighted to reflect the proportion of SNF stays for residents who switch payers, but are not physically discharged from the facility. Added burden in minutes per staff type was then converted to hours and multiplied by the doubled hourly wage to identify the annual cost per staff type. Given these wages and time estimates, the total cost related to the SNF PPS Part A Discharge Assessment and SNF QRP measures is estimated at $4,630.20 per SNF annually, or $71,402,283.86 for all SNFs annually.

4. Detailed Economic Analysis

The FY 2016 SNF PPS payment impacts appear in Table 12. Using the most recently available data, in this case FY 2014, we apply the current FY 2015 wage index and labor-related share value to the number of payment days to simulate FY 2015 payments. Then, using the same FY 2014 data, we apply the proposed FY 2016 wage index and labor-related share value to simulate FY 2015 payments. We tabulate the resulting payments according to the classifications in Table 12 (for example, facility type, geographic region, facility ownership), and compare the difference between current and proposed 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 2016 payments. The update of 1.4 percent (consisting of the market basket increase of 2.6 percentage points, reduced by the 0.6 percentage point forecast error adjustment and further reduced by the 0.6 percentage point MFP adjustment) is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 1.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 12, 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 rural Pacific region would experience a 1.6 percent increase in FY 2016 total payments.

TABLE 12—PROJECTED IMPACT TO THE SNF PPS FOR FY 2016

	Number of facilities FY 2016	Update wage data (%)	Total change (%)
Group:			
Total	15,421	0.0	1.4
Urban	10,887	0.1	1.5
Rural	4,534	−0.5	0.8
Hospital based urban	546	0.1	1.5
Freestanding urban	10,341	0.1	1.5
Hospital based rural	626	−0.6	0.8
Freestanding rural	3,908	−0.5	0.9
Urban by region:			
New England	801	0.7	2.1
Middle Atlantic	1,485	0.7	2.1
South Atlantic	1,853	−0.1	1.3
East North Central	2,068	−0.2	1.2
East South Central	543	0.0	1.4
West North Central	899	−0.4	1.0
West South Central	1,310	−0.1	1.3
Mountain	501	−0.1	1.3
Pacific	1,420	0.2	1.6
Outlying	7	−1.5	−0.1
Rural by region:			
New England	142	−0.7	0.7
Middle Atlantic	222	−1.2	0.2
South Atlantic	510	−0.1	1.3
East North Central	937	−0.2	1.2
East South Central	535	−0.7	0.7
West North Central	1,089	−0.7	0.7
West South Central	764	−1.1	0.3
Mountain	232	−0.6	0.8
Pacific	103	0.2	1.6
Ownership:			
Government	881	0.1	1.5
Profit	10,862	0.0	1.4
Non-profit	3,678	0.0	1.4

Note: The Total column includes the 2.6 percent market basket increase, reduced by the 0.6 percentage point forecast error adjustment and further reduced by the 0.6 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

5. Alternatives Considered

As described in this section, we estimate that the aggregate impact for FY 2016 would be an increase of $500 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the applicable forecast error adjustment and by the MFP adjustment.

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

6. Accounting Statement

As required by OMB Circular A–4 (available online at *www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf*), in Table 13, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 13 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this proposed rule, based on the data for 15,421 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 13—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2015 SNF PPS FISCAL YEAR TO THE 2016 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers.	$500 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

*The net increase of $500 million in transfer payments is a result of the forecast error and MFP adjusted market basket increase of $500 million.

7. Conclusion

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2015 (79 FR 45628). Based on the above, we estimate the overall estimated payments for SNFs in FY 2016 are projected to increase by $500 million, or 1.4 percent, compared with those in FY 2015. We estimate that in FY 2016 under RUG–IV, SNFs in urban and rural areas would experience, on average, a 1.5 and 0.8 percent increase, respectively, in estimated payments compared with FY 2015. Providers in the urban New England and Middle Atlantic regions would experience the largest estimated increase in payments of approximately 2.1 percent. Providers in the urban Outlying region would experience a small decrease in payments of 0.1 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by reason of their non-profit status or by having revenues of $27.5 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, we estimate approximately 91 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $27.5 million or less in any 1 year. (For details, see the Small Business Administration's Web site at *http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards*). In addition, approximately 25 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2015 (79 FR 45628). Based on the above, we estimate that the aggregate impact would be an increase of $500 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment and forecast error adjustment. While it is projected in Table 12 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 2016 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. According to MedPAC, Medicare covers approximately 12 percent of total patient days in freestanding facilities and 22 percent of facility revenue (Report to the Congress: Medicare Payment Policy, March 2015, available at *http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf*). However, it is worth noting that the distribution of days and payments is highly variable. That is, the majority of SNFs have significantly lower Medicare utilization (Report to the Congress: Medicare Payment Policy, March 2015, available at *http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf*). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 12. As indicated in Table 12, the effect on facilities is projected to be an aggregate positive impact of 1.4 percent. As the overall impact on the industry as a whole, and thus on small entities specifically, is less than the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of

a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area 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 2014 (78 FR 47968)), 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 12, the effect on facilities is projected to be an aggregate positive impact of 1.4 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small rural hospitals.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately $144 million. This proposed rule would not impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector, of $144 million.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This proposed rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

E. Congressional Review Act

This proposed regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

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

List of Subjects in 42 CFR Part 483

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

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 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 1. The authority citation for part 483 is revised to read as follows:

Authority: Secs. 1102, 1128I, 1819, 1871 and 1919 of the Social Security Act, (42 U.S.C. 1302, 1320a–7, 1395i, 1395hh and 1396r).

■ 2. Section 483.75 is amended by adding paragraph (u) to read as follows:

§ 483.75 Administration.

* * * * *

(u) *Mandatory submission of staffing information based on payroll data in a uniform format.* Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

(1) *Submission requirements.* The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:

(i) The category of work for each individual that performs direct care (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);

(ii) Resident census data; and

(iii) Information on staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

(2) *Distinguishing employee from agency and contract staff.* When reporting direct care staffing information for an individual, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

(3) *Data format.* The facility must submit direct care staffing information in the format specified by CMS.

(4) *Submission schedule.* The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently then quarterly.

Dated: April 7, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 13, 2015.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2015–08944 Filed 4–15–15; 4:15 pm]

BILLING CODE 4120–01–P