Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

[CMS-1696-P]

Summary of Proposed Rule

TABLE OF CONTENTS

Issue	Page
I. Overview	1
II. Background on SNF PPS	2
III. SNF PPS Rate Setting Methodology and FY 2019 Update	2
IV. Additional Aspects of the SNF PPS (e.g., administrative presumption, consolidated billing, and payment for SNF-level swing bed services)	5
V. Proposed Revisions to SNF PPS Case-Mix Classification Methodology	7
A. Issues Relating to the Current SNF PPS Case-Mix System	7
B. Summary of the SNF Payment Models Research Project	8
C. Revisions to SNF PPS Federal Base Payment Rate Components	9
D. Proposed Design and Methodology for Case-Mix Adjustment of Federal Rates	13
E. Use of the Resident Assessment Instrument—Minimum Data Set, Version 3	22
F. Proposed Revisions to Therapy Provision Policies Under the SNF PPS	26
G. Proposed Interrupted Stay Policy	27
H. Proposed Relationship of PDPM to Existing SNF Level of Care Criteria	28
I. Effect of Proposed PDPM on Temporary AIDS Add-on Payment	28
J. Potential Impacts of Implementing the PDPM & Parity Adjustment	29
VI. Other Issues	31
A. Other Proposed Revisions to the Regulation Text	31
B. SNF Quality Reporting Program	31
C. SNF Value-Based Purchasing Program	35
VII. Promoting Electronic Health Record Interoperability: Request for Information	40
VIII. Economic Analysis	42
Appendix: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes (Urban and Rural); RUG-IV Case-Mix Adjusted Federal Rates by Labor and Non-Labor Component (Urban and Rural); and Proposed PDPM Impact Analysis (Resident and Facility-level)	44

I. Overview

On April 27, 2018, the Centers for Medicare and Medicaid Services (CMS) placed on public display a proposed rule updating for FY 2019 the Medicare skilled nursing facility (SNF) payment rates, quality reporting requirements, and the SNF Value-Based Purchasing Program (VBP). Of particular importance, CMS proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG-IV) model, with a revised case-mix methodology called the Patient Driven Payment Model (PDPM) effective beginning

FY 2020. CMS is not proposing to adopt any new measures for the SNF Quality Reporting Program (QRP) in this proposed rule. On the SNF VBP, CMS proposes updates to its policies, including the performance and baseline periods for the FY 2021 VBP Program year, an adjustment to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception policy. This proposed rule was subsequently in the May 8th *Federal Register* (83 FR 21018-21101). Page references given in this summary are to the *Federal Register*. **Comments on the proposed rule are due to CMS by June 26, 2018.**

CMS estimates that the overall impact of the proposed rule will be an increase of $850 million (2.4 percent) in Medicare payments to SNFs during FY 2019. This overall total and percentage increase, however, does not take into account the estimated reduction of $211 million in aggregate payments to SNFs from the SNF VBP program during FY 2019.[1]

II. Background on SNF PPS (pages 21020-21021)

CMS reviews the statutory and regulatory history, including the Protecting Access to Medicare Act (PAMA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. PAMA required the Secretary to establish a Value-Based-Purchasing (VBP) Program for Medicare SNFs. The IMPACT Act required the Secretary to implement a quality reporting program for SNFs and requires SNFs to report standardized data for specified quality and resource use domains.

III. SNF PPS Rate Setting Methodology and FY 2019 Update (pages 21021-21032)

A summary of key data for the proposed SNF PPS for FY 2019 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed SNF PPS for FY 2019				
Statutory SNF update (Bipartisan Budget Act of 2018)				2.4%
Proposed wage index budget neutrality adjustment				1.0002
Proposed labor-related share				70.7%
FY 2018[1/] and Proposed FY 2019 Unadjusted Federal Rates Per Diem				
Rate component	**Urban**		**Rural**	
	FY 2018	**FY 2019**	**FY 2018**	**FY 2019**
Nursing-case-mix	$177.21	$181.50	$169.29	$173.39
Therapy-case-mix	$133.48	$136.71	$153.92	$157.65
Therapy-non-case-mix	$17.58	$18.01	$18.78	$19.23
Non-case-mix	$90.44	$92.63	$92.11	$94.34
[1/]FY 2018 from FY 2018 Final Rule Correction Notice (82 *FR* 46163-46170), October 4, 2017				

A. Federal Base Rates

CMS reviews the history of the process for setting the federal base rates.

[1] The SNF VBP program is not budget neutral. CMS estimates that the total reduction in payments resulting from

B. SNF Market Basket Update

Section 53111 of the Bipartisan Budget Act (BBA) of 2018 requires CMS to use a market basket percentage of 2.4 percent, after application of the multifactor productivity (MFP) to adjust the federal rates for FY 2019.[2] Thus, CMS will use a market basket percentage of 2.4 percent to update the proposed SNF federal rates.

Absent Section 53111 of the BBA 2018, CMS would have proposed a market basket increase of 2.7 percent. This is based on the first quarter 2018 forecast from IHS Global Insight, Inc. (IGI) of the SNF market basket percentage. CMS would have also accounted for forecast errors in previous market basket estimates. There was, however, no difference in the forecasted and actual 2017 market basket estimates (and thus does not exceed the 0.5 percentage point threshold) and no adjustment would have been necessary.

The multifactor productivity (MFP) adjustment required under the Affordable Care Act (ACA) is estimated to have been -0.8 percentage points. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2019, based on IGI's first quarter 2018 forecast.

Absent enactment of section 53111 of the BBA of 2018, the resulting net SNF market basket update would have been equal to 1.9 percent (2.7 percent less the 0.8 percentage point MFP reduction).

Based on a market basket percentage of 2.4 percent (as required by section 53111 of the BBA 2018), CMS proposes FY 2019 unadjusted federal rates for each component of the payment for urban and rural areas. CMS Tables 4 and 5 in the proposed rule, summarized below, present the proposed per diem rates.

Proposed Unadjusted FY 2019 Federal Rate Per Diem, Urban and Rural*		
	Urban	**Rural**
Nursing-case-mix	$181.50	$173.39
Therapy-case-mix	$136.71	$157.65
Therapy- non-case-mix	$18.01	$19.23
Non-case mix	$92.63	$94.34
*Based on CMS Tables 4 and 5		

CMS also proposes that it would apply a 2.0 percentage point reduction to the SNF market basket percentage changes for SNFs that do not satisfy the reporting requirements for the FY 2019 SNF QRP. CMS explains that this is derived by subtracting 2.0 percent from the MFP-adjusted market basket update of 1.9 percent resulting in negative 0.1 percentage point update.[3]

[2]BBA 2018 amended section 1888(e) of the Social Security Act to add section 1888(e)(5)(B)(iv) of the Act.

[3] This results in an effective -2.5 percentage point reduction as other SNFs that meet the quality reporting requirements are set to receive a 2.4 percentage update. The special rule for fiscal year 2019 (2.4 percent update) or 1888(e)(5)(B)(iv) of the Act is not referenced in the section that addresses the reduction in the update for failure to report (section 1888(e)(6)(A)(iii)). It is not clear whether this was a legislative drafting error or intentional, as CMS does not discuss.

C. Case-Mix Adjustment

For FY 2019, no change is proposed in the use of the Resource Utilization Groups, Version 4 (RUG-IV) case-mix classification system, along with version 3.0 of the Minimum Data Set (MDS 3.0) for collecting the clinical data used for case-mix classification under RUG-IV. The case-mix adjusted RUG-IV payments for urban and rural SNFs are listed, along with corresponding case-mix values, in the proposed rule Tables 6 (Urban) and 7 (Rural), which are reproduced in the Appendix to this summary.

Note: CMS proposes in this rule (Section V) to replace the existing case-mix classification methodology, the RUG-IV model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) beginning in FY 2020.

In addition to the case-mix classifications, the add-on of 128 percent for SNF residents with Acquired Immune Deficiency Syndrome (AIDS) initially required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 remains in effect. CMS uses ICD-10-CM code B20 to identify those patients qualifying for this add-on (CMS does not provide an estimate of the number of patients qualifying for this add-on, but, in the past, it has been around 5,000). CMS provides an example of the calculation: a patient in an urban SNF with AIDS in RUG-IV group HC2 would have a case-mix adjusted payment of $453.68 before application of this special 128 percent add-on adjustment. After the 128 percent adjustment, the facility would receive a payment of $1,034.39. CMS notes that the add-on is applied only after all other adjustments, such as wage index and case mix.

D. Wage-Index Adjustment

CMS proposes to continue to apply the wage index adjustment to the labor-related portion of the federal rate. As in the past, CMS uses the hospital inpatient wage index exclusive of the occupational mix adjustment. For FY 2019, CMS uses updated wage data for hospital cost reporting periods in FY 2015.

CMS proposes, as in the past, a wage index budget neutrality adjustment, and computes that adjustment at 1.0002 for FY 2019. CMS notes that Wage Index Tables are available exclusively through the CMS Web site, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

The wage index adjustment is applied to the labor-related share. CMS uses a four-step process to trend forward the base year (2014) weights to FY 2019 price levels. This process includes computing the FY 2019 price index level for the total market basket and each cost category of the market basket. Based on this update, the proposed SNF labor-related share is 70.7 percent (virtually the same as the 2018 estimate of 70.8 percent). Table 8 in the proposed rule (page 21028) summarizes the proposed updated labor-related share for FY 2019 compared with FY 2018 overall, and for each of the cost categories.

CMS Tables 9 and 10, included in the Appendix to this summary, provide the labor and non-labor related shares of case-mix adjusted RUG-IV payments for urban and rural SNFs,

respectively.

E. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, CMS is implementing the requirements of the SNF VBP program as specified under section 1888(h) of the Act. CMS proposes to add a new paragraph (f) to §413.337 to implement these requirements. See Section VI.C. of the summary for further information on the SNF VBP program.

IV. Additional Aspects of the SNF PPS (pages 21032-21034)

A. SNF Level of Care: Administrative Presumption

CMS continues to use an administrative presumption that beneficiaries correctly assigned to one of the upper 52 groups in the 66 RUG-IV groups on the initial 5-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 5-day assessment. In the 2018 final rule, CMS finalized a policy to disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website.[4]

As specified, there are 52 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; and
- Clinically Complex.

Beneficiaries assigned to one of the lower 14 RUG-IV groups would continue to receive an individual level of care determination using existing administrative criteria.

CMS stresses 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.

[44] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

Note: CMS proposes modifications to the administrative level of care presumption in order to accommodate its proposed case-mix classification system (PDPM) to begin in FY 2020 (discussed in section V.H. of this proposed rule).

B. Consolidated Billing

The consolidated billing requirements for SNFs are reviewed, including billing for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a non-covered stay. CMS also reviews the specific exclusions from that requirement that remain separately billable, including a number of "high cost, low probability" services identified by Healthcare Common Procedure Coding System (HCPCS) codes, within four categories:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

CMS further notes that the codes targeted for exclusion from consolidated billing represent events that could have significant financial impacts because their costs far exceed SNF PPS payments.

CMS invites comments that identify 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 the criteria for exclusion from SNF consolidated billing. Commenters should identify 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. CMS notes that if it identifies any such codes through the current rulemaking cycle the exclusion of these HCPCS codes would be in effect as of a specific date (in this case, as of October 1, 2018). CMS notes that by making any new exclusions in this manner, it could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

C. Payment for SNF-level Swing-bed Services

CMS notes that critical access hospitals (CAHs) continue to be paid on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement and that all non-CAH swing-bed rural hospitals continue to be paid under the SNF PPS. CMS refers readers to section V.E.2 of the proposed rule where it discusses its proposal to add items to the swing-bed assessment for use in classifying swing bed residents under the proposed SNF PDPM.

V. Proposed Revisions to the SNF PPS Case-Mix Classification Methodology (pages 21034-21080)

A. Issues Relating to the Current SNF PPS Case-Mix System Payment Issues

The Balanced Budget Act of 1997 (BBA 1997, Pub. L. 105-33) amended section 1888(c) of the Act to create the SNF PPS. The statute also requires the Secretary to make case-mix adjustments to the per diem rates and to adjust for area wage variation. SNF PPS payments are determined by adjusting a federal per diem base payment (computed as separate urban and rural rates) for geographic factors and case mix. The case-mix adjustment must be based upon a resident classification system established by the Secretary; resident assessment data; and other data considered appropriate by the Secretary.

The case mix adjustment currently classifies residents into payment classification groups, called resource utilization groups (RUGs). The unadjusted federal per diem rate is the sum of the following components:

- A nursing component which is case-mixed adjusted,
- A therapy component which is case-mix adjusted for rehabilitation RUGs or a therapy component which is not case-mix adjusted for non-rehabilitation RUGs, and
- A non-case mix adjusted component reflecting the costs of room and board, linens, and administrative services.

The SNF PPS is updated annually, reflecting a productivity adjustment and SNF-specific market basket.

The PPS was implemented in FY 1999 and employed the RUG-III resident classification system. The current RUG-IV system took effect in FY 2011. Each RUG is assigned a set of case-mix indexes (CMIs) that reflect relative differences in cost and resource intensity for each case-mixed adjusted component. Patients' characteristics and services are determined by periodic assessments using the SNF patient assessment instrument, the Minimum Data Set (MDS). The higher the CMI, the higher the expected intensity for each case-mix adjusted component. Under the existing methodology, there are two case-mixed components: the nursing component and the therapy component. Nursing and therapy case-mix indices (CMIs) are assigned to each RUG resident classification group to capture resource use and cost differences across RUGs. Non-therapy ancillary (NTA) costs (e.g., drugs, lab tests) are embedded in the nursing component. Payment is based upon the higher per diem of a resident's nursing or therapy RUG (most often the therapy RUG). The FY 2018 case-mix adjustment applies the RUG-IV system (comprising 66 groups) and MDS 3.0 assessment data to the therapy and nursing SNF per diem rate components.[5]

Concerns About the Provision of Therapy Services. The RUG-IV model assigns SNF residents into rehabilitation or non-rehabilitation RUGs. Each RUG has associated therapy and nursing

[5] In the FY 2006 SNF PPS final rule (70 FR 45032), RUG-III was refined by adding 9 groups, creating RUG-53. Updated staff time utilization data (STRIVE project) were incorporated to create RUG-IV for FY 2011.

case mix indexes (CMIs), reflecting resource use relativity for that RUG versus all others. Resident assignment into a RUG is based upon the factors below, as documented in periodic resident assessments using MDS 3.0:

- Total minutes of therapy provided each week (combining physical (PT), occupational (OT), and speech language pathology (SLP);
- Need for "extensive" or skilled services (e.g., respiratory therapy) or "special care" (e.g., quadriplegia);
- Presence of "clinically complex" conditions (e.g., burns or pneumonia); and
- Ability to independently perform certain activities of daily living (ADL).

Directly connecting payment to the actual therapy services provided to residents under the PPS was intended to protect beneficiaries from stinting of services. However, multiple reports from the Office of the Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC), and CMS itself have concluded that SNF payments are being inflated by the amount therapy provided to maximize billing rather than tailored to SNF residents' needs. All reports have called for SNF PPS changes.[6] Supporting observations from these reports include:

- Over 90 percent of Part A covered SNF days now are paid through rehabilitation RUGs, for which CMIs depend largely on therapy minutes provided.
- Resident assignments to Very High and Ultra High rehabilitation RUGs have increased without proportional changes in resident clinical characteristics.
- The percentage of MDS assessments reporting 720-739 therapy minutes – the threshold for reaching an Ultra High RUG – has steadily increased.
- Claims improperly upcoded to Ultra High therapy are common.

Nursing and Non-Therapy Ancillary (NTA) Payment Accuracy. CMS notes two issues involving RUG-IV nursing payment accuracy. First, rehabilitation RUGs are assigned across multiple, distinct therapy minute ranges while nursing CMIs for those RUGs are far less granular. Nursing CMIs for non-rehabilitation RUGs are determined more directly by resident conditions and/or special care needs. Nursing CMIs, therefore, likely do not accurately capture the true relativity of nursing resources used across the entire SNF resident population. Second, NTA costs (e.g., drugs, laboratory tests) are included in the nursing component of payment and thereby subject to nursing CMI payment adjustments rather than separately addressed. Accounting for resource use variations in both nursing care and NTA items through nursing CMIs likely degrades SNF payment accuracy, absent clear and current evidence that NTA and nursing cost variations are highly correlated.

B. Summary of the SNF Payment Models Research Project (SNF PMR)

Ongoing concerns that the RUG-IV classification system no longer produces appropriate and accurate case-mix adjustments led CMS to contract with Acumen, LLC to identify methodologic alternatives. CMS wanted alternatives that would use beneficiary complexity and required care resources to pay SNFs more accurately; avoid incentivizing therapy delivery by payment policy;

[6] For hyperlinks to reports (OIG 2010, 2012, 2015; MedPAC 2017; CMS 2014), see 82 FR 20982-20983.

and maintain administrative simplicity (e.g., across case-mix elements and resident assessment requirements). Work under this contract, termed the SNF PMR project, spanned four phases:

- Literature review and environmental scan of therapy payment issues;[7]
- Identification of models suitable for further analysis, including but not limited to therapy considerations;
  - Acumen hosted four Technical Expert Panels (TEPs) targeting, respectively: therapy case-mix, nursing case-mix and NTA items, revised case-mix adjusted components and associated policies, and a revised PPS model with impact analysis.[8]
- Technical report development for an alternative case-mix classification under consideration by CMS, the Resident Classification System, Version 1.0 (RCS-I);[9] and
- Additional analyses and refinement of RCS-I plus technical report development for a revised alternative model (the PDPM).[10]

On May 5, 2017 (between the third and fourth phases of the SNF PRM project), CMS published an Advance Notice of Proposed Rulemaking entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology" (84 FR 20980-21012). (This notice is referred to in the proposed rule and in this summary as "the ANPRM"). The ANPRM presented the methodology and structure of the RCS-I for stakeholder comment. CMS received over 250 comments which was incorporated into phase four and the resultant proposed PDPM.

C. Revisions to SNF PPS Federal Base Payment Rate Components

1. Overview

CMS notes that by utilizing data and methodology from the original federal payment rate-setting calculations in 1998,[11] the proposed PDPM modifies the existing base rate case-mix components for therapy and nursing. CMS proposes to separate the "therapy case-mix" rate component into a "PT component, "OT" component, and a "SLP" component. CMS also proposes to separate the "nursing case-mix" rate component into a "Nursing" Component and a "Non-Therapy Ancillary" (NTA) component. Under the PDPM all SNF residents would be assigned to a classification group for each of the three proposed therapy-related case-mix adjusted components. Thus, CMS proposes eliminating the "therapy non-case-mix rate" and distribute the dollars associated with this current rate component to the three proposed PDPM therapy components. The existing non-case-mix component would be maintained as it is under the

[7] For SNF Therapy Payment Models Base Year Final Summary Report: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Summary_Report_20140501.pdf
[8] For TEP session slides and reports: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
[9] For RCS-I technical report: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
[10] For SNF PDPM technical report: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
[11] Original rates were based on FY 1995 costs updated for inflation to the first SNF PPS period (began July 1, 1998).

existing SNF PPS. The federal base rate components of the RUG IV, RCS-I, and the PDPM are compared below.

SNF Base Rate Components		
Resource Utilization Group, Version IV (RUG-IV) (Current)	**Resident Classification System, Version I (RCS-I) (Discussed in the Advanced Notice of Proposed Rulemaking)[a]**	**Patient-Driven Payment Model (PDPM) (Proposed for FY 2020)**
Non-Case Mix)[2]	Other	Other
Therapy Non-Case Mix[c]	(Component Eliminated)	(Component Eliminated)
Therapy Case-Mix [d]	PT & OT	PT
		OT
	SLP	SLP
Nursing Case-Mix[e]	Nursing Care	Nursing Care
	Non-Therapy Ancillary	Non-Therapy Ancillary

[a]The Advanced Notice of Proposed Ruling was published May 5, 2017 ("Medicare Program: Prospective Payment System and Consolidated Billing for SNFs: Revision to Case-Mix Methodology", 84FR 20980-21012).
[b]Non-Case Mix is also referred to as "Other" which includes room and board, linen and administrative services.
[c]Therapy Non-Case Mix is also referred to as "Therapy for Nonrehabilitation RUGs".
[d]Therapy Case-Mix is also referred to as Therapy for Rehabilitation RUGs.
[e]Nursing Case-Mix also includes Non-Therapy Ancillary (NTA).

CMS invites comments "on any and all aspects" of the proposed PDPM, the research analyses as described in the rule, and technical reports.[12]

2. Data Sources for Proposed Revisions to Federal Base Payment Rate Components

While proposing to revise the base rate components, CMS attempts to replicate, whenever possible, the original SNF PPS rate-setting process, by aligning the revised component base rates as closely as possible with what they would have been had the revised components been established in 1998. To do so, CMS proposes to utilize primarily FY 1995 cost reports as specified in the final rule that implemented the SNF PPS (63 FR 26256 through 26260). In that rule, CMS separated nursing case-mix component costs into distinct nursing and NTA percentages but did not provide separate PT, OT, and SLP cost data within the therapy case-mix component.

To establish separate PT, OT, and SLP component rates as proposed for PDPM requires that CMS compute the PT, OT, and SLP percentage of the current combined therapy case-mix component. CMS begins by defining source data for the computations to be those described in the 1998 implementing rule (i.e., hospital-based and freestanding SNF cost reports beginning in 1995 and spanning 10-13 months). CMS notes two exclusions and adjustments needed for its calculations. Specifically, currently available data are insufficient for excluding cost-limit-

[12] For related reports https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

exempted facilities and for excluding exceptions payments and educational activities. CMS also notes that few facilities were exempted in 1998, and that excluding high-cost facilities defined by identical criteria for the original and current computations negates their potential impact. CMS further observes that exceptions payments were not granted for therapy costs and that educational costs were <0.01% of overall SNF costs. CMS believes that these data differences do not importantly affect the validity of the therapy discipline-specific computations.

CMS next addresses the need to estimate Part B payments for covered SNF services provided to Part A SNF residents as part of computing the PT, OT, and SLP percentages. CMS states that although details are incomplete, the implementing rule indicates that Part B payments were accounted for at the facility-level. To estimate therapy discipline-specific Part B costs, CMS similarly matched Part B claims to Part A SNF claims and extracted total charges for each facility's PT, OT, and SLP cost centers. Total Part B charges were divided by their matched Part A charges, creating a ratio used to guide increasing Part A costs to account for linked Part B costs. CMS believes this approach mimics closely the original Part B cost estimation process, given the data currently available.

Finally, CMS discusses controlling for geographic-related wage differences and case-mix effects by standardizing facility cost data, as was done for the 1998 calculations. In computing specific PT, OT, and SLP base rate percentages, CMS manages wage differences by following the original method (63 FR 26259-26260), using the same labor-related cost share (75.888%), and applying an FY 1994 hospital wage index. Case-mix adjustment was originally accomplished by mapping claims-derived information to RUG-III clinical categories at the individual resident level and creating an average case-mix value for each facility. Facility per diem costs were multiplied by the inverse of the average value. According to CMS, because information about the mapping and the necessary data are now unavailable, the case-mix adjustment step cannot be replicated for therapy discipline-specific component base rate computation. CMS notes, however, the impact of omitting this step is small as long as the range of average facility case-mix values is narrow, as they were found to be in 1998.

3. Methodology for Calculating the Proposed Federal Base Payment Rate Components

CMS discusses the methodology it used to calculate the percentage of the current therapy component of the federal base rate that corresponds to each of the three proposed therapy components. CMS notes that SNF cost reports include Part A utilization days and distinct PT, OT, and SLP cost centers, permitting facility-level calculation of average total therapy costs per day and average therapy costs by therapy discipline. CMS used these average costs and the original base payment methodology (63 FR 26260) to compute therapy discipline-specific cost percentages. CMS computed:

- Mean cost measures (PT, OT, SLP, and total therapy costs per day) using freestanding SNF cost report data, weighted by facility-level total Medicare days.
- Mean cost measures (PT, OT, SLP, and total therapy costs per day) using hospital-based and freestanding SNF cost report data, weighted by facility-level total Medicare days.
- Arithmetic means were calculated for each of the four measures of cost (PT, OT, SLP, and total therapy costs per day) for the amounts calculated for the above two measures.

These calculations resulted in a measure of costs per day by therapy discipline and a measure of total therapy costs per day.

CMS then calculated the percentage of the therapy component that corresponds to each therapy discipline. Specifically, the therapy discipline-specific arithmetic mean cost measures were each divided by the total therapy arithmetic mean cost measure. The therapy discipline specific percentages are summarized below.

Federal Per Diem Rate	Therapy Discipline-Specific Percentage		
	PT	OT	SLP
Urban	43.4	40.4	16.2
Rural	42.9	39.4	17.7

CMS used a similar methodology to separate the current nursing case-mix component into a nursing case-mix component and an NTA component. CMS calculated the percentage of the current nursing component of the federal base rate that corresponds to the proposed NTA and nursing components. CMS notes that the 1998 SNF PPS implementing rule provides the specific percentages within the nursing component attributable to NTA and nursing, shown below. CMS verified the original percentage distribution by calculating NTA costs using the methodology applied to therapy shares. The 1998 percentages and CMS' certified 1998 calculations of the percentages of the nursing components are summarized below.

Federal Per Diem Rate	1998 NTA and Nursing Component Percentage	
	NTA	Nursing
Urban	43.4	56.6
Rural	42.7	57.3
	1998 NTA and Nursing Component Percentage	
	NTA	Nursing
Urban	43.6	Not performed
Rural	45.1	Not performed

Finally, Tables 12 and 13 from the proposed rule (reproduced below) illustrate the unadjusted federal per diem rates for each of the case-mix adjusted components if the PDPM as proposed were applied to the proposed FY 2019 base rates (Tables 4 and 5).

Table 12: FY 2019 PDPM Unadjusted Federal Rate Per Diem -- Urban						
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.21	$22.15	$92.63

Table 13: FY 2019 PDPM Unadjusted Federal Rate Per Diem -- Rural						
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

4. Proposed Updates and Wage Adjustments of PDPM Federal Base Payment Rate Components

SNF PPS rated are adjusted for geographic difference in wages using the most recent hospital wage index data. CMS proposes to continue to update the federal base payment rates and adjust for geographic differences in wages following the current methodology. Specifically, CMS would continue to update the base payment rates using the SNF market basket and to adjust for geographic-related wage differences as described previously.

D. Proposed Design and Methodology for Case-Mix Adjustment of Federal Rates

Derivation of PDPM design elements, methodology, and rationales are presented in detail in the SNF PDPM technical report. The SNF PMR project technical report provides similar information for the predecessor RCS-I system. Both reports are accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

Highlights of the proposed case-mix adjustment of the federal per diem rates are discussed below.

1. PDPM Overview and Case-Mix Adjustment Data Sources

Replacing RUG-IV with the proposed PDPM would largely shift the basis for payment away from service provision (e.g., RUG therapy minutes) to verifiable resident characteristics (e.g., PDPM reason for SNF admission). CMS reports that as of FY 2017, more than half of the days billed under the SNF PPS effectively utilize only a resident's therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payments for a resident's care. Deemphasizing the duration of therapy provided should improve SNF PPS payment accuracy by reducing incentives for maximizing billing through excess therapy delivery. This change addresses concerns raised by OIG, MedPAC, and CMS itself. CMS believes that linking each resident to five PDPM case-mix adjusted components rather than a single RUG should create a more nuanced resident-centered payment.

Development of the proposed PDPM began during the SNF PMR project by exploring the ability of resident-centered variables to predict individual-level SNF costs. A large pool of potentially predictive variables was identified through literature review and input from Technical Expert Panels (TEPs). Sources for potential variables included Medicare enrollment and claims data (e.g., reason for qualifying hospital stay), as well as resident assessments used across Medicare's various post-acute care sites (including MDS 3.0). Facility data (e.g., ownership) were gathered from SNF Certification and Survey Provider Enhanced Reports and publicly available sources (e.g., Nursing Home Compare), allowing impact analyses to identify any disproportionate facility or population effect (e.g., rural location, vulnerable populations).

2. Proposed Resident Classification under PDPM: General Considerations

The methodology followed to create the proposed PDPM case-mix adjusted components was similar across all components. This methodology had been developed and used previously to

create the RCS-I. Additional analyses and stakeholder input about RCS-I were incorporated into the process and the steps were repeated for determining the proposed PDPM case-mix adjustments. The methodology included the following:

- SNF costs were derived from charges (from claims) and cost-to-charge ratios (from facility cost reports) to serve as the best available measure of resource use. Cost-center data from cost reports allowed analysis for specific costs of interest (e.g., SLP costs).
- Correlations between potential predictive variables (resident characteristics) and costs were explored through regression analyses. Results were grouped then refined to identify concise sets of highly-predictive but practicable variables (categories) for each case-mix adjusted component.
- Inputs for use in assigning residents into categories were identified and specified.
- The Classification and Regression Trees (CART) statistical technique was used to create an appropriate number of case-mix groups for each case-mix adjusted component.
- Further refinements were made by CMS to maximize administrative simplicity and operational feasibility.

3. Proposed Resident Classification under PDPM: Component-Specific Considerations

a. PT and OT Case-Mix Classification

Analyses conducted during the early phases of the SNF PMR project showed very poor correlation between PT/OT and SLP costs per day, and poor overlap between the MDS characteristics predictive of PT/OT resource use and those predictive for SLP. PT and OT costs were found to be highly correlated and costs for each were predicted by similar MDS items. Under RCS-I, therefore, PT and OT costs were combined as a single case-mix adjusted component and a separate component was created for SLP. However, for the proposed PDPM, CMS was persuaded to create separate PT and OT case-mix adjusted components based upon comments received on the ANPRM and input from TEP members and professional associations. Rationales for distinct PT and OT components include:

- A single component could encourage providers to inappropriately substitute PT for OT and vice versa.
- The aims of PT and OT differ, as do the characteristics of the resident subpopulations who can benefit from appropriate provision of PT or OT services only or both.

However, because of extensive overlap among resident characteristics most predictive of PT and OT costs, CMS proposes to maintain the same case-mix classification for both components, as was done for the RCS-I. While the same characteristics would be used to classify a resident for PT or OT component assignment, the resident will be placed into distinct PT and OT case-mix groups with differing payment rates. At the time of SNF admission, each resident will be assigned into a single PT case-mix group and a single OT case-mix group. The best categories for predicting PT and OT costs per day were found to be the clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment.

CMS proposes ten inpatient clinical categories that it believes capture the range of general resident types found in a SNF (Table 14 (page 21043) and Table 15 (reproduced below)). CMS proposes to categorize each resident into a PDPM clinical category using item I8000 on the MDS 3.0. Providers would use the first line in item I8000 to report the ICD-10-CM code that represents the primary reason for the Part A SNF stay.[13] For residents with a related surgical procedure during the prior inpatient stay, a provider would need to indicate the type of procedure performed to be appropriately classified under PDPM. Specifically, CMS proposes that providers record the type of surgical procedure performed by coding the appropriate ICD-10-PCS code in the second line of item I8000. The clinical category the resident is classified would be used to classify the resident into a PT and OT category and as discussed below, a SLP category.

As an alternative to using item I8000 for classifying a resident into a clinical category, CMS considered using a resident's primary diagnosis in MDS item I0020 for assigning a resident to a clinical category. Using the MDS item I0020, a provider would select a primary diagnosis from a pre-populated list of primary diagnoses representing the most common types of beneficiaries treated in a SNF. CMS notes that using item I0020 would not require providers to record additional information on inpatient surgical procedures as it expects the primary diagnosis provided through item I0020 to be sufficient for assigning a resident to a clinical category.

CMS conducted additional regression analyses to determine if any of the proposed clinical categories predicted similar level of PT and OT and if they could be combined. For the RCS-I model, CMS found that the ten inpatient clinical categories could be collapsed into five clinical categories. Based on comments received and additional analyses, CMS proposes to collapse the clinical categories into four categories for PT and OT clinical categories.

Table 15: Proposed Collapsed Clinical Categories for PT and OT Classification

PDPM Clinical Category	Collapsed PT and OT Clinical Category
Major Joint Replacement of Spinal Surgery	Major Joint Replacement of Spinal Surgery
Non-Orthopedic Surgical	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

CMS discusses how regression analyses demonstrated that the resident's functional status is also predictive of PT and OT costs. Based on comments received about the RCS-I functional score, CMS proposes a new functional score for PT and OT payments based on section GG functional items (IMPACT Act-compliant items). Specifically, CMS proposes that section G items would

[13] The mapping between ICD-10-CMS codes and the clinical categories is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

be replaced with functional items from section GG of the MDS 3.0 (Functional Abilities and Goals) for calculating the functional score for resident classification under PDPM. A list of the proposed section GG items included in the functional measure for the PT and OT components is shown in Table 18 in the proposed rule (reproduced below).

CMS proposes that each section GG item would be assigned a score of up to 4 points. CMS notes that in contrast to the RUG-IV ADL score, points are assigned to each response level to track functional independence instead of functional dependence such that higher points are assigned to higher levels of independence. Based on its analyses, CMS observed that residents who were unable to complete an activity had similar PT and OT as dependent residents and proposes to group an activity that cannot be completed with the GG response "dependent" for assigning points. CMS also proposes an additional response level for the walking items to reflect residents who are unable to walk. Tables 16 and 17 in the proposed rule (page 21045) provide the proposed scoring algorithm for the PT and OT functional measure. The proposed scoring algorithm produces a function score that ranges from 0 to 24.

Table 18: Proposed Section GG Items Included in PT and OT Functional Measure		
Section GG Number	**Section GG Descriptor**	**Score**
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

Under the RCS-I case mix model, in addition to the primary reason for SNF care and functional ability, CMS used cognitive status to also classify residents. As discussed in the proposed rule, CMS does not propose the cognitive score as a factor of classification for the PT and OT components under PDPM.

CMS discusses the analyses it did using CART and administrative decisions made to develop case-mix groups to classify residents for PT and OT payments. CMS proposes 16 case-mix groups to classify residents for PT and OT payment; all residents would be classified into one and only one of these 16 PT and OT case-mix groups for each of the two components. Table 21 in the rule (reproduced below) displays the case-mix groups and CMIs for PT and OT.

Table 21: Proposed PT and OT Case-Mix Classification Groups				
Clinical Category	**Section GG Function Score**	**PT OT Case-Mix Group**	**PT Case-Mix Index**	**OT Case-Mix Index**
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

b. SPL Case-Mix Classification

CMS notes that strong predictors of increased PT/OT costs often were found to predict lower SLP costs, providing a compelling rationale for a separate SLP component within the proposed PDPM. Using the methods described above, CMS identified a set of three categories of predictors relevant in predicting relative differences in SLP cost: clinical reasons for the SNF

stay; swallowing disorder or mechanically-altered diet; and a SLP-related co-morbidity or cognitive impairment.

Using the set of clinical categories used for PT and OT (Table 14 and 15), CMS evaluated which categories may be predictive of generally higher relative SLP costs. This analysis found that one clinical category, the Acute Neurologic group, was particularly predictive of increased SLP costs. To determine the initial classification into a SLP group, CMS proposes that residents would first be categorized into one of two groups for the clinical reason for the SNF stay. Similar to the proposal for PT and OT, CMS proposes that based on the first line of Item I8000 on the MDS assessment, residents would be classified into either the "Acute Neurologic" clinical category or a "Non-Neurologic" group that includes the remaining nine clinical categories.

Based on cost regression analyses and feedback from TEP, CMS also identified the presence of a swallowing disorder or a mechanically altered diet as a predictor of relative increases in SLP costs. In addition to the clinical categorization, CMS proposes to also classifying residents as having a swallowing disorder, being on a mechanically altered diet, both or neither under the SLP component. CMS plans to monitor for any increase in the use of mechanically altered diets to ensure beneficiaries are being prescribed this diet based on clinical needs and not for financial considerations.

CMS explored how SLP costs vary according to cognitive status and observed that SLP costs were notably higher for residents who had a mild to severe cognitive impairment (Table 20 page 21047) or who had an SLP-related comorbidity. CMS identified 12 SLP-related comorbidities that it believes best predict relative differences in SLP costs (Table 22 reproduced below).

Table 22: Proposed SLP-related Comorbidities	
Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

CMS discusses the analyses it did using CART and decisions made to develop case-mix groups to classify residents for SLP payments. For this analysis, CMS used three variables: clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically altered diet, and the presence of an SLP-related comorbidity or cognitive impairment. CMS proposes 12 case-mix groups to classify residents for SLP costs; all residents would be classified into one and only one of these case-mix groups. Table 23 in the rule displays the case-mix groups and CMIs for SLP.

c. Nursing Case-Mix Classification

CMS discusses concerns with the current nursing case-mix classification. The RUG-IV classification system initially sorts residents into rehabilitation versus non-rehabilitation cohorts based on the amount of therapy a resident receives. CMS notes that over 90 percent of resident days are billed using a rehabilitation RUG. An additional concern is that the RUG-IV system uses therapy minutes to also determine nursing payments. CMS believes, however, that the

RUG-IV non-rehabilitation groups are associated with nursing utilization. The non-rehabilitation groups classify residents based on their ADL score, extensive service use, complex conditions, and use of restorative nursing services. CMS reports that all of these characteristics and results from the Staff Tiime and Resource Intensity Verification (STRIVE) study accounted for relative differences across groups. [14]

CMS proposes to use the existing RUG-IV methodology for classifying residents into non-rehabilitation RUGs to develop a proposed nursing classification. CMS proposes several modifications to the RUG-IV nursing component. As discussed in the proposed rule, CMS proposes reducing the 43 nursing RUGs to 25 case-mix groups for nursing payment. Another modification would update the nursing ADL score to incorporate section GG items. CMS proposes that section G items of MDS 3.0 would be replaced with a functional score based on seven section GG items (Table 25 reproduced below). In addition, CMS proposes to update the existing CMIs using the STRIVE staff time measurement data that were originally used to create these indexes.

Table 25: Section GG Items Included in Proposed Nursing Functional Measure		
Section GG Number	**Section GG Descriptor**	**Score**
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to chair transfer	
GG0170F1	Mobility: Toilet transfer	

Table 26 in the rule lists the proposed nursing CMIs for PDPM. Nursing group CMIs would be calculated based on the average per diem nursing WWST of a case-mix group relative to the population average.

CMS also used the STRIVE data to quantify the effects of an HIV/AIDS diagnosis on nursing resource use. After controlling for nursing RUG, HIV/AIDS status is associated with a positive and significant increase in nursing utilization. Thus, as part of the case-mix adjustment of the nursing component, CMS proposes an 18 percent increase in payment for the nursing component for residents with HIV/AIDS. CMS notes this adjustment would be based on the presence of ICD-10-CM code B20 on the SNF claim.

d. NTA Case-Mix Classification

The current SNF PPS, in which NTA resource use is incorporated into the nursing component, has been criticized for failing to adequately and accurately reimburse NTA costs. CMS proposes to address this criticism by creating a distinct NTA services component within PDPM. The proposed methodology mirrors that previously described for subdividing therapy services into distinct components. Cost regression models used to identify resident characteristics predictive

[14] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/STRIVE_Final_Report_Phase_I_Sampling_Methodology.pdf

of NTA cost increases yielded three categories: resident comorbidities, use of extensive services (e.g., expensive, invasive), and resident age. In response to comments from TEP members, CMS removed age.

CMS then identified comorbidities and extensive services associated with high NTA utilization. CMS mapped ICD-10 diagnosis codes from the prior inpatient claim, the first SNF claims, and section I8000 of the 5-day MDS assessment to condition categories from the Part C risk adjustment model and the Part D risk adjustment model. CMS decided to use the diagnosis-defined conditions from the Part C and Part D risk adjustment models to define conditions and services that were not defined on the MDS. Cost regression analyses identified 50 condition categories and types of extensive services as highly predictive of NTA cost differences (Table 27 page 21058). Esophageal reflux and migraine headache were excluded.

After considering options available for capturing the NTA cost variations using the identified predictor condition categories and services, CMS proposes basing a resident's NTA score would be used to classify the resident into an NTA case-mix classification group on a weighted-count methodology. Each comorbidity and services that factor into a resident's NTA classification would be assigned a certain number of points based on its relative impact on a resident's NTA costs (Table 27). Conditions and services with a greater impact on NTA costs are assigned more points. CMS believes that under this methodology, the NTA component would adequately reflect differences in the NTA costs for each condition or service as well as the additive effect of having multiple comorbidities. A resident's total comorbidity score (the sum of points associated with all of the resident's comorbidities and services) would be used to classify the resident into a NTA case-mix group.

Using the same methodology used for the PT, OT, and SLP components, CMS used the CART algorithm to determine the most appropriate splits in the resident NTA case-mix groups. CMS determined that six case-mix groups would be necessary to classify residents in terms of their NTA cost (Table 28 in the proposed rule). To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. CMS uses two factors for the calculation of CMIs for the NTA component: (1) the average per diem costs of a case-mix group relative to the population average and (2) the average variable per diem adjustment factor of the group relative to the population average.

CMS proposes that all residents would be classified into one and only one of these six NTA case mix groups under the PDPM.

e. Payment Classifications under PDPM

RUG-IV classifies each resident into a single RUG that generates a single payment for all services. The proposed PDPM would separately classify residents into the five components: PT, OT, SLP, NTA, and nursing. A single payment is based on the sum of these individual classifications. The payment for each component would be calculated by multiplying the CMI for the resident's group first by the component federal base rate and then by the specific day in the variable per diem adjustment schedule (see discussion below in Section D.4). For residents

with HIV/AIDS indicated on their claim the nursing portion of payment would be multiplied by 1.18. Under the proposed PDPM, these payments would then be added together along with the non-case-mix component payment rate to create a resident's total SNF per diem rate. CMS provides two hypothetical residents and how they would be classified into payment groups under the current RUG-IV model and proposed PDPM.

4. Proposed Variable Per Diem Adjustment Factors and Payment Schedule

The SNF PPS currently makes payment at a constant per diem rate for each RUG regardless of the duration of a resident's classification into a given RUG. SNF PRM researchers, however, found that resource utilization, as measured by claims-derived costs, varies during a SNF stay. PT, OT, and NTA costs typically decline (at different rates) while SLP costs remain constant over time. The analyses found that PT and OT components decline slowly over the course of the SNF stay. The NTA component cost analyses indicated significantly increased NTA costs at the beginning and then drops to a much lower level, which is relatively constant over the remainder of the SNF stay. CMS notes this is consistent with the finding that most SNF drug costs are typically incurred at the onset of a SNF stay. Because nursing costs are not tracked separately they could not be analyzed. TEP members also believe these costs remain fairly constant over a resident's stay.

CMS proposes applying variable per diem adjustments to PDPM payments for the PT, OT, and NTA components to accurately account for length of stay effects. CMS is not proposing similar adjustments to the SLP and nursing components. The case-mix adjusted federal per diem payment for a given component and a given day would be equal to base rate for the relevant component (either urban or rural), multiplied by the CMI for that resident, multiplied by the variable per diem adjustment factor for that specific day, as applicable

Distinct adjustment factors would reflect the different rates of decline for various components. Proposed PT/OT and NTA adjustment factors and schedules are shown in Tables 30 and 31 of the rule, respectively, and reproduced below. For PT and OT components, the adjustment factor is 1.00 for days 1 to 20. CMS proposes to set the adjustment factor such that payment would decline 2 percent every 7 days, a 0.3 percent rate of decline. The adjustment factor would be 0.76 for days 98-100. Based on the analyses of NTA services, CMS proposes to set the NTA adjustment factor to 3.00 for days 1 to 3 (Reflecting the extremely high initial costs, then setting it at 1.00 for subsequent days.

Table 30: Proposed Variable Per-diem Adjustment Factors and Schedule – PT and OT	
Medicare Payment Days	**Adjustment Factor**
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94

Table 30: Proposed Variable Per-diem Adjustment Factors and Schedule – PT and OT	
Medicare Payment Days	**Adjustment Factor**
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Table 31: Proposed Variable Per-diem Adjustment Factors and Schedule - NTA	
Medicare Payment Days	**Adjustment Factor**
1-3	3.0
4-100	1.0

E. Use of the Resident Assessment Instrument - Minimum Data Set, Version 3

1. Potential Revisions to the MDS Completion Schedule

To classify residents under the SNF PPS, CMS uses the MDS 3.0 Resident Assessment Instrument (RAI). The SNF PPS has been criticized for the administrative burden of its resident assessments (scheduled and unscheduled required assessments) and associated complex assessment rules. SNFs are required to complete scheduled assessments on days 5, 14, 30, 60, and 90. Unscheduled assessments, such as the Start of Therapy and the Significant Change in Status (SCSA) may be required when triggered by certain defined events. Unscheduled assessments may also mandate completion of the Care Area Assessment process along with the MDS reporting. All portions of the RAI data are used to classify SNF residents for payment.

Because many resident classification characteristics are relatively stable over time and to reduce administrative burden, CMS proposes to revise the assessments that would be required under the proposed PDPM. Specifically, the 5-day SNF PPS scheduled assessment would be used to classify a resident for the entirety of their Part A stay. This would become effective beginning FY 2020 in conjunction with the implementation of the proposed PDPM.

To allow SNFs to capture resident's clinical changes, effective October 1, 2019, CMS proposes to require providers to reclassify residents as appropriate from the initial 5-day classification using a new assessment called the Interim Payment Assessment (IPA). The IPA would be comprised of the 5-day SNF PPS MDS Item Set (Item Set NP). CMS proposes that providers would be required to complete an IPA when the following two criteria are met:

1. There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the proposed PDPM (see the first column in Tables 21, 23, 26 and 27), such that the resident would be classified into a classification group for that component that differs from that provided by the 5-day scheduled PPS assessment, and the change results in a payment either in one particular payment component or in the overall payment for the resident; and
2. The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

CMS proposes that the Assessment Reference Date (ARD) for the IPA would be no later than 14 days after a change in the resident's first tier classification is identified. When an IPA is required and a facility fails to complete one, CMS proposes that the facility would follow the guidelines for late and missed unscheduled MDS assessments.[15] CMS provides clinical examples requiring completion of an IPA and the ARD window.

CMS discusses the implications of a SNF completing an IPA on the variable per diem adjustment schedule. CMS proposes that although IPA completion follows a resident status change that triggers resident reclassification under the PDPM, the resident's variable per diem adjustment schedule would not be reset. Through this proposal, CMS intends to discourage IPA completion primarily for the purpose of resetting the variable per diem adjustment schedule.

CMS also proposes to require that SNFs continue to complete the PPS Discharge Assessment for each SNF Part A resident at the time of Part A or facility discharge. Currently, the Part A PPS Discharge Assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility. CMS believes that its proposal to also require the assessment at the time of facility discharge for Part A residents, will help ensure that residents are receiving therapy that is reasonable, necessary, and tailored to meet their needs.

Finally, CMS proposes to eliminate so-called "grace days" and instead incorporate them into the assessment time window. This proposal would eliminate grace days from the SNF PPS assessment calendar and provide for only a standard assessment window.

Table 33 (reproduced below) is the proposed SNF PPS assessment schedule, which would be effective October 1, 2019 concurrently with the proposed PDPM.

[15] Guidelines are explained in Chapters 2.13 and 6.8 of the MDS RAI Manual (https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf)

Table 33: Proposed PPS Assessment Schedule Under PDPM		
Medicare MDS Assessment Schedule Type	**Assessment Reference Date**	**Applicable Standard Medicare Payment Days**
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified	ARD of the assessment through Part A discharge (unless another IPA is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

2. Proposed Item Addition to the Swing Bed PPS Assessment

Certain small, rural hospitals enter into a Medicare swing-bed agreement, under which the hospital can provide either acute or SNF level care ("swing beds"). For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. Services furnished by non-CAH rural hospitals are paid under the SNF PPS.

CMS proposes to add three items to the Swing Bed PPS Assessment for the proposed PDPM (Table 34 reproduced below).

Table 34: Proposed Items to Add to Swing Bed PPS Assessment		
MDS Item Number	**Y7**	**Related PDPM Payment Component**
K0100	Swallowing Disorder	SLP
I4300	Active Diagnosis: Aphasia	SLP
O0100D2	Special Treatments, Procedures and Programs; Suctioning, While a Resident	NTA

3. Proposed Items to be Added to the PPS Discharge Assessment

The PPS Discharge Assessment uses the Item Set NPE and does not currently contain section O of the MDS 3.0. CMS notes that the therapy items in section O would allow it to collect data from providers on the volume, type (PT, OT and SPL) and mode (individual, concurrent or group therapy) of the therapy provided to SNF residents. CMS proposes to add 18 therapy collection items to the PPS Discharge assessment and to require providers to complete these items beginning October 1, 2019 (Table 35 reproduced below).

Table 35: Proposed Items to Add to SNF PPS Discharge Assessment	
MDS Item Number	**Item Name**
O0400A5	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy Start Date
O0400A6	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy End Date
O0400A7	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Individual Minutes
O0400A8	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Concurrent Minutes
O0400A9	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Group Minutes
O0400A10	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Days
O0400B5	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy Start Date
O0400B6	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy End Date
O0400B7	Special Treatments, Procedures and Programs: Occupational Therapy: Total Individual Minutes
O0400B8	Special Treatments, Procedures and Programs: Occupational Therapy: Total Concurrent Minutes
O0400B9	Special Treatments, Procedures and Programs: Occupational Therapy: Total Group Minutes
O0400B10	Special Treatments, Procedures and Programs: Occupational Therapy: Total Days
O0400C5	Special Treatments, Procedures and Programs: Physical Therapy: Therapy Start Date
O0400C6	Special Treatments, Procedures and Programs: Physical Therapy: Therapy End Date
O0400C7	Special Treatments, Procedures and Programs: Physical Therapy: Total Individual Minutes
O0400C8	Special Treatments, Procedures and Programs: Physical Therapy: Total Concurrent Minutes
O0400C9	Special Treatments, Procedures and Programs: Physical Therapy: Total Group Minutes
O0400C10	Special Treatments, Procedures and Programs: Physical Therapy: Total Days

CMS discusses how this information would allow it to not only monitor the total minutes of therapy but also assess the daily intensity of therapy provided to SNF residents under the PDPM. CMS notes if the amount of therapy provided to SNF residents does change significantly under the PDPM, it will assess the need for additional policies to ensure that SNF residents receive sufficient and appropriate therapy.

F. Potential Revisions to the SNF PPS Therapy Provision Policies

CMS discusses the policies it has implemented to ensure that the amount of therapy provided did not exceed the resident's actual needs. In the SNF PPS FY 2010 final rule, CMS decided to allocate concurrent therapy minutes for purpose of establishing the RUG-IV group to which the patient belongs and to limit concurrent therapy to two patients at a time who are performing different activities. Because of a significant increase in group therapy, in the FY 2012 SNF PPS final rule CMS defined group therapy as exactly four residents who are performing the same or similar activities. In addition, the total amount of time that a therapist spends with a group would be divided by the number of patients in the group to establish the patient's RUG-IV group. Table 36 (reproduced below), which appeared in the FY 2014 SNF proposed rule, demonstrates the distribution of therapy modes (individual, concurrent, and group) from the STRIVE study, FY 2011 and FY 2012.

Table 36: Mode of Therapy Provision			
Mode of Therapy	**STRIVE**	**FY 2011**	**FY 2012**
Individual	74%	91.8%	99.5%
Concurrent	25%	0.8%	0.4%
Group	<1%	7.4%	0.1%

CMS is concerned that based on the policies in the proposed SNF, providers may base decisions regarding the mode of therapy for a given resident on financial considerations rather than on clinical needs. CMS believes that individually tailored therapy is generally best provided one-on-one. Therefore, CMS proposes to impose group and concurrent therapy limits in conjunction with PDPM implementation, similar to the existing group therapy constraints. Group and concurrent therapy minutes combined could not constitute more than 25 percent of a resident's therapy minutes. This limit would ensure that at least 75 percent of a resident's therapy minutes would be provided on an individual basis. The total unallocated minutes as reported in the MDS would be used to determine compliance with the proposed limit.

CMS considered alternative limits to group and concurrent therapy, including no limit and separate limits of 25 percent each for group and concurrent therapy. Although no limit would maximize flexibility for providers, responders to the ANPRM, expressed concerns that this approach lacked safeguards to ensure that residents receive an appropriate amount of individual therapy. Imposing separate group and concurrent therapy limits of 25 percent attempts to balance provider flexibility with appropriate requirements for individual therapy. The separate limits would, however, allow up to 50 percent of a resident's therapy to be delivered at other than the individual level, and CMS expresses considerable concern about this possibility. CMS also notes that assuming the existing therapy patterns are accurate (Table 36), the number of

group and concurrent minutes that have been reported by SNFs are significantly lower that the proposed 25 percent limit. CMS notes that providers should document rationales providing group or concurrent therapy to a resident.

Relatedly, CMS notes that compliance with the current group therapy limit is tracked through the RUG-IV system grouper and excess group therapy minutes are not counted towards resident classification into RUGs. Because the PDPM does not utilize therapy minutes for resident classification, a new audit mechanism for compliance with the proposed therapy limit would be needed. CMS proposes to use the validation reports issued to providers when submitting their resident MDS assessments to the Quality Improvement Evaluation System (QIES). When the 25 percent limit is exceeded a warning of a non-fatal error would appear in the provider's validation report. The non-fatal warning would serve as a reminder to the facility that they are out of compliance with the proposed therapy limit. CMS plans to monitor rates and patterns of QIES combined limit warnings and a provider who consistently exceeded the combined limit could be flagged for additional review. If necessary, CMS will also consider policy changes if QIES warning patterns suggest inappropriate patterns of therapy provision at other than the individual level.

G. Proposed Interrupted Stay Policy

An interrupted stay occurs when a resident leaves a SNF and returns to the same SNF one or more times within the same SNF Part A benefit period. Currently about 25% of benefit periods involve an interrupted stay and some SNF readmissions are contingent upon an intervening qualifying inpatient hospital stay. Unlike other Medicare PAC programs, the SNF PPS has not included an "interrupted stay" policy because under the RUG-IV given a resident's case-mix group, payment doesn't vary during a SNF stay (absent a change in a RUG group assignment).

The proposed PDPM, however, includes variable per diem payment adjusters for the PT, OT, and NTA base rate components, creating the potential need for a SNF PPS interrupted stay policy. Such a policy would serve to discourage inappropriate SNF discharges aimed at increasing payment by resetting the variable per diem payment adjustment schedule. The source of the readmission (e.g., acute care hospital) would not factor into the proposed policy. For interrupted stay payment under the PDPM system, CMS proposes that:

- The variable per diem adjustment be reset whenever a resident is discharged then readmitted to a different SNF (where a new MDS assessment would be required);
- The variable per diem adjustment be reset when a resident is discharged then readmitted to the same SNF only if the resident were out of the SNF at least 3 days;
- Readmission of a resident to the same SNF more than 3 days after discharge would trigger a required new MDS assessment (and possible PDPM reclassification); and
- The resident's PDPM classification would not change from admission for a readmission to the same SNF occurring in 3 or fewer days after discharge. A new MDS assessment wouldn't be required, although the SNF could choose to complete an IPA assessment for reclassification if clinically appropriate.

CMS walks through several scenarios of applying the proposed interrupted stay policy. CMS believes that frequent SNF readmissions may be an indicator of poor quality of care and will monitor readmissions to identify patterns for which enhanced review is appropriate.

H. Proposed Relationship of the PDPM to Existing SNF Level of Care Criteria

Presently, SNF level of care necessity determinations are coordinated with resident assessment and classifications processes, so that the initial assignment to specified RUGs presumptively qualifies the admission for SNF care. As part of PDPM implementation, administrative presumption of SNF necessity would be applied at the time of the initial MDS assessment to residents who meet certain criteria, at the time of the MDS Day 5 assessment. These administrative presumption criteria were presented in the ANPRM as part of RCS-I and have been further modified for PDPM use based upon commenter feedback.[16] CMS proposes that the criteria include residents:

- Assigned to the four most intensive RUG nursing categories (the PDPM nursing component includes a non-rehabilitation nursing RUG-IV group assignment);[17] or
- Receive the highest range PT or OT component functional score; or
- Receive the uppermost NTA component comorbidity score.

Consistent with current practice, a beneficiary who is not assigned to one of the designated groups would receive an individual care determination using the existing administrative criteria.

I. Effect of Proposed PDPN on Temporary AIDS Add-on Payment

Section 511(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with AIDS, effective with services furnished on or after October 1, 2004. The MMA specified that this special add-on was to remain in effect only until the Secretary certified there is an appropriate adjustment in the case-mix to compensate for the increase costs associated with residents with AIDS.

CMS discusses how the progress in HIV/AIDS care has decreased the magnitude of the differential resource used, although some costs have shifted some from nursing costs to NTA due to antiretroviral drugs. CMS noted in the ANPRM that the RCS-I could potentially lead to expiration of the AIDS temporary add-on payment. Some commenters responded that the projected 40 percent drop in overall payments for AIDS SNF residents would impair access to care. CMS undertook additional analyses and (as noted previously in discussion of the nursing and NTA components) believes that under the proposed PDPM, the four proposed ancillary payment components (PT, OT, SLP and NTA) adequately reimburse ancillary costs associated with HIV/AIDS residents. However, to ensure that the proposed PDPM would account as fully as possible for any remaining disparity with regard to nursing costs, CMS proposes an 18 percent

[16] Concerns about the criteria included impeding access to care for some beneficiaries; whether patients having high functional scores are appropriate for care level presumption; the omission of the SLP component as a factor; and the inclusion of NTA component in the criteria.
[17] The categories are: Extensive Services; Special Care High; Special Care Low; and Clinically Complex.

increase in payment for the nursing component for HIV/AIDS residents (see related discussion above in section V.D). The 18 percent adjustment would be applied to the unadjusted base rate for the nursing component, which would be further case-mix adjusted per the resident's PDPM classification.

CMS acknowledges that the payment changes could be disruptive financially for facilities serving large populations of residents with AIDS and therefore invites specific comments on possible ways to help mitigate any potential disruption stemming from the proposed replacement of the special add-on payment with the permanent case-mix adjustments for SNF residents with AIDS under the proposed PDPM.

J. Potential Impacts of the Proposed PDPM Implementation and Proposed Parity Adjustment

CMS presents an impact analysis, assuming that the proposed PDPM implementation as described herein (plus associated policies) will be budget-neutral and will not require provider behavioral offsets at the time of initial implementation. CMS also assumes that changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays.

As with prior system transitions, CMS proposes to implement the PDPM case-mix system in a budget neutral manner through application of a parity adjustment to the case-mix weights. A parity multiplier is proposed for PDPM components to maintain the relative value of each CMI while achieving parity on overall SNF payments under both the proposed PDPM and existing RUG-4 systems.

CMS discusses the methodology used for calculation of the parity adjustment. RUG-IV total payments would be calculated from FY 2017 claims, and total estimated payments for the same claims under the PDPM case-mix adjusted components would be computed. The non-case-mix component payments would be subtracted from the RUG-IV actual payments as this component does not change under the proposed PDPM. The subtraction does not include the AIDS temporary add-on payments since analogous payments are made through the PDPM case-mix adjusted components. Finally, the estimated PDPM payments are set to equal the total allowable Medicare payments under RUG-IV, by dividing the remaining RUG-IV actual payments by the estimated remaining total PDPM payments. The result of the division is a ratio (parity adjustment) of 1.46 by which the proposed CMIs are multiplied so that the total estimated payments under the proposed PDPM would be equal to total payments under the RUG-IV (assuming no changes in the population, provider behavior, and coding). If the parity adjustment had not been applied, total estimated payments under the proposed PDPM would be 46 percent lower than total actual payments under RUG-IV.

Projected resident-level impacts from the proposed PDPM are presented in Table 37 (included in the Appendix of this summary). The most significant shift in payments would be to redirect payments from residents receiving very high amounts of therapy under the current SNF PPS to resident with more complex clinical needs. CMS projects that for residents whose most common therapy level is RU (ultra-high therapy), the highest therapy level, there would be a reduction in

associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent. Resident groups with the following characteristics would also see higher payments: high NTA costs; receiving extensive services; dually enrolled in Medicare and Medicaid; use of IV medication; have end-stage renal disease or diabetes or a wound infection; receive post-amputation prosthesis care; and/or have longer prior qualifying inpatient stays. In response to comments received on the ANPRM, CMS did additional subpopulation analyses and projects increases for residents with addiction, bleeding disorders behavioral issues, chronic neurological conditions, and bariatric care.

The projected provider level impacts are presented in Table 38 (included in the Appendix of this summary). CMS notes that the most significant shift in payments would be from facilities with a high proportion of rehabilitation residents (particularly facilities with high proportions of Ultra-High Rehabilitation residents) to facilities with high proportions of non-rehabilitation residents. CMS projects that payments to facilities that bill 0 to 10 percent of utilization days as RU would increase an estimated 27.6 percent under the proposed PDPM while facilities that bill 90 to 100 percent of utilization days as RU would see an estimated decrease in payments of 9.8 percent. Potential increases are also forecasted for small, non-profit, government-owned, hospital-based and swing-bed facilities.

Due to proposed changes in the MDS assessment schedule, CMS expects a significant reduction in regulatory burden under the SNF PPS. CMS anticipates that the proposed changes would both reduce administrative costs by approximately $12,000 and reduce the time for administrative issues by approximately 183 hours for each provider.

CMS proposes to implement the PDPM as a single transition to be completed in FY 2020, rather than a multiyear phased transition. CMS states that the administrative and operational burdens created by the need for the agency and providers to maintain two case-mix systems (and resultant payments) as disparate as RUG-IV and PDPM to implement blended multiyear transition rates would be excessive. CMS also considered effective dates for PDPM implementation other than FY 2020. It believes that the proposed year allows sufficient time for transition preparation without imposing excessive delay in addressing ongoing criticisms of the current SNF PPS.

CMS specifically invites comments on their assumptions that behavior would remain unchanged under the proposed PDPM and that changes in state Medicaid payments from PDPM implementation would be of minimal impact. CMS further invites comments specifically on the possible impacts on Medicaid programs. Finally, comments are invited on the projected impacts and on the proposals and alternatives discussed.

VI. Other Issues (pages 21080-21089)

A. Other Revisions to the Regulatory Text

In addition to changes to regulatory text mentioned in other parts of the proposed rule, CMS proposes two other revisions.

CMS proposes to revise §411.15(p)(3)(iv) to specify that for consolidated billing purposes, a beneficiary's "resident" status would end whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF "before the following midnight." CMS notes that this revision would not alter the underlying principle that a beneficiary's SNF "resident" status ends upon departure from the SNF unless he or she returns to that or another SNF later on that same day. It would simply serve to conform the actual wording of the applicable regulations text with the Medicare manual's standard definition of the starting point of a patient "day."

A technical correction is proposed to conform §424.20(a)(1)(i) more closely to the corresponding statutory requirements at section 1814(a)(2)(B) of the Act. Specifically, it would provide that the SNF-level care must be for either (1) an ongoing condition that was one of the conditions that the beneficiary had during the qualifying hospital stay, or (2) a new condition that arose while the beneficiary was in the SNF for treatment of that ongoing condition. The current regulatory text inadvertently omits the second point, which would be added under the proposed rule.

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

1. Background

The SNF QRP was established pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Under the program, freestanding SNFs, SNFs affiliated with acute hospitals and all non-Critical Access Hospital swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the update factor beginning in FY 2018.

SNFs report data on SNF QRP assessment-based measures and standardized resident assessment data by reporting the designated data elements for each applicable resident on the Minimum Data Set (MDS) resident assessment instrument and then submitting completed instruments to CMS using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system. No changes are proposed in this rule to the form, manner or timing of data submission for the SNF QRP.

2. Accounting for Social Risk Factors

CMS reviews its past discussion of accounting for social risk factors in its quality reporting and value-based purchasing programs. It cites the July 2017 final report of the National Quality Forum (NQF) on its 2-year trial period of risk adjustment for social risk factors, and notes that NQF has launched a follow-up 3-year initiative that will continue to include social risk factors in

outcome measures submitted for endorsement and will also explore unresolved issues that surfaced in the initial trial. In addition, CMS notes that the Assistant Secretary for Planning and Evaluation (ASPE) is working on a second report to Congress on this topic required by the IMPACT Act, which is due in the fall of 2019.

As a next step, CMS is considering options to increase the transparency of quality measure disparities shown among patient groups within and across hospitals, such as stratification of Inpatient Quality Reporting Program outcome measures. It plans to continue to work with ASPE, the public, and other stakeholders to identify policy solutions that improve health equity while minimizing unintended consequences.

3. New Measure Removal Factor for Previously Adopted SNF QRP Measures

CMS references its Meaningful Measures Initiative, launched in October 2017, which is intended to reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care. Meaningful Measures is part of the agency's Patients Over Paperwork Initiative, which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience.

The previously adopted seven factors that CMS considers for removal of a measure from the SNF QRP are reviewed, and CMS proposes an eighth new factor. The seven current removal factors consider whether 1) measure performance is so high and unvarying and meaningful distinctions in improvements in performance can no longer be made; 2) performance or improvement on the measure does not result in better resident outcomes; 3) the measure does not align with current clinical guidelines or practice; 4) another more broadly applicable measure is available; 5) another measure that is more proximal in time to desired patient outcomes is available; 6) a measure more strongly associated with desired resident outcomes is available, and 7) collection or public reporting of the measure leads to negative unintended consequences other than patient harm. CMS notes that none of the factors results in automatic removal; these are considerations that are taken into account on a case-by-case basis.

The proposed eighth removal factor would be the costs associated with a measure outweigh the benefit of its continued use in the program. CMS reviews the different types of costs associated with measures. It also notes that beneficiaries may find it confusing to see public reporting on the same measure in different programs. CMS says its goal is to move the program forward in the least burdensome manner possible while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize quality improvement.

The existing removal factors and the proposed new factor would be codified in regulatory text in a new 42 CFR 360(b)(3).

4. SNF QRP Measures for FY 2020

No changes are proposed to the measure set previously adopted for the SNF QRP for the FY 2020 payment year, which is shown in the table below, reproduced from the proposed rule.

Table 39: Quality Measures Currently Adopted for the FY 2020 SNF QRP	
Short Name	**Measure Name**
Pressure Ulcers	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury*
Application of Falls	Application of the NQF-endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/ Care Plan	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Change in Self-Care Score	Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
	Claims-based
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) – Post Acute Care Skilled Facility Quality Reporting Program*
DTC	Discharge to Community-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program*
*The pressure ulcer measure NQF #0678 will be replaced by the pressure ulcer/injury measure effective October 1, 2018.	

5. IMPACT Act Implementation Update

The IMPACT Act requires the Secretary to implement quality measures for specified quality measure domains using standardized data elements to be nested within the assessment instruments currently required for submission by IRFs and other post-acute care providers (LTCHs, IRFs, and HHAs). Other measures are to address resource use, hospitalization, and discharge to the community. The intent of the Act is to enable interoperability and access to longitudinal information among post-acute providers to facilitate coordinated care, improve outcomes, and provide for quality comparisons across providers.

In the FY 2018 SNF PPS proposed rule and related post-acute care rules, CMS proposed the adoption of standardized patient assessment data that would form the foundation of cross-cutting quality measures. These data elements were not finalized, however, due to commenter concerns about reporting burden.

In this rule, CMS reports on its ongoing work on developing two measures that would satisfy the IMPACT Act domain of accurately communicating the existence and provision of the transfer of health information and care preferences. It plans on reconvening a Technical Expert Panel in mid-2018 and specifying the measures no later than October 1, 2019. CMS intends then to propose adoption beginning with the FY 2022 SNF QRP. Readers are referred to the CMS IMPACT Act downloads and videos webpage for more information on pilot measure testing: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html

6. Reconsideration Requirements

CMS proposes to modify the regulatory text at 42 CFR 413.360(d)(1) to expand the methods by which it would notify a SNF of non-compliance with the SNF QRP requirements for a year. CMS would notify SNFs of noncompliance via a letter sent through one or more of the following: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). CMS believes this responds to providers requesting additional modes of notification. The same notification processes would be used to communicate CMS' final decision regarding any reconsideration request.

7. Public Display of SNF QRP Measures

CMS proposes to increase the number of years of data used to calculate the Medicare Spending Per Beneficiary (MSPB SNF) and Discharge to Community (DTC SNF) SNF QRP measures for purposes of display from 1 year to 2 years. In the FY 2018 SNF PPS final rule, these measures were finalized for public reporting in 2018 using data for FY 2017. Under the proposal, data on these measures would be publicly reported in CY 2019, or as soon thereafter as feasible, based on discharges from October 1, 2016 through September 30, 2018.

The reason CMS offers for proposing to increase the measure calculation and public display periods from 1 to 2 years of data is that it would increase the number of SNFs with adequate data for public reporting. For the MSPB SNF measure, the percentage of SNFs for which data could be publicly reported would increase from 86 percent (2016 data) to 95 percent (2015-2016 data), and for the DTC SNF measure this increase would similarly be from 83 percent to 94 percent. CMS says that increasing the measure public display periods to 2 years would also align with the public display periods of these measures in the IRF and LTCH QRPs.

In addition, CMS proposes to begin public display of four assessment-based measures: (1) Change in Self-Care Score (NQF #2633); (2) Change in Mobility Score (NQF #2634); (3) Discharge Self-Care Score (NQF #2635); and (4) Discharge Mobility Score (NQF #2636). SNFs will begin submitting data on these four assessment-based measures for admissions as well as

discharges occurring on or after October 1, 2018. Under the proposal, public display of data for these measures would be based on data beginning with January 1, 2019 through December 31, 2019, and then 4 rolling quarters of data after that. To ensure the statistical reliability of the measure rates, CMS proposes that if a SNF has fewer than 20 eligible cases on a measure during any 4 consecutive rolling quarters of data, the public display would note that the number of cases/resident stays is too small to publicly report the measure for that SNF. Public display would begin in 2020, or as soon thereafter as feasible.

C. SNF Value Based Purchasing (VBP) Program

1. Background

The SNF VBP Program will be implemented for discharges beginning in FY 2019. Measures for the program were adopted in the FY 2016 and 2017 SNF PPS final rules (80 FR 46409 through 46410 and 81 FR 51986 through 52009, respectively). These rules also gave an overview of statutory requirements, finalized a performance scoring methodology, and addressed other topics. The measures that have been adopted are the SNF 30-Day All-Cause Readmission Measure (SNFRM) and the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR). As required by statute, CMS intends to replace the SNFRM with the SNFPPR as soon as is practicable. More information on the SNF VBP can be found on the CMS web page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html. In the FY 2018 final rule, CMS adopted additional requirements for the SNF VBP Program, and codified policies in regulations at 42 CFR 413.338.

2. Accounting for Social Risk Factors in the SNF VBP

CMS discusses the issue of accounting for social risk factors that is similar to the one described in section VI.B.2 above with respect to the SNF QRP.

3. FY 2021 Performance Standards, and Performance and Baseline Periods

CMS previously adopted performance standards (achievement threshold and benchmark) for the SNFRM for FY 2020, which are shown in Table 40 of the proposed rule, but notes that it is unable to provide estimated numerical values for the FY 2021 performance period because of timing constraints associated with the compilation of the FY 2017 MedPAR file to include 3 months of data following the last discharge date. It does not expect either the achievement threshold or benchmark to change significantly from what was finalized for the FY 2020 and will publish the final values in the FY 2019 SNF PPS final rule.

CMS proposes a policy to address the situation where, subsequent to publishing the numerical values for the finalized performance standards for a program year, it discovers an error in the numerical values. Specifically, CMS proposes that if it discovers an error in the calculations subsequent to having published the numerical values for the performance standards for a program year, the values would be updated to correct the error. Recognizing that SNFs rely on the published performance standards, CMS proposes that such an update would only occur once, even if subsequent errors were discovered. Any update would be announced via the CMS

website, listservs, and other available channels to ensure that SNFs are made fully aware of the update.

4. FY 2021 Performance Period and Baseline Period for Subsequent Years

CMS continues to believe that 12 months is the appropriate duration for the performance and baseline periods for the SNF VBP Program. It proposes to adopt FY 2019 as the performance period for the FY 2021 SNF VBP Program year, and FY 2017 as the baseline period.

For subsequent program years (beginning with FY 2022), CMS proposes to adopt for each a performance period that is the 1-year period following the performance period for the previous program year. Similarly, the baseline period would be the 1-year period following the baseline period for the previous year. Under this policy, the performance period for the FY 2022 program year would be FY 2020 and the baseline period would be FY 2018. CMS believes adopting this policy would provide certainty to SNFs regarding future periods for performance assessment.

5. SNF VBP Performance Scoring

Three modifications are proposed to the SNF VBP performance scoring methodology, which was previously finalized in the SNF PPS final rules for FYs 2017 (81 FR 52000 - 52005) and 2018 (82 FR 36614 - 36616).

Scoring Policy for SNFs with Insufficient Baseline Data. CMS proposes that a SNF would only be scored on achievement (not improvement) if there is insufficient data for the SNF from the baseline period. Based on an analysis of Pearson correlation coefficients at various patient stay counts, CMS would define a SNF as having insufficient baseline data if it had fewer than 25 eligible stays during the baseline period for a fiscal year. The proposal would be codified at a new §413.338(d)(1)(iv). Analysis of Pearson correlation coefficients at various denominator counts used in developing this proposal can be found in the memo provided at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNFRM-Reliability-Testing-Memo.pdf. (The link provided in the proposed rule appears to be broken.)

SNF VBP Adjustment for Low-Volume SNFs. CMS proposes that a low-volume SNF (one with fewer than 25 eligible stays during the performance period) would be assigned a performance score for the fiscal year such that the SNF would receive the same per adjusted federal per diem rate they would receive if the SNF VBP were not in effect. That is, the net effect of the 2 percent withhold and the incentive payment adjustment on the SNF's adjusted federal per diem rate would be zero. CMS notes that the actual performance score assigned would depend on the distribution of all scores among SNFs and the exchange function used to calculate the SNF VBP adjustment. The low-volume SNF would be notified that it would be receiving an assigned performance score no later than 60 days prior to the fiscal year involved. CMS cites the same analysis of Pearson correlation coefficients shown above in describing its conclusion that the reliability of a SNF's measure rate and resulting performance score is adversely impacted if it has fewer than 25 eligible stays during the performance period.

CMS proposes to codify definitions of low-volume SNF and eligible stay at §413.338(a). The low-volume scoring adjustment proposal would be codified at §413.338(d)(3) and a confirming edit is proposed for the payback percentage policy at §413.338(c)(2)(i) to allow for the addition of the low-volume SNF adjustment payments to the payback percentage.

The proposed adjustment for low-volume SNFs is estimated to result in a total of $15.3 million in SNF VBP payments made to these SNFs for FY 2019. Without the proposed adjustment, CMS estimates that these SNFs would receive $8.6 million in SNF VBP incentive payments, so the net effect of the proposal is an additional $6.7 million in payments to low-volume SNFs. As discussed further in the impact analysis section of the proposed rule (section VI.C.7 below), the proposed adjustment would result in an effective payback percentage of 61.27 percent for FY 2019, instead of the 60 percent payback percentage that would otherwise be in effect[18]. CMS notes that for any future year, the effective payback percentage would depend on the number of low-volume SNFs and the distribution of performance scores among all SNFs for the year.

Comments are sought on an alternative as well as the proposal. Under the alternative that CMS considered, a low-volume SNF would receive a value-based incentive payment of 1.2 percent – 60 percent of the 2.0 percent withhold. This alternative policy would increase payments to low-volume SNFs by $1 million (instead of the $6.7 million increment estimated to result from the proposal), and the overall payback percentage would be 60.18 percent for FY 2019.

Extraordinary Circumstances Exception Policy. During the FY 2018 SNF PPS rulemaking cycle, CMS sought and received comments on a possible extraordinary circumstances exception (ECE) policy for the SNF VBP Program that would be similar to those in effect for other Medicare value-based purchasing and quality reporting programs, such as the SNF QRP.

CMS proposes to adopt an ECE policy for the SNF VBP Program that would provide relief to SNFs affected by natural disasters or other circumstances outside the facility's control that can affect the care provided to its residents. Under the proposal, if a SNF demonstrates that an extraordinary circumstance affected patient care, CMS would exclude the affected calendar months from the calculation of the SNF's measure rate for the measurement period. The proposal would be codified at a new §413.338(d)(4).

Within 90 days following the extraordinary circumstance, SNFs would submit an ECE request via a form on the QualityNet website. In addition to the request form, the SNF would submit any available evidence of the effects of the extraordinary circumstance on care provided to patients and other information that would assist CMS in making its determination. CMS may provide exceptions to SNFs that have not requested them if it determines that an extraordinary circumstance affects an entire region or locale. This decision would be communicated via routine channels such as email, notices on the CMS SNF VBP website.

[18] To fund the value-based incentive payments under the SNF VBP Program, the statute requires that the adjusted federal per diem rate for a fiscal year be reduced by 2 percent beginning with FY 2019, and that the total amount of value-based incentive payments paid to SNFs under the SNF VBP Program must equal at least 50 percent, but no more than 70 percent, of the total amount of the reductions withheld. In the FY 2018 SNF PPS final rule, CMS adopted a "payback percentage" of 60 percent.

If an exception is granted, CMS proposes to score the SNF on achievement for any remaining months during the performance period as long as it met the 25-eligible stay minimum during the performance period, as proposed above. An improvement score would be calculated if during the remining months in the baseline period the SNF met the 25-eligible stay requirement.

6. SNF Value-Based Incentive Payments

Readers are referred to the FY 2018 SNF PPS final rule (82 FR 36616-36621) for a description of the exchange function methodology adopted for the SNF VBP Program under which CMS will calculate the incentive payment adjustments from the performance scores.

CMS reviews previously adopted policies which will be implemented for the first time as the SNF VBP is first implemented for FY 2019. At least 60 days prior to the start of FY 2019, CMS will inform SNFs of their SNF VBP payment adjustment. The SNF Performance Score Reports will be circulated to SNFs using the QIES-Certification and Survey Provider Enhanced Reports (CASPER) system. These are also used for the confidential quarterly SNF readmission measure feedback reports. The reports will include the SNF's performance score, ranking and value-based incentive payment adjustment factor. SNFs will have 30 days to submit corrections to CMS of the SNF performance score and ranking. The 2 percent withhold reduction and the SNF's value-based incentive payment adjustment will be made simultaneously. SNF proposes to codify this simultaneous payment adjustment at a new §437.337(f).

CMS has not yet completed SNF performance score calculations for FY 2019 but plans to include the range of value-based payment adjustment factors in the final rule.

7. Impact Analysis

CMS estimates that the total reduction in payments required under the statute for the SNF VBP (i.e., the 2.0 percent withhold) will total $527.4 million for FY 2019, with $316.4 million returned to SNFs under the previously adopted 60 percent payback provision, for a total savings to the Medicare program of $211 million. Under the proposed low-volume adjustment discussed above in VI.C.5, however, the Medicare program savings would be reduced by $6.7 million, to about $204 million.

In Tables 44 and 45 of the Regulatory Impact section of the proposed rule, CMS displays the estimated effects in FY 2019 of the SNF VBP Program by types of providers and location with and without the proposed low-volume adjustment, respectively.

Table 45, which includes the effects of the proposed low-income adjustment, is reproduced below. The mean incentive multipliers listed in Table 45 are those estimated to be applied to SNFs' adjusted federal per diem rates *after* application of the required 2 percent reduction to those rates. Among the results, SNFs in urban areas, on average, are estimated to receive a 1.177 percent incentive multiplier, compared with a multiplier of 1.181 percent for rural SNFs, on average. Wide variation is shown by region, and for-profit SNFs show much lower multiplier (1.127 percent) compared with government-owned (1.38 percent) and non-profit SNFs (1.353 percent).

TABLE 45: Estimated SNF VBP Program Impacts Including Effects of the Proposed Low-Volume Scoring Adjustment

Category	Criterion	# of facilities	RSRR (mean)	Mean SNF Performance Score	Mean Incentive Multiplier (60% Payback)	% of Proposed Payback
Group	**Total**	**12,845**	0.18912	41.371	1.192%	99.9%*
	Urban	9,604	0.18957	40.956	1.177%	84.4%
	Rural	3,241	0.18779	41.011	1.181%	15.4%
Urban by Region	**Total**	**9,604**	--	---	--	--
	01=Boston	713	0.19089	37.26777	1.059%	4.9%
	02=New York	836	0.19029	40.90383	1.165%	11.8%
	03=Philadelphia	1,040	0.18601	45.31896	1.325%	10.1%
	04=Atlanta	1,767	0.19332	37.28735	1.052%	13.3%
	05=Chicago	1,961	0.18784	43.06368	1.246%	16.0%
	06=Dallas	1,134	0.19416	34.53275	0.949%	6.1%
	07=Kansas City	510	0.19057	39.26278	1.132%	2.6%
	08=Denver	241	0.17832	57.62596	1.790%	2.9%
	09=San Francisco	1,098	0.18908	40.80722	1.176%	12.5%
	10=Seattle	304	0.17808	56.67839	1.713%	4.2%
Rural by Region	**Total**	**3,241**	--	---	--	--
	01=Boston	115	0.18133	51.89294	1.568%	0.9%
	02=New York	77	0.18366	50.48193	1.569%	0.5%
	03=Philadelphia	240	0.18789	42.12621	1.218%	1.3%
	04=Atlanta	764	0.19283	36.51452	1.032%	3.3%
	05=Chicago	818	0.18397	47.85089	1.399%	4.5%
	06=Dallas	557	0.19355	34.00868	0.952%	1.7%
	07=Kansas City	421	0.18634	42.64769	1.236%	1.2%
	08=Denver	132	0.18000	52.38900	1.544%	0.7%
	09=San Francisco	48	0.17780	61.50419	1.931%	0.6%
	10=Seattle	69	0.17628	60.70084	1.836%	0.7%
Ownership Type	**Total**	**12,847**	--	---	--	--
	Government	688	0.18529	46.450	1.380%	5.2%
	Profit	9,250	0.19039	39.526	1.127%	72.0%
	Non-Profit	2,909	0.18597	46.038	1.353%	22.9%
No. of Beds	**Total**	**12,847**	--	---	--	--
	1st Quartile:	3,222	0.18760	42.466	1.226%	24.6%
	2nd Quartile:	3,221	0.18878	40.971	1.175%	24.4%
	3rd Quartile:	3,197	0.19048	40.242	1.153%	23.3%
	4th Quartile:	3,207	0.18963	41.800	1.212%	27.7%

* This category does not add to 100% because a small number of SNFs are missing urban/rural designations in the data.

VII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through CMS Health and Safety Requirements (pages 21089-21094)

CMS discusses the status of adoption of health IT among Medicare and Medicaid participating providers. It says that as of 2015, 96 percent of hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care, yet significant obstacles to electronic exchange of health information remain. It reviews CMS and Office of National Coordinator (ONC) initiatives and regulatory activities aimed at advancing health information exchange. The January 2018 ONC draft Trusted Exchange Framework and Common Agreement (TEFCA)[19] is highlighted.

CMS is interested in feedback from stakeholders on how it should use the Conditions of Participation (CoPs), Conditions of Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care (LTC) Facilities to advance electronic exchange of health information in support of care transitions between hospitals and community providers. As an example, CMS says it might consider revising the hospital CoPs to require that hospitals electronically transfer medically necessary patient information to the other facility when a patient is transferred. Similarly, they might require that hospitals electronically send discharge information to a patient's community provider when possible, and to provide discharge instructions electronically to patients or a third-party application, if requested.

Relevant provisions of proposed CoP regulations are discussed including the November 3, 2015 proposed rule to implement provisions of the IMPACT Act (80 FR 68126), June 16, 2016 proposed changes to CoPs for hospitals and CAHs (81 FR 39448), and an October 4, 2016 final rule on requirements for LTC facilities (81 FR 68688).

In this rule, CMS requests stakeholder feedback on the following questions:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

[19] The draft is available at https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement

- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?
- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

In addition, CMS discusses the MyHealthEData initiative to promote patient access to their medical records and the Blue Button 2.0 initiative for beneficiary access to Medicare claims information through API technology.

CMS seeks ideas from the public on how best to accomplish the goal of fully interoperable health IT and EHR systems for providers and suppliers and how to advance the MyHealthEData initiative for patients. In particular, it would like to identify fundamental barriers to interoperability and patient access and how they might be reduced through revisions to the CoPs, CfCs, and RfPs for hospitals and other Medicare providers and suppliers. CMS has a particular interest in hearing about issues for providers and suppliers who are ineligible for the Medicare and Medicaid EHR Incentives program, such as long-term care and post-acute care providers, behavioral health providers, clinical laboratories and social service providers.

The usual disclaimers applied to a Request for Information are included.

VIII. Economic Analyses (pages 21094-21099)

CMS estimates that in FY 2019 SNFs would experience an increase of $850 million in payments or an average increase of 2.4 percent, compared with FY 2018. This increase is a result of the SNF update of 2.4 percent, as required by section 53111 of the BBA 2018. Absent this requirement, the aggregate impact would have been an increase of 1.9 percent or $670 million in payments. CMS notes that these impact numbers, however, do not incorporate the SNF VBP reductions and the proposed low-volume adjustment, which would reduce aggregate payments to SNFs by an estimated $204 million.[20]

Table 43 of the proposed rule (reproduced below) gives the estimated impact of various elements of the proposed rule by SNF classification. Variation from the overall impact is due to distributional effects of the annual update to the wage index. CMS estimates that in FY 2019 SNFs in the urban Pacific region would experience the largest estimated increase in payment of 3.4 percent and rural areas in the Pacific region would experience the smallest estimated increase in payments of 1.5 percent. There was almost no variation in overall impact by rural/urban or ownership (i.e., government, profit, and nonprofit) status.

Table 43: Projected Impact to the SNF PPS for FY 2019			
	Number of Facilities FY 2019	**Update Wage Data**	**Total Change**
Group			
Total	15,455	0.0%	2.4%
Urban	11,031	0.0%	2.4%
Rural	4,424	0.1%	2.5%
Hospital-based urban	498	0.0%	2.4%
Freestanding urban	10,533	0.0%	2.4%
Hospital-based rural	551	0.0%	2.4%
Freestanding rural	3,873	0.1%	2.5%
Urban by region			
New England	789	-0.7%	1.7%
Middle Atlantic	1,479	0.0%	2.4%
South Atlantic	1,869	-0.2%	2.2%
East North Central	2,126	-0.4%	2.0%
East South Central	555	-0.3%	2.1%
West North Central	920	-0.4%	2.0%
West South Central	1,344	0.2%	2.6%
Mountain	525	-0.6%	1.8%
Pacific	1,419	1.0%	3.4%
Outlying	5	-0.7%	1.7%

[20] Under the proposed low-volume adjustment, the $211 million in Medicare program savings would be reduced by $6.7 million, to about $204 million.

Table 43: Projected Impact to the SNF PPS for FY 2019			
	Number of Facilities FY 2019	**Update Wage Data**	**Total Change**
Rural by region			
New England	135	-0.7%	1.7%
Middle Atlantic	215	0.2%	2.6%
South Atlantic	494	0.0%	2.4%
East North Central	930	0.2%	2.6%
East South Central	523	-0.5%	1.9%
West North Central	1,072	0.4%	2.8%
West South Central	733	0.8%	3.2%
Mountain	227	0.5%	2.9%
Pacific	95	-0.8%	1.5%
Ownership			
Government	1,011	-0.1%	2.3%
Profit	10,872	0.0%	2.4%
Non-Profit	3,572	-0.1%	2.3%
Note: The Total column includes the 2.4 percent market basket increase required by section 53111 of the BBA 2018. Additionally, CMS found no SNFs in rural outlying areas.			

CMS considers the proposed rule economically significant and hence a major rule under the Congressional Review Act. CMS concludes that the proposed rule would have a net positive impact on a substantial number of small entities, and that it would not have a significant impact (that is, not greater than 3 percent) on rural hospitals. CMS also concludes that the proposed rule will not have a substantial effect on state or local governments, preempt state law, or otherwise have a federalism implication.

Appendix Tables

TABLE 6: 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	$484.61	$255.65		$92.63	$832.89
RUL	2.57	1.87	$466.46	$255.65		$92.63	$814.74
RVX	2.61	1.28	$473.72	$174.99		$92.63	$741.34
RVL	2.19	1.28	$397.49	$174.99		$92.63	$665.11
RHX	2.55	0.85	$462.83	$116.20		$92.63	$671.66
RHL	2.15	0.85	$390.23	$116.20		$92.63	$599.06
RMX	2.47	0.55	$448.31	$75.19		$92.63	$616.13
RML	2.19	0.55	$397.49	$75.19		$92.63	$565.31
RLX	2.26	0.28	$410.19	$38.28		$92.63	$541.10
RUC	1.56	1.87	$283.14	$255.65		$92.63	$631.42
RUB	1.56	1.87	$283.14	$255.65		$92.63	$631.42
RUA	0.99	1.87	$179.69	$255.65		$92.63	$527.97
RVC	1.51	1.28	$274.07	$174.99		$92.63	$541.69
RVB	1.11	1.28	$201.47	$174.99		$92.63	$469.09
RVA	1.10	1.28	$199.65	$174.99		$92.63	$467.27
RHC	1.45	0.85	$263.18	$116.20		$92.63	$472.01
RHB	1.19	0.85	$215.99	$116.20		$92.63	$424.82
RHA	0.91	0.85	$165.17	$116.20		$92.63	$374.00
RMC	1.36	0.55	$246.84	$75.19		$92.63	$414.66
RMB	1.22	0.55	$221.43	$75.19		$92.63	$389.25
RMA	0.84	0.55	$152.46	$75.19		$92.63	$320.28
RLB	1.50	0.28	$272.25	$38.28		$92.63	$403.16
RLA	0.71	0.28	$128.87	$38.28		$92.63	$259.78
ES3	3.58		$649.77		$18.01	$92.63	$760.41
ES2	2.67		$484.61		$18.01	$92.63	$595.25
ES1	2.32		$421.08		$18.01	$92.63	$531.72
HE2	2.22		$402.93		$18.01	$92.63	$513.57
HE1	1.74		$315.81		$18.01	$92.63	$426.45
HD2	2.04		$370.26		$18.01	$92.63	$480.90
HD1	1.60		$290.40		$18.01	$92.63	$401.04
HC2	1.89		$343.04		$18.01	$92.63	$453.68
HC1	1.48		$268.62		$18.01	$92.63	$379.26
HB2	1.86		$337.59		$18.01	$92.63	$448.23
HB1	1.46		$264.99		$18.01	$92.63	$375.63
LE2	1.96		$355.74		$18.01	$92.63	$466.38

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
LE1	1.54		$279.51		$18.01	$92.63	$390.15
LD2	1.86		$337.59		$18.01	$92.63	$448.23
LD1	1.46		$264.99		$18.01	$92.63	$375.63
LC2	1.56		$283.14		$18.01	$92.63	$393.78
LC1	1.22		$221.43		$18.01	$92.63	$332.07
LB2	1.45		$263.18		$18.01	$92.63	$373.82
LB1	1.14		$206.91		$18.01	$92.63	$317.55
CE2	1.68		$304.92		$18.01	$92.63	$415.56
CE1	1.50		$272.25		$18.01	$92.63	$382.89
CD2	1.56		$283.14		$18.01	$92.63	$393.78
CD1	1.38		$250.47		$18.01	$92.63	$361.11
CC2	1.29		$234.14		$18.01	$92.63	$344.78
CC1	1.15		$208.73		$18.01	$92.63	$319.37
CB2	1.15		$208.73		$18.01	$92.63	$319.37
CB1	1.02		$185.13		$18.01	$92.63	$295.77
CA2	0.88		$159.72		$18.01	$92.63	$270.36
CA1	0.78		$141.57		$18.01	$92.63	$252.21
BB2	0.97		$176.06		$18.01	$92.63	$286.70
BB1	0.90		$163.35		$18.01	$92.63	$273.99
BA2	0.70		$127.05		$18.01	$92.63	$237.69
BA1	0.64		$116.16		$18.01	$92.63	$226.80
PE2	1.50		$272.25		$18.01	$92.63	$382.89
PE1	1.40		$254.10		$18.01	$92.63	$364.74
PD2	1.38		$250.47		$18.01	$92.63	$361.11
PD1	1.28		$232.32		$18.01	$92.63	$342.96
PC2	1.10		$199.65		$18.01	$92.63	$310.29
PC1	1.02		$185.13		$18.01	$92.63	$295.77
PB2	0.84		$152.46		$18.01	$92.63	$263.10
PB1	0.78		$141.57		$18.01	$92.63	$252.21
PA2	0.59		$107.09		$18.01	$92.63	$217.73
PA1	0.54		$98.01		$18.01	$92.63	$208.65

TABLE 7: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes--RURAL

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$462.95	$294.81		$94.34	$852.10
RUL	2.57	1.87	$445.61	$294.81		$94.34	$834.76
RVX	2.61	1.28	$452.55	$201.79		$94.34	$748.68
RVL	2.19	1.28	$379.72	$201.79		$94.34	$675.85
RHX	2.55	0.85	$442.14	$134.00		$94.34	$670.48
RHL	2.15	0.85	$372.79	$134.00		$94.34	$601.13
RMX	2.47	0.55	$428.27	$86.71		$94.34	$609.32
RML	2.19	0.55	$379.72	$86.71		$94.34	$560.77
RLX	2.26	0.28	$391.86	$44.14		$94.34	$530.34
RUC	1.56	1.87	$270.49	$294.81		$94.34	$659.64
RUB	1.56	1.87	$270.49	$294.81		$94.34	$659.64
RUA	0.99	1.87	$171.66	$294.81		$94.34	$560.81
RVC	1.51	1.28	$261.82	$201.79		$94.34	$557.95
RVB	1.11	1.28	$192.46	$201.79		$94.34	$488.59
RVA	1.10	1.28	$190.73	$201.79		$94.34	$486.86
RHC	1.45	0.85	$251.42	$134.00		$94.34	$479.76
RHB	1.19	0.85	$206.33	$134.00		$94.34	$434.67
RHA	0.91	0.85	$157.78	$134.00		$94.34	$386.12
RMC	1.36	0.55	$235.81	$86.71		$94.34	$416.86
RMB	1.22	0.55	$211.54	$86.71		$94.34	$392.59
RMA	0.84	0.55	$145.65	$86.71		$94.34	$326.70
RLB	1.50	0.28	$260.09	$44.14		$94.34	$398.57
RLA	0.71	0.28	$123.11	$44.14		$94.34	$261.59
ES3	3.58		$620.74		$19.23	$94.34	$734.31
ES2	2.67		$462.95		$19.23	$94.34	$576.52
ES1	2.32		$402.26		$19.23	$94.34	$515.83
HE2	2.22		$384.93		$19.23	$94.34	$498.50
HE1	1.74		$301.70		$19.23	$94.34	$415.27
HD2	2.04		$353.72		$19.23	$94.34	$467.29
HD1	1.60		$277.42		$19.23	$94.34	$390.99
HC2	1.89		$327.71		$19.23	$94.34	$441.28
HC1	1.48		$256.62		$19.23	$94.34	$370.19
HB2	1.86		$322.51		$19.23	$94.34	$436.08
HB1	1.46		$253.15		$19.23	$94.34	$366.72
LE2	1.96		$339.84		$19.23	$94.34	$453.41
LE1	1.54		$267.02		$19.23	$94.34	$380.59
LD2	1.86		$322.51		$19.23	$94.34	$436.08
LD1	1.46		$253.15		$19.23	$94.34	$366.72

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
LC2	1.56		$270.49		$19.23	$94.34	$384.06
LC1	1.22		$211.54		$19.23	$94.34	$325.11
LB2	1.45		$251.42		$19.23	$94.34	$364.99
LB1	1.14		$197.66		$19.23	$94.34	$311.23
CE2	1.68		$291.30		$19.23	$94.34	$404.87
CE1	1.50		$260.09		$19.23	$94.34	$373.66
CD2	1.56		$270.49		$19.23	$94.34	$384.06
CD1	1.38		$239.28		$19.23	$94.34	$352.85
CC2	1.29		$223.67		$19.23	$94.34	$337.24
CC1	1.15		$199.40		$19.23	$94.34	$312.97
CB2	1.15		$199.40		$19.23	$94.34	$312.97
CB1	1.02		$176.86		$19.23	$94.34	$290.43
CA2	0.88		$152.58		$19.23	$94.34	$266.15
CA1	0.78		$135.24		$19.23	$94.34	$248.81
BB2	0.97		$168.19		$19.23	$94.34	$281.76
BB1	0.90		$156.05		$19.23	$94.34	$269.62
BA2	0.70		$121.37		$19.23	$94.34	$234.94
BA1	0.64		$110.97		$19.23	$94.34	$224.54
PE2	1.50		$260.09		$19.23	$94.34	$373.66
PE1	1.40		$242.75		$19.23	$94.34	$356.32
PD2	1.38		$239.28		$19.23	$94.34	$352.85
PD1	1.28		$221.94		$19.23	$94.34	$335.51
PC2	1.10		$190.73		$19.23	$94.34	$304.30
PC1	1.02		$176.86		$19.23	$94.34	$290.43
PB2	0.84		$145.65		$19.23	$94.34	$259.22
PB1	0.78		$135.24		$19.23	$94.34	$248.81
PA2	0.59		$102.30		$19.23	$94.34	$215.87
PA1	0.54		$93.63		$19.23	$94.34	$207.20

Table 9: 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	$832.89	$588.85	$244.04
RUL	$814.74	$576.02	$238.72
RVX	$741.34	$524.13	$217.21
RVL	$665.11	$470.23	$194.88
RHX	$671.66	$474.86	$196.80
RHL	$599.06	$423.54	$175.52
RMX	$616.13	$435.60	$180.53
RML	$565.31	$399.67	$165.64
RLX	$541.10	$382.56	$158.54
RUC	$631.42	$446.41	$185.01
RUB	$631.42	$446.41	$185.01
RUA	$527.97	$373.27	$154.70
RVC	$541.69	$382.97	$158.72
RVB	$469.09	$331.65	$137.44
RVA	$467.27	$330.36	$136.91
RHC	$472.01	$333.71	$138.30
RHB	$424.82	$300.35	$124.47
RHA	$374.00	$264.42	$109.58
RMC	$414.66	$293.16	$121.50
RMB	$389.25	$275.20	$114.05
RMA	$320.28	$226.44	$93.84
RLB	$403.16	$285.03	$118.13
RLA	$259.78	$183.66	$76.12
ES3	$760.41	$537.61	$222.80
ES2	$595.25	$420.84	$174.41
ES1	$531.72	$375.93	$155.79
HE2	$513.57	$363.09	$150.48
HE1	$426.45	$301.50	$124.95
HD2	$480.90	$340.00	$140.90
HD1	$401.04	$283.54	$117.50
HC2	$453.68	$320.75	$132.93
HC1	$379.26	$268.14	$111.12
HB2	$448.23	$316.90	$131.33
HB1	$375.63	$265.57	$110.06
LE2	$466.38	$329.73	$136.65
LE1	$390.15	$275.84	$114.31
LD2	$448.23	$316.90	$131.33

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
LD1	$375.63	$265.57	$110.06
LC2	$393.78	$278.40	$115.38
LC1	$332.07	$234.77	$97.30
LB2	$373.82	$264.29	$109.53
LB1	$317.55	$224.51	$93.04
CE2	$415.56	$293.80	$121.76
CE1	$382.89	$270.70	$112.19
CD2	$393.78	$278.40	$115.38
CD1	$361.11	$255.30	$105.81
CC2	$344.78	$243.76	$101.02
CC1	$319.37	$225.79	$93.58
CB2	$319.37	$225.79	$93.58
CB1	$295.77	$209.11	$86.66
CA2	$270.36	$191.14	$79.22
CA1	$252.21	$178.31	$73.90
BB2	$286.70	$202.70	$84.00
BB1	$273.99	$193.71	$80.28
BA2	$237.69	$168.05	$69.64
BA1	$226.80	$160.35	$66.45
PE2	$382.89	$270.70	$112.19
PE1	$364.74	$257.87	$106.87
PD2	$361.11	$255.30	$105.81
PD1	$342.96	$242.47	$100.49
PC2	$310.29	$219.38	$90.91
PC1	$295.77	$209.11	$86.66
PB2	$263.10	$186.01	$77.09
PB1	$252.21	$178.31	$73.90
PA2	$217.73	$153.94	$63.79
PA1	$208.65	$147.52	$61.13

Table 10: 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	$852.10	$602.43	$249.67
RUL	$834.76	$590.18	$244.58
RVX	$748.68	$529.32	$219.36
RVL	$675.85	$477.83	$198.02
RHX	$670.48	$474.03	$196.45
RHL	$601.13	$425.00	$176.13
RMX	$609.32	$430.79	$178.53
RML	$560.77	$396.46	$164.31
RLX	$530.34	$374.95	$155.39
RUC	$659.64	$466.37	$193.27
RUB	$659.64	$466.37	$193.27
RUA	$560.81	$396.49	$164.32
RVC	$557.95	$394.47	$163.48
RVB	$488.59	$345.43	$143.16
RVA	$486.86	$344.21	$142.65
RHC	$479.76	$339.19	$140.57
RHB	$434.67	$307.31	$127.36
RHA	$386.12	$272.99	$113.13
RMC	$416.86	$294.72	$122.14
RMB	$392.59	$277.56	$115.03
RMA	$326.70	$230.98	$95.72
RLB	$398.57	$281.79	$116.78
RLA	$261.59	$184.94	$76.65
ES3	$734.31	$519.16	$215.15
ES2	$576.52	$407.60	$168.92
ES1	$515.83	$364.69	$151.14
HE2	$498.50	$352.44	$146.06
HE1	$415.27	$293.60	$121.67
HD2	$467.29	$330.37	$136.92
HD1	$390.99	$276.43	$114.56
HC2	$441.28	$311.98	$129.30
HC1	$370.19	$261.72	$108.47
HB2	$436.08	$308.31	$127.77
HB1	$366.72	$259.27	$107.45
LE2	$453.41	$320.56	$132.85
LE1	$380.59	$269.08	$111.51
LD2	$436.08	$308.31	$127.77

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
LD1	$366.72	$259.27	$107.45
LC2	$384.06	$271.53	$112.53
LC1	$325.11	$229.85	$95.26
LB2	$364.99	$258.05	$106.94
LB1	$311.23	$220.04	$91.19
CE2	$404.87	$286.24	$118.63
CE1	$373.66	$264.18	$109.48
CD2	$384.06	$271.53	$112.53
CD1	$352.85	$249.46	$103.39
CC2	$337.24	$238.43	$98.81
CC1	$312.97	$221.27	$91.70
CB2	$312.97	$221.27	$91.70
CB1	$290.43	$205.33	$85.10
CA2	$266.15	$188.17	$77.98
CA1	$248.81	$175.91	$72.90
BB2	$281.76	$199.20	$82.56
BB1	$269.62	$190.62	$79.00
BA2	$234.94	$166.10	$68.84
BA1	$224.54	$158.75	$65.79
PE2	$373.66	$264.18	$109.48
PE1	$356.32	$251.92	$104.40
PD2	$352.85	$249.46	$103.39
PD1	$335.51	$237.21	$98.30
PC2	$304.30	$215.14	$89.16
PC1	$290.43	$205.33	$85.10
PB2	$259.22	$183.27	$75.95
PB1	$248.81	$175.91	$72.90
PA2	$215.87	$152.62	$63.25
PA1	$207.20	$146.49	$60.71

Table 37: Proposed PDPM Impact Analysis, Resident-Level

Resident Characteristics	% of Stays	Percent Change
All Stays	100.0%	0.0%
Sex		
Female	60.3%	-0.8%
Male	39.7%	1.2%
Age		
Below 65 years	10.3%	7.2%
65-74 years	24.1%	3.1%
75-84 years	32.5%	-0.4%
85-89 years	17.6%	-3.1%
Over 90 years	15.6%	-4.3%
Race/Ethnicity		
White	83.8%	-0.2%
Black	11.2%	0.8%
Hispanic	1.7%	0.9%
Asian	1.3%	-0.6%
Native American	0.5%	7.1%
Other or Unknown	1.5%	0.8%
Medicare/Medicaid Dual Status		
Dually Enrolled	34.7%	3.3%
Not Dually Enrolled	65.3%	-2.1%
Original Reason for Medicare Enrollment		
Aged	74.6%	-1.7%
Disabled	24.5%	4.8%
ESRD	0.9%	10.5%
Utilization Days		
1-15 days	35.4%	13.7%
16-30 days	33.8%	0.0%
31+ days	30.9%	-2.5%
Utilization Days = 100		
No	98.4%	0.1%
Yes	1.6%	-1.9%
Length of Prior Inpatient Stay		
0-2 days	2.2%	1.3%
3 days	22.5%	-3.3%
4-30 days	73.6%	0.7%
31+ days	1.7%	6.7%
Most Common Therapy Level		
RU	58.4%	-8.4%
RV	22.4%	11.4%
RH	6.8%	27.4%
RM	3.3%	41.1%
RL	0.1%	67.5%
Non-Rehab	9.1%	50.5%
Number of Therapy Disciplines Used		
0	2.3%	63.1%

Resident Characteristics	% of Stays	Percent Change
1	2.4%	44.2%
2	51.6%	1.6%
3	43.7%	-3.1%
Physical Therapy Utilization		
No	3.7%	50.9%
Yes	96.3%	-0.7%
Occupational Therapy Utilization		
No	4.5%	47.7%
Yes	95.5%	-0.8%
Speech Language Pathology Utilization		
No	55.0%	2.8%
Yes	45.0%	-2.5%
Therapy Utilization		
PT+OT+SLP	43.7%	-3.1%
PT+OT Only	50.8%	1.3%
PT+SLP Only	0.4%	27.3%
OT+SLP Only	0.4%	30.1%
PT Only	1.3%	41.3%
OT Only	0.6%	47.9%
SLP Only	0.5%	46.8%
Non-Therapy	2.3%	63.1%
NTA Costs ($)		
0-10	13.7%	-3.5%
10-50	44.5%	-3.2%
50-150	32.2%	4.2%
150+	9.6%	18.7%
NTA Comorbidity Score		
0	23.5%	-10.4%
1-2	30.5%	-4.7%
3-5	31.0%	4.0%
6-8	9.9%	15.0%
9-11	3.6%	24.4%
12+	1.4%	27.2%
Extensive Services Level		
Tracheostomy and Ventilator/Respirator	0.3%	22.2%
Tracheostomy or Ventilator/Respirator	0.6%	7.3%
Infection Isolation	1.1%	9.1%
Neither	98.0%	-0.3%
CFS Level		
Cognitively Intact	58.5%	-0.3%
Mildly Impaired	20.7%	-0.2%
Moderately Impaired	16.8%	-0.7%
Severely Impaired	3.9%	8.8%
Clinical Category		
Acute Infections	6.5%	3.4%
Acute Neurologic	6.4%	-3.7%
Cancer	4.6%	-3.2%
Cardiovascular and Coagulations	9.8%	0.5%

Resident Characteristics	% of Stays	Percent Change
Major Joint Replacement or Spinal Surgery	8.6%	-2.1%
Medical Management	30.4%	0.0%
Non-Orthopedic Surgery	10.8%	5.7%
Non-Surgical Orthopedic/Musculoskeletal	5.9%	-6.1%
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	8.9%	-2.4%
Pulmonary	8.1%	5.4%
Level of Complications in MS-DRG of Prior Inpatient Stay		
No Complication	35.8%	-3.1%
CC/MCC	64.2%	1.7%
Stroke		
No	90.9%	0.0%
Yes	9.1%	0.3%
HIV/AIDS		
No	99.7%	0.3%
Yes	0.3%	-40.5%
IV Medication		
No	91.7%	-2.1%
Yes	8.3%	23.5%
Diabetes		
No	64.0%	-3.0%
Yes	36.0%	5.4%
Wound Infection		
No	98.9%	-0.3%
Yes	1.1%	22.2%
Amputation/Prosthesis Care		
No	100.0%	0.0%
Yes	0.0%	6.4%
Presence of Dementia		
No	70.9%	0.5%
Yes	29.1%	-1.2%
MDS Alzheimer's		
No	95.2%	0.0%
Yes	4.8%	-0.3%
Unknown	0.0%	5.0%
Presence of Addictions		
No	94.6%	-0.1%
Yes	5.4%	1.8%
Presence of Bleeding Disorders		
No	90.9%	-0.1%
Yes	9.1%	1.5%
Presence of Behavioral Issues		
No	53.1%	-0.9%
Yes	46.9%	1.0%
Presence of Chronic Neurological Conditions		
No	74.4%	-0.2%
Yes	25.6%	0.6%
Presence of Bariatric Care		
No	91.3%	-0.6%

Resident Characteristics	% of Stays	Percent Change
Yes	8.7%	6.5%

Table 38: Proposed PDPM Impact Analysis, Facility-level

Provider Characteristics	% of Providers	Percent Change
All Stays	100.0%	0.0%
Ownership		
For profit	72.0%	-0.7%
Non-profit	22.6%	1.9%
Government	5.4%	4.2%
Number of Certified SNF Beds		
0-49	10.0%	3.5%
50-99	38.2%	0.6%
100-149	34.7%	-0.2%
150-199	11.1%	-0.3%
200+	5.9%	-1.8%
Location		
Urban	72.7%	-0.7%
Rural	27.3%	3.8%
Facility Type		
Freestanding	96.2%	-0.3%
Hospital-Based/Swing Bed	3.8%	16.7%
Location by Facility Type		
Urban | Freestanding	70.6%	-1.0%
Urban | Hospital-Based/Swing Bed	2.2%	15.3%
Rural | Freestanding	25.6%	3.2%
Rural | Hospital-Based/Swing Bed	1.6%	21.1%
Census Division		
New England	5.9%	2.0%
Middle Atlantic	10.8%	-2.6%
East North Central	20.6%	0.7%
West North Central	12.5%	6.7%
South Atlantic	15.7%	-0.4%
East South Central	6.6%	1.0%
West South Central	13.1%	-1.0%
Mountain	4.7%	1.1%
Pacific	10.1%	-0.8%
Location by Region		
Urban | New England	5.1%	1.8%
Urban | Middle Atlantic	9.5%	-2.9%
Urban | East North Central	14.4%	-0.1%
Urban | West North Central	6.0%	4.6%
Urban | South Atlantic	12.6%	-1.1%
Urban | East South Central	3.6%	0.3%
Urban | West South Central	8.7%	-1.2%
Urban | Mountain	3.4%	0.1%
Urban | Pacific	9.5%	-0.9%
Rural | New England	0.8%	4.0%
Rural | Middle Atlantic	1.3%	2.7%
Rural | East North Central	6.2%	3.6%
Rural | West North Central	6.5%	10.5%

Provider Characteristics	% of Providers	Percent Change
Rural | South Atlantic	3.1%	4.2%
Rural | East South Central	3.0%	2.1%
Rural | West South Central	4.4%	-0.1%
Rural | Mountain	1.3%	6.2%
Rural | Pacific	0.6%	2.2%
% Stays with Maximum Utilization Days = 100		
0-10%	94.4%	0.1%
10-25%	5.1%	-2.8%
25-100%	0.4%	-3.6%
% Medicare/Medicaid Dual Enrollment		
0-10%	8.6%	-1.3%
10-25%	17.5%	-1.3%
25-50%	36.0%	0.3%
50-75%	26.5%	1.3%
75-90%	8.2%	0.4%
90-100%	3.1%	1.6%
% Utilization Days Billed as RU		
0-10%	8.9%	27.6%
10-25%	8.0%	15.5%
25-50%	24.1%	7.0%
50-75%	39.2%	-0.4%
75-90%	17.2%	-6.0%
90-100%	2.6%	-9.8%
% Utilization Days Billed as Non-Rehab		
0-10%	79.8%	-1.5%
10-25%	16.6%	8.6%
25-50%	2.7%	23.1%
50-75%	0.4%	35.8%
75-90%	0.2%	41.8%
90-100%	0.4%	33.6%