1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

MEMORANDUM

To: AHCA Members

From: Elise Smith, Senior Fellow, Health Policy and Post-Acute Care

Subject: Overview of the Skilled Nursing Facility Payment System Final Rule for FY 2015

Date: August 5, 2014

On Thursday, July 31, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2015 update: *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015*, 79 Federal Register 45628, August 5, 2014.

The Federal Register copy of the final rule is at:
http://www.gpo.gov/fdsys/pkg/FR-2014-08-05/pdf/2014-18335.pdf

The final FY 2015 SNF PPS wage index file is posted separately. The wage index tables for this final rule are available exclusively through the Internet on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/SNFPPS/WageIndex.html*. CMS indicates that readers who experience any problems accessing any of the tables that are posted on this CMS Web site identified above should contact Kia Sidbury at (410) 786–7816.

We have provided below highlights of the final rule followed by a more detailed overview of key provisions.

HIGHLIGHTS

- The final rule provides for **a net market basket increase for SNFs of 2.0% beginning October 1, 2014**.

- The 2.0 % market basket update reflects a full market basket increase of 2.5%, less a 0.5 percentage point multifactor productivity adjustment required by Section 3401(b) of the Affordable Care Act (ACA).
  .
- For the FY 2015 final rule, the FY 2010-based SNF market basket growth rate is estimated to be 2.5 percent, which is based on the IHS Global Insight, Inc. (IGI) second quarter 2014 forecast with historical data through first quarter 2014.

- CMS estimates that the net market basket update will **increase** Medicare SNF payments by approximately $750 million in FY 2015.

- CMS has not made a forecast error correction. Since the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the payment rates for FY 2015 do not include a forecast error adjustment.

- The labor-related weight for FY 2015 is 69.180%, down from 69.545% for FY 2014.

- In accordance with the Medicare Modernization Act (MMA), the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) had been increased by 128% as of October 1, 2004. Under the CMS notice, this add-on will remain in effect for FY 2015.

- On February 28, 2013, OMB issued OMB Bulletin No. 13-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas.

    - CMS is implementing new OMB delineations for SNF PPS wage index beginning in FY 2015.
    - CMS is also implementing a one-year transition with a blended wage index for all providers in FY 2015 to assist providers in adapting to the new OMB delineations.

- All rates and wage indexes outlined in the final rule for the SNF PPS for FY 2015 apply to all swing-bed rural hospitals but not to critical access hospitals (CAHs). CAHs will continue to be paid on a reasonable cost basis for SNF services furnished under a swing-bed agreement.

- In the proposed rule, CMS had provided data and discussed recent observed trends in the provision of therapy services in the SNF PPS. CMS specifically focused on: 1) the overall case-mix distribution trending towards more patients being classified into the ultra-high rehabilitation RUG-IV groups, and 2) the high distribution of therapy being reported on the MDS in amounts that are just above the relevant therapy payment threshold for any given RUG category.

  In the final rule, CMS re-affirmed its concerns and singled out some submitted comments alleging that internal provider rules were promising clinicians against their own professional judgment from providing therapy above the RUG threshold levels. CMS remarked that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies, or the professional judgment of clinicians.

- CMS had contracted with Acumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. In the proposed rule, CMS had updated the public on the current state of this project.

According to the report issued in conjunction with the rule, Acumen will focus on two options in the next phase of their research: a resident characteristics model and a hybrid model that includes both resident characteristics and resource pricing adjustments such as a fee schedule add-on, block pricing, or an outlier payment adjustment.

In its comments, AHCA agreed with the general approach that CMS is taking regarding analyzing the therapy component, and with much of the information contained in the Acumen report findings. We also commented that AHCA was investing in research efforts to help CMS in this endeavor. However, we identified certain limitations to what CMS presented in the proposed rule and offered specific recommendations.

CMS emphasized that the therapy research project does not have a specific timeframe for completing this work and implementing a new payment model. Consistent with AHCA's comments, CMS stated that it is important for any policy change to:

- Ensure that changes to the therapy payment model address any limitations of the current model,
- Provide the proper incentives to ensure appropriate and efficient treatment, and
- Provide sufficient time for providers to understand and prepare for implementation of such a model.

The CMS final rule suggests that the agency has heard AHCA's and other stakeholder comments and is taking a deliberative approach of gathering more information from multiple sources before considering and implementing dramatic changes to the therapy payment model within the SNF PPS.

- CMS is revising the existing Change of Therapy (COT) Other Medicare Required (OMRA) policy to permit providers to complete a COT OMRA for certain residents who is not currently classified into a RUG-IV therapy group, or receiving a level of therapy sufficient for classification into a RUG-IV therapy group.

- CMS is changing the CMS enforcement regulations to clarify and strengthen current provisions to provide more specific instructions to states regarding the use of Civil Monetary Penalties (CMPs) and the approval process, and to permit an opportunity for greater transparency and accountability of CMP monies utilized by states. As detailed in this memo, CMS accepted many of the recommendations provided by AHCA in its comments.

- The Office of the National Coordinator for Health Information Technology (ONC)[1], located within the Department of Health and Human Services (HHS), has issued a proposed rule concerning a voluntary 2015 Edition of EHR certification criteria. In the proposed rule, ONC and CMS expressed the

[1] ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

- hope that this edition would more easily accommodate certification of HIT used in other types of health care settings where individual or institutional health care providers are not typically eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs, such as long-term and post-acute care and behavioral health settings.

The following is an overview of the key issues in the final rule. For further information on the following issues, please contact:

• SNF Therapy Research Project :	Daniel Ciolek 202- 898-3174, dciolek@ahca.org
• Observations on Therapy Utilization Trends:	Daniel Ciolek 202- 898-3174, dciolek@ahca.org
• Civil Monetary Penalties:	Lyn Bentley 202- 898-6304, lbentley@ahca.org
• Revisions to Policies Related to the COT OMRA:	Holly Harmon 202-898-6317, hharmon@ahca.org
• Wage Index OMB Delineations:	Elise Smith 202-898-6305, esmith@ahca.org

OVERVIEW

I. The SNF PPS Market Basket Update

The final rule provides for **a net market basket increase for SNFs of 2.0% beginning October 1, 2014**. The 2.0 % market basket update reflects a full market basket increase of 2.5 percentage points, less a 0.5 percentage point multifactor productivity adjustment required by Section 3401(b) of the Affordable Care Act (ACA).

CMS estimates that the net market basket update would **increase** Medicare SNF payments by approximately $750 million in FY 2015.

The **distributional effect** of the budget neutral adjustment to the wage index, OMB delineations (explained in section IV. B. of this memo), and the market basket update are shown in Table 13 of the final rule, as follows:

Table 13 of the Final Rule*
RUG-IV Projected Impact to the SNF PPS for FY 2015

	Update Wage Data	OMB Delineations	Total Impact On the Market Basket
Total	0.0%	0.0%	2.0%
Urban	0.0%	0.0%	2.0%
Rural	0.2%	-0.2%	1.9%
Hospital based urban	0.1%	0.0%	2.1%
Freestanding urban	0.0%	0.0%	2.0%
Hospital based rural	0.2%	-0.3%	1.9%
Freestanding rural	0.2%	-0.2%	1.9%
Government	0.1%	-0.1%	2.0%
Profit	0.0%	-0.1%	1.9%
Non-profit	0.1%	0.0%	1.9%

*Abbreviated version of Table 13 in the final rule.

II. Forecast Error Adjustment to the SNF Market Basket

The regulations at 42 CFR §413.337(d)(2) provide for an adjustment to account for market basket forecast error. Adjustments take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. CMS originally used a 0.25 percentage point threshold for this purpose but adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent fiscal years. The adjustment reflects both upward and downward adjustments, as appropriate.

For FY 2013 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.5 percentage points, while the actual increase for FY 2013 was 2.2 percentage points, resulting in the actual increase being 0.3 percentage point lower than the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the payment rates for FY 2015 do not include a forecast error adjustment. Table 1 of the final rule shows the forecasted and actual market basket amounts for FY 2013.

Table 1 of the Final Rule
Difference Between The Forecasted & Actual Market Basket Increases for FY 2013

Index	Forecasted FY 2013 Increase*	Actual FY 2013 Increase**	FY 2013 Difference
SNF	2.5%	2.2%	-0.3%

*Published in **Federal Register**; based on second quarter 2012 IGI forecast (2004-based index).
**Based on the second quarter 2014 IHS Global Insight forecast, with historical data through the first quarter 2014.

III. Multifactor Productivity Adjustment

Section 3401(b) of the Affordable Care Act requires that the market basket percentage under the SNF payment system is to be reduced annually by the productivity adjustment. The statute defines the productivity adjustment to be equal to "the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period, or other annual period)."

The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business multifactor productivity (MFP). [2] The projection of MFP is currently produced by IGI, an economic forecasting firm. To generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models.

For the FY 2015 update, the MFP adjustment is 0.5 percentage points[3] and is based on IGI's second quarter 2014 forecast. The resulting MFP-adjusted SNF market basket update is equal to 2.0 percent, or 2.5 percent less 0.5 percentage points.

[2] See http://www.bls.gov/mfp to obtain the BLS historical published MFP data.
[3] Calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2015.

IV. Wage Index Adjustment

CMS adjusts the federal rates to account for differences in area wage levels. Since the inception of the SNF PPS, CMS has used hospital inpatient wage data in developing a wage index to be applied to SNFs. CMS proposes to continue this practice for FY 2015.[4] CMS is required to apply this wage index in an overall budget neutral manner. In addition:

- For rural geographic areas that do not have hospitals, and therefore, lack hospital wage data on which to base an area wage adjustment, CMS will continue to use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2015, there are no rural geographic areas that do not have hospitals, and thus, this methodology would not be applied.

- For rural Puerto Rico, CMS does not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, CMS would continue to use the most recent wage index previously available for that area.

- For urban areas without specific hospital wage index data, CMS uses the average wage indexes of all of the urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2015, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

Once calculated, CMS applies the wage index adjustment to the labor-related portion of the federal rate.

A. Labor-Related Portion of the Federal Rate

Each year, CMS calculates a revised labor-related share based on the relative importance of labor-related cost categories in the SNF market basket .CMS calculates the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2015. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2015 than the base year weights from the SNF market basket.

Table 12 of the final rule summarizes the updated labor-related share for FY 2015, compared to the labor-related share that was used for the FY 2014 SNF PPS final rule.

[4] Section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554, enacted on December 21, 2000) authorized CMS to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. However, CMS continues to assert that this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

Table 12 of the Final Rule
Labor Related Relative Importance, FY 2014 and FY 2015

	Relative Importance, labor-related, FY 2014 13:2 forecast*	Relative Importance, labor-related, FY 2015 14:2 forecast**
Wages and salaries	49.118	48.816
Employeebenefits	11.423	11.365
Non medical Professional fees: labor-related	3.446	3.450
Administrative and facilities support services	0.499	0.502
All Other: Labor-related services	2.287	2.276
Capital-related (.391)	2.772	2.771
Total	69.545	69.180

*Published in the **Federal Register**, based on second quarter 2013 IGI forecast.
**Based on the second quarter 2014 IHS Global Insight forecast, with historical data through the first quarter 2014.

B. Changes to the SNF PPS Wage Index

1. OMB Bulletin No. 13-01 and Revised Delineations

On February 28, 2013, OMB issued OMB Bulletin No. 13-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.

According to OMB, "[t]his bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 - 37252) and Census Bureau data."

CMS is implementing the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13-01, for SNF PPS wage index beginning in FY 2015. CMS indicates that while the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the February 28, 2013 OMB bulletin does contain a number of significant changes.

For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. In addition,

- 63 percent of providers would be unaffected by the proposed implementation of the new the OMB delineations;
- 22 percent of providers would experience a decrease in their wage index value due to the new the OMB delineations; and

- 15 percent of providers would experience an increase in their wage index value due to the proposed implementation of the new OMB delineations.

However, CMS believes that it is important for the SNF PPS to use the latest OMB delineations available in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions.[5]

2. Transition Period

CMS is implementing a one-year transition with a blended wage index for all providers in FY 2015 to assist providers in adapting to the new OMB delineations.

CMS will calculate the FY 2015 wage indexes using both the current FY 2014 and proposed new labor market delineations. Specifically, providers will receive 50 percent of their FY 2015 wage index based on the new OMB delineations, and 50 percent of their FY 2015 wage index based on the labor market area delineations for FY 2014 (both using FY 2011 hospital wage data). This ultimately results in an average of the two values. This transition policy will be for a one year period, going into effect October 1, 2014, and continuing through September 30, 2015. Thus, beginning October 1, 2015, the wage index for all SNFs would be fully based on the new OMB delineations.

In its comments, AHCA had recommended, among other things, that CMS should consider establishing a floor and ceiling such that changes to wage indices do not exceed a certain percentage in any one year; and should provide a rural floor to all rural providers; CMS should consider a phase in for the changes in OMB delineations such as the following:

- **50% same as current concept**: 50% FY 2015 OMB delineation with FY 2015 wage index; and 50% FY 2014 OMB delineation with FY 2015 wage index
- **50% different**: based on FY 2014 final rule wage index; and

CMS did not accept the recommendations. In explaining its action, the agency stressed that more providers will experience a decrease in wage index due to implementation of the proposed new OMB delineations than would experience an increase. Therefore, CMS believes that it would be appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impacts on these providers, and to provide time for providers to adjust to their new labor market similar to the policy adopted in the FY 2006 SNF PPS final rule when CMS first adopted OMB's CBSA definitions for purposes of the SNF PPS wage index.

Thus, according to CMS, a one-year transition blended wage index for all SNFs to assist providers in adapting to the new OMB delineations would assist the percent of providers that would be adversely affected by the proposed implementation of the new OMB delineations without reducing the base rates for all providers.

CMS notes that the implementation of the revised OMB delineations sets SNF payments at a level that more accurately reflects the costs of labor in a SNF's geographic area. Accordingly, under this policy, SNFs will experience a decrease from their current wage index value only to

[5] While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html), no consensus has been achieved regarding how best to implement a replacement system.

the extent that their current wage index value actually exceeds what the latest area wage data warrants using the revised OMB delineations. They will experience an increase from their current wage index value to the extent that their current wage index value is less than what the latest area wage data warrants using the revised OMB delineations.

CMS believes that pursuing a longer transition period than one year would advantage the former group by delaying implementation of the full decrease in their wage index values under the new OMB delineations, at the further expense of the latter group which would experience an extended delay in implementation of the full increase in their wage index values. CMS concludes that utilizing a 1-year (rather than a multiple-year) transition with a blended wage index in FY 2015 strikes an appropriate balance between the interests of these two groups of providers.

V. SNF Therapy Research Project

In the proposed rule, CMS indicated that it had contracted with Acumen, LLC and the Brookings Institution "to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS." CMS provided an update on the project and findings, and on contractor recommendations to date.

In its comments, AHCA agreed with the general approach that CMS is taking regarding analyzing the therapy component, and with much of the information contained in the Acumen report findings. We also commented that AHCA was investing in research efforts to help CMS in this endeavor. However, we identified a few limitations to what CMS presented in the proposed rule and offered the following specific recommendations:

- CMS should provide a more detailed research plan and timeline for the Acumen study than currently offered;
- CMS should assure that Acumen gathers information beyond currently available administrative data during the second phase of the research project, and that the data samples gathered are adequate from all three distinct therapy disciplines for payment modeling purposes; and
- CMS should assure that Acumen engages stakeholders, including convening the Technical Expert Panel, prior to conducting additional analysis and developing payment alternatives.

In the final rule response, CMS indicated that existing research is insufficient and that additional information is needed to consider revising the therapy payment system. In addition, CMS stated that they "recognize the importance of seeking input from stakeholders on how best to revise the current therapy payment model," and are doing this through a variety of avenues including that of a technical expert panel in the near future.

CMS emphasized that the therapy research project does not have a specific timeframe for completing this work and implementing a new payment model. Consistent with AHCA's comments, CMS stated that it is important for any policy change to:

- Ensure that changes to the therapy payment model address any limitations of the current model,
- Provide the proper incentives to ensure appropriate and efficient treatment, and
- Provide sufficient time for providers to understand and prepare for implementation of such a model.

In summary, the CMS final rule suggests that it has heard AHCA's and other stakeholder comments and is taking a deliberative approach of gathering more information from multiple sources before considering and implementing dramatic changes to the therapy payment model within the SNF PPS. AHCA continues to engage with CMS on this issue.

VI. Observations on Therapy Utilization Trends

In the proposed rule, CMS provided data and discussed recent observed trends in the provision of therapy services in the SNF PPS. CMS specifically focused on: 1) the overall case-mix distribution trending towards more patients being classified into the ultra-high rehabilitation RUG-IV groups, and 2) the high distribution of therapy being reported on the MDS in amounts that are just above the relevant therapy payment threshold for any given RUG category.

AHCA's comments were not directed at disputing the observations, but towards encouraging the pursuit of information that would put the observations into a more-appropriate clinical context. AHCA's specific recommendations were as follows:

- CMS should continue the prudent approach of avoiding the implementation of arbitrary payment policy changes based solely upon the trends CMS has identified.

- As CMS continues its monitoring efforts, the agency should:

    - Provide more detailed information regarding the observed trends.
    - Consider whether changes to Medicare regulations and payment methodologies related to other post-acute providers may have influenced the therapy utilization trends in ways that cannot be adequately measured by currently available clinical and outcomes data.
    - Incorporate lessons learned from related CMS projects that are gathering and analyzing therapy-related function and outcomes-related standardized assessment data.

In the final rule response, CMS did not indicate that it was considering implementing any changes based solely on the observed trends, and indicated that with respect to different patient populations, that "we will examine our current monitoring efforts to identify any revisions which may be necessary to account appropriately for these populations." Of ongoing concern to AHCA is that while CMS did not indicate any potential policy interventions related to the observed trends at this time, CMS' response discussion focused on the high distribution just above the RUG thresholds.

CMS noted that a commenter voiced a perception that "some providers may implement internal rules that prohibit clinicians, against their own professional judgment from providing therapy above the RUG levels." CMS concluded that, given these comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, "… it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest." CMS concluded that:

> With regard to the comment which highlighted potential explanatory factors for the observed trends, such as internal pressure within SNFs that would override clinical judgment, we find these potential explanatory factors troubling and entirely inconsistent with the intended use of the SNF benefit. Specifically, the minimum therapy minute

thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision…

Therefore, services which are not specifically tailored to meet the individualized needs and goals of the resident, based on the resident's condition and the evaluation and judgment of the resident's clinicians, may not meet this aspect of the definition for covered SNF care, and we believe that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies, or the professional judgment of clinicians.

VII. Revisions to Policies Related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA)

In the proposed rule, CMS responded to AHCA and other provider concerns, and proposed changing the existing COT OMRA policy to permit providers to complete a COT OMRA for a special situation when a therapy patient, who previously qualified for a RUG-IV therapy group, dropped to a RUG-IV nursing group on a subsequent assessment due to insufficient qualifying therapy services, then the amount of therapy returned to a level that would qualify for a RUG-IV therapy group. Under the existing rule, SNF providers cannot use the COT OMRA to return to the more appropriate RUG-IV therapy group rate, but instead must wait until the next regularly scheduled assessment.

AHCA commented that we supported the proposed policy revision, but noted that the second example provided by CMS appeared incorrect. AHCA also asked CMS to assure that the RAI Manual guidance be clearly aligned with the rule change.

In the final rule response, CMS indicated that it will be finalizing the proposed rule change supported by AHCA. CMS also acknowledged that it made an error in the second example furnished in the proposed rule, and provided a corrected version of the example in the final rule. In addition, CMS indicated that the policy would become effective October 1, 2014, with further details provided in a forthcoming MDS RAI manual revision and in other guidance.

VIII. Civil Monetary Penalties

The final rule clarifies statutory requirements regarding the approval and use of CMPs imposed by CMS. These clarifications not only apply to the federal share of collected CMP funds granted for approved projects that benefit residents but they also apply to the portion of the CMPs collected by CMS that is disbursed to the states based on the proportion of Medicaid eligible nursing home residents.

The amendments that had been made by the ACA made it clear that the specified use of CMP funds collected from SNFs, SNF/NFs, and NF-only facilities as a result of CMPs imposed by CMS, must be approved by CMS by specifying that the activities that CMP funds are used for must be approved by the Secretary. However, CMS admitted that it is aware of instances in which states have used federal CMP funds without obtaining prior approval from CMS, have used these funds even though CMS had disapproved their intended use, have not used these funds at all, or have used these funds for purposes other than to support activities that benefit residents as specified in statute and regulation. CMS cites several examples in all of these categories.

CMS changes to the CMS enforcement regulations seek to clarify and strengthen current provisions to provide more specific instructions to states regarding the use of CMPs and the

approval process, and to permit an opportunity for greater transparency and accountability of CMP monies utilized by states. Among the improvements are several that AHCA recommended in its comments on the proposed rule, as follows. CMS will:

- Consider issuing guidance to states regarding making the information about their state plans for civil money penalties as well as approved civil money penalty projects publicly available, as required in this final rule, by posting on a state website and making sure that this information is updated on an annual basis. As to the length of time of the posting, CMS anticipates that states would post a new report about the use of penalty funds on an annual basis that would include currently funded projects as well as information, or links to the information, for projects funded after this regulation even if the projects have ended;

- Develop a standardized application that states may make available to any entities seeking to submit proposals for projects to be funded with civil money penalties. CMS expects that such a template should be completed by early CY 2015; and

- Consider ways in which states may gain more autonomy over time, as CMS learns more about projects that are successful, are able to fully implement the additional processes in this regulation, and work with stakeholders. CMS recognizes the critical role that states play and wishes to bolster state ability to use civil money penalty funds effectively. Under the arrangements already in place, proposals for projects utilizing civil money penalty funds are submitted directly to the state survey agency. The state conducts the initial review of all proposals and forwards those that meet CMS criteria and that they are recommending for final approval to the CMS regional office.

CMS expresses its belief that the regulations in this final rule will make the entire state civil money penalty program more coherent, more transparent, and more effective. AHCA will continue to monitor CMS' efforts and their impact.

IX. Accelerating Health Information Exchange in SNFs

In the final rule, CMS reiterated its commitment to accelerating health information exchange (HIE) through the use of electronic health records (EHRs) and other types of health information technology (HIT) across the broader care continuum through a number of initiatives including:

> (1) alignment of incentives and payment adjustments to encourage provider adoption and optimization of HIT and HIE services through Medicare and Medicaid payment policies;
> (2) adoption of common standards and certification requirements for interoperable HIT;
> (3) support for privacy and security of patient information across all HIE-focused initiatives; and
> (4) governance of health information networks.

The Office of the National Coordinator for Health Information Technology (ONC)[6], located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS), has

[6] ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

issued a proposed rule concerning a voluntary 2015 Edition of EHR certification criteria. ONC hopes that this would more easily accommodate certification of HIT used in other types of health care settings where individual or institutional health care providers are not typically eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs, such as long-term and post-acute care and behavioral health settings.

It is CMS' belief that HIE and the use of certified EHRs by SNFs and other types of providers that are ineligible for the Medicare and Medicaid EHR Incentive Programs can effectively and efficiently help providers improve internal care delivery practices, support management of patient care across the continuum, and enable the reporting of electronically specified clinical quality measures (eCQMs).

All of the comments received on this topic supported the overall agency goal to accelerate HIE within SNFs, and among post-acute care providers generally. A few commenters urged CMS to consider potential barriers to HIE for certain providers, such as those within mountainous or rural areas where connectivity may be an issue. Other commenters also asked that CMS continue to coordinate with the Office of the National Coordinator for Health Information Technology. One commenter asked CMS to consider providing a financial incentive for providers to adopt health information technology.

CMS indicated that it will share these comments with the appropriate CMS staff and other governmental agencies to ensure they are taken into account as we continue to encourage adoption of health information technology.

More information on the identification of EHR certification criteria and development of standards applicable to SNFs can be found at: http://healthit.gov/policy-researchers-implementers/standards-and-certification.