Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Fiscal Year 2024
[CMS-1779-P]

Summary

On April 10, 2023, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (88 FR 21316) a proposed rule updating for fiscal year (FY) 2024 the Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). The proposed rule would update the federal per diem rates under the SNF Prospective Payment System (PPS); the ICD-10 code mappings for patient classification; and the SNF QRP and SNF VBP Programs. CMS also proposes revisions in the procedures for facilities facing civil monetary penalties (CMPs) to actively waive their right to a hearing in writing to receive a penalty reduction.

For the SNF QRP, CMS proposes adopting three new measures, removing three measures, and modification of one measure. CMS also proposes public reporting of four measures. Substantive proposals are made for the SNF Value-Based Purchasing (VBP) Program that progressively change the program's measure set and make policy revisions to implement the larger measure set. CMS proposes a Health Equity Adjustment that would reward SNFs that perform well and whose resident population during the applicable performance period includes at least 20% of residents with dual eligibility status; this adjustment would begin with the FY 2027 program year and FY 2025 performance year. In addition, CMS proposes to increase the payback percentage policy under the SNF VBP program.

CMS estimates that the overall impact of the proposed rule will be an increase of $1.2 billion (+3.7 percent) in Medicare payments to SNFs during FY 2024. Wage index tables are no longer published in the Federal Register. Instead, these tables are available exclusively at: Wage Index | CMS.

Comments on the proposed rule are due by June 5, 2023.

Table of Contents – Needs to be UPDATED

I. Background on SNF PPS

CMS reviews relevant 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 Medicare SNF VBP Program. 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. CMS also notes that section 1888(e)(4) of the Social Security Act (the Act) requires that the SNF PPS be updated annually and that certain elements be published in the *Federal Register* including the unadjusted federal per diem rates for covered SNF services, the applicable case-mix classification system, and the factors to be applied in making the area wage adjustment for these services.

CMS also provides an update on ongoing HHS initiatives to advance health information exchange within the post-acute care (PAC) settings and within the larger health care environment including the Post-Acute Care Interoperability Workgroup (PACIO), CMS Data Element Library (DEL), and the Trusted Exchange Framework and Common Agreement (TEFCA). The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement is a contract that advances those principles.[1] HHS recently recognized the

[1] Additional information is available at https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.

first set of applicants accepted to the Qualified Health Information Network (QHINs), entities that will connect directly to each other as the core for nationwide interoperability.[2]

II. SNF PPS Rate Setting Methodology and FY 2024 Update

A summary of key data under the proposals for the SNF PPS for FY 2024 is presented below with additional details in the subsequent sections.

Summary of Key Data under Proposed SNF PPS for FY 2024	
Market basket update factor	
Market basket increase	+2.7%
Forecast error adjustment for FY 2022	+3.6%
Total Factor Productivity (TFP) adjustment	-0.2%
Parity adjustment for Patient Driven Payment Model (PDPM)	-2.3%
Net TFP-adjusted update	**+3.7%**
Wage index budget neutrality adjustment	0.9998
Labor-related share	71.0%
Note: CMS uses a multiplicative formula to derive the 3.7% total percentage change with the parity adjustment. This formula is (1 + Parity Adjustment Percentage) * (1 + Wage Index Update Percentage) * (1 + Payment Rate Update Percentage) – 1. The total change figure is 3.7% or (1 – 2.3%) * (1 + 0.0%) * (1 + 6.1%) - 1.	

A. Federal Base Rates

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

B. SNF Market Basket Update

CMS proposes a market basket increase for FY 2024 of 2.7 percent based on the fourth quarter 2022 forecast from IHS Global Insight, Inc. (IGI), with historical data through the third quarter of 2022. The forecast addresses the percentage increase in the FY 2018-based SNF market basket index for routine, ancillary, and capital-related expenses.

For FY 2022—the most recent year for which actual data are available—CMS applied a market basket of 2.7 percent, but the actual increase was 6.3 percent. As the difference (3.6 percentage points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposes to apply a 3.6 percentages point adjustment to the proposed FY 2024 SNF market basket. The market basket of 2.7 percent would be increased by 3.6 percentage points to 6.3 percentage points with this proposal.

The total factor productivity (TFP) adjustment required under the Affordable Care Act (ACA) is estimated to be -0.2 percentage points. CMS uses the TFP adjustment as calculated by the

[2] https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.

Bureau of Labor Statistics (BLS).[3] 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, 2024, based on IGI's fourth quarter 2022 forecast.

Since PDPM implementation in FY 2020, CMS' initial data analysis demonstrated an unintended increase in payments of approximately 5% or $1.7 billion per year. In the FY 2023 SNF final rule (87 FR 47502), CMS finalized a PDPM parity adjustment factor of 4.6% with a two-year phase in period. This resulted in a 2.3% reduction in FY 2023 and a second 2.3% reduction in FY 2024.

CMS also proposes to 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 2024 SNF QRP. This is before application of the PDPM parity adjustment.

Based on the proposed productivity-adjusted update, CMS proposes FY 2024 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables below. Under the PDPM case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five of these are case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). The remaining component is a non-case-mix component, as existed under the previous RUG-IV classification system.

Final FY 2023 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$66.06	$75.30
Occupational Therapy	$61.49	$69.16
Speech-Language Pathology	$24.66	$31.07
Nursing	$115.15	$110.02
Non-Therapy Ancillaries	$86.88	$83.00
Non-case mix adjusted	$103.12	$105.03

Proposed FY 2024 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$70.08	$79.88
Occupational Therapy	$65.23	$73.36
Speech-Language Pathology	$26.16	$32.96
Nursing	$122.15	$116.71
Non-Therapy Ancillaries	$92.16	$88.05
Non-case mix adjusted	$109.39	$111.41

[3] Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). This is a change in terminology not a change in data or methodology.

C. Case-Mix Adjustment

As noted earlier, CMS replaced its previous case-mix classification methodology, the RUG-IV model, with the PDPM effective October 1, 2019. The PDPM model was designed to classify patients into payment groups based on patient characteristics, rather than the volume of therapy services provided to patients, as was done in the RUG-IV model. The proposed FY 2024 payment rates reflect the use of the PDPM classification system from October 1, 2023 through September 30, 2024. Tables 5 and 6 of the proposed rule (reproduced in the appendix of this summary) show the proposed PDPM case-mix adjusted federal rates and associated indexes. These include the second phase of the PDPM parity adjustment recalibration.

D. Wage Index Adjustment

CMS proposes to continue to apply the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2024, CMS proposes to use updated wage data for hospital cost reporting periods in FY 2020. It notes that to use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources from CMS and the Medicare Administrative Contractors that is not feasible at this time.

As CMS is using the IPPS wage index to adjust SNF payments for the area difference in the cost of labor, it must have a policy when there is a SNF in an urban or rural area that has no hospitals, and therefore, no applicable wage index. CMS proposes to use the same policy it has used in prior years. For rural areas without hospitals, CMS would use the average wage index from all contiguous urban areas as the SNF proxy wage index. For urban areas without hospitals, CMS would use the average wage index of all urban areas within the state as the SNF proxy wage index. These policies are only applicable in one urban area—CBSA 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2023 SNF final rule (87 FR 47521-47525), CMS finalized a policy to apply a permanent 5 percent cap on any decreases to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. CMS also finalized that a new SNF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new SNF would not have a wage index in the prior FY.

The Office of Management and Budget (OMB) provides the Core-Based Statistical Area (CBSA) delineations that are the basis of the labor market areas that CMS uses for the wage index adjustment. In the FY 2021 SNF PPS final rule, CMS indicated that it intended to adopt the latest revision to the OMB area delineations for purposes of the FY 2022 SNF wage index. CMS determined that the changes in the OMB Bulletin 20-01, published on March 6, 2020, did not impact the CBSA-based labor market area delineations adopted in FY 2021 and did not propose to adopt these changes for FY 2022, 2023, and 2024. The wage index applicable to FY 2024 is available on the CMS website.[4]

[4] https://www.cms/gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

The wage index adjustment is applied to the labor-related share. The labor-related share of the 2018-based SNF market basket is the sum of the cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-related; Administrative and Facilities Support services; Installation, Maintenance, and Repair services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

CMS uses a four-step process to trend forward the base year (2018) weights to FY 2024 price levels. This process includes computing the FY 2024 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 71.0 percent, compared to a FY 2023 final labor-related share of 70.8 percent. Table 7 in the proposed rule summarizes the proposed labor-related share for FY 2024 (based on the IGI fourth quarter 2022 forecast) compared with FY 2023 for each of the cost categories.

To calculate the labor portion of the case-mix adjusted per diem rate, CMS multiplies the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies and the non-case-mix component rate, by the FY 2023 labor-related share percentage provided in Table 7. The remaining portion of the rate would be the non-labor portion. Tables 8-10 of the proposed rule provide a hypothetical rate calculation to illustrate the methodology including the wage index adjustment and case mix adjustment.

The change to the labor share and wage index is required by law to be budget neutral. CMS meets this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor, equal to the ratio of the weighted average wage adjustment factor for FY 2023 to the weighted average wage adjustment factor for FY 2024. For this calculation, CMS uses the same FY 2022 claims utilization data for both the numerator and denominator of this ratio. The proposed budget neutrality factor for FY 2024 is 0.9998.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

CMS proposes to continue using an administrative presumption that beneficiaries who are correctly assigned one of the designated case-mix classifiers on the 5-day Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date for that assessment. CMS notes that a beneficiary who does not qualify for the presumption is not automatically classified as either meeting or not meeting the level of care definition, but instead receives an individual determination using the existing administrative criteria.

In the 2019 SNF PPS final rule, CMS finalized the designation of the following classifiers for purposes of applying the administrative presumption under the PDPM. This information is posted on the SNF PPS website in the paragraph entitled "Case Mix Adjustment".[5]

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. For

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

example, the presumption would not apply in a situation where the sole classifier that triggers the presumption is itself assigned through the receipt of services that are subsequently determined to be not reasonable and necessary. Further, CMS will do careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the assessment reference date of the initial Medicare assessment.

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 five categories:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services;
- Customized prosthetic devices; and
- Blood clotting factor used for treatment of hemophilia and other blood disorders along with items and services related to the furnishing these products.

The rule indicates 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 to identify specific HCPCS codes in any of these five service categories** (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices and blood clotting factor) representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. It may consider excluding a particular service if it meets the criteria for exclusion: they must be included in the five categories and also must meet criteria as high cost and low probability in the SNF setting.[6]

If CMS identifies any new services that actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, it will identify these additional excluded services by means of the HCPCS codes that are in effect as of October 1, 2021. The latest list of excluded codes can be found on the SNF Consolidated Billing website.[7]

C. Payment for SNF-level Swing-bed Services

CMS discusses the statutory requirement 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. As discussed in the FY 2019 SNF PPS final rule, revisions were made to the swing-bed assessment

[6] See the FY 2001 final rule (65 FR 46790) for discussion of these criteria, which are tied to the Conference Report discussion section 103(a) of the Balanced Budget Reduction Act (P.L. 106-113); (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.))
[7] https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling.

in order to support implementation of PDPM. The latest changes in the MDS for swing-bed rural hospitals can be found at the SNF PPS website.

D. Revisions to the Regulation Text

CMS proposes several revisions to reflect the recently-enacted exclusion of marriage and family therapist services and mental health counselor services from SNF consolidated billing at section 1888(e)(2)(A)(ii) of the Act. This includes redesignating current §411.15(p)(2)(vi) through (xviii) to §411.15(p)(2)(viiii) through (xx) and to redesignate current §489.20(s)(6) through (18) as §489.20(s)(8) through (20). CMS also proposes to revise §§411.15(p)(2)(vi) and 489.20(s)(6) to reflect the exclusion of services performed by a marriage and family therapist (as defined in section 1861(111)(2) of the Act). Proposed new §§411.15(p)(2)(vii) and 489.20(s)(7) would reflect the exclusion of services performed by a mental health counselor (as defined in section 1861(111)(4) of the Act).

IV. Other SNF PPS Issues

A. Technical Updates to PDPM ICD-10 Mappings

ICD-10 codes are used in various components of the PDPM, including assigning patients to clinical categories. The ICD-10 code mappings and lists used under PDPM, including proposed changes discussed below, are available on the PDPM website.[8]

The ICD-10 codes are updated each year in June and become effective October 1 of the same year. In the FY 2020 SNF PPS[9], CMS outlined the process it uses to maintain and update ICD-10 code mappings and lists associated with the PDPM and the SNF Grouper software. Beginning with the FY 2020 updates, nonsubstantive changes to the ICD-10 codes would be applied through the subregulatory process and substantive revisions would be proposed and finalized through notice and comment rulemaking.

- Nonsubstantive changes are changes that are necessary to maintain consistency with the most current ICD-10 medical code data set.
- Substantive changes are changes that go beyond the intention of maintaining consistency with the most current ICD-10 medical code data set. Changes to the assignment of a code to a comorbidity or other changes that amount to a change in policy would be a substantive change.

1. Proposed Clinical Category Changes for New ICD-10 Codes for FY 2023.

CMS proposes changing the clinical category assignment for the following five new ICD-10 codes that were effective on October 1, 2022:

[8] PDPM Website is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payments/SNFPP/PDPM
[9] 84 FR 38750

ICD-10 Code	Diagnosis	CMS Proposal
D75.84	Other platelet-activating anti-platelet factor 4 (PF4) disorders	Remap from "Return to Provider" to "Medical Management"
F43.81	Prolonged grief disorder	Remap from "Medical Management" to Return to Provider"
F43.89	Other reactions to severe stress	Remap from "Medical Management" to Return to Provider"
G90.A	Postural orthostatic tachycardia syndrome (POTS)	Remap from "Acute Neurologic" to "Medical Management"
K76.82	Hepatic encephalopathy	Remap from "Return to Provider" to "Medical Management

2. Proposed Clinical Category Changes for Unspecified Substance Use Disorder Codes

CMS reviewed all ICD-10 substance use disorder (SUD) codes (a total of 458 codes) from code categories F10 to F19 and proposes reassigning 168 unspecified SUD codes to Return to Provider from Medical Management; these codes are not specific because they do not indicate if they refer to abuse or dependence. Based on data from FY 2021 these codes were used as a primary diagnosis for only 323 SNF stays (0.02 percent) and as secondary diagnosis for 9,537 SNF stays (0.54 percent). CMS encourages providers to continue reporting these codes as secondary diagnosis to enable CMS to identify these patients and ensure they are receiving appropriate care.

Table 1, Proposed Clinical Category Changes for Unspecified Substance Use Disorder Codes is available on the CMS website**. CMS invites comments including additional substantive and nonsubstantive changes that commenters believe are necessary**.

3. Proposed Clinical Category Changes for Certain Subcategory Fracture Codes

In the FY 2023 final rule (87 FR 47524), several commenters highlighted that certain select encounter codes for humeral fracture are permitted to be coded under the current ICD-10 mapping, but not other encounter codes. The commenters suggested that all the encounter codes associated with these fracture codes be included in the appropriate clinical category. CMS agreed and reviewed all subcategory S42.2-fracture codes to ensure that the appropriate surgical clinical category could be selected for joint aftercare.

CMS proposes allowing 45 subcategory S42.2-codes for displaced fractures to be eligible for one of two orthopedic surgery categories. CMS notes this proposal does not extend to subcategory S42.2-codes for nondisplaced fractures, which typically do not require surgery. CMS also proposes adding the surgical option to subcategory 46 M84.5-codes for pathological fractures to certain major weight-bearing bones to be eligible for one of two orthopedic surgery categories. Table 2, Proposed Clinical Category Changes for S42.2 and M84.5 Fracture Codes, lists all 91 codes included in this proposal and is available on the PDPM website.

4. Proposed Clinical Category Changes for Unacceptable Principal Diagnosis Codes

In the FY 2023 final rule (87 FR 47525), several commenters discussed SNF claims denied when they included a primary diagnosis code listed as an PDPM ICD-10 valid code but were not accepted by some Medicare Administrative Contractors (MACs) that use the Hospital Inpatient Prospective Payment System (IPPS) Medicare Code Editor (MCE) lists when evaluating the primary diagnosis codes listed on the SNF claims. CMS noted that all codes on the MCE lists are able to be reported; however, a code edit may be triggered that the MAC may either choose to bypass or return to the provider to resubmit. Commenters recommended that CMS align the PDPM ICD-10 code mapping with the MCE in treating diagnosis that are Return to Provider.

CMS identified 95 codes from the MCE Unacceptable Principal Diagnosis edit code list that are mapped to a valid clinical category on the PDPM ICD-10 code mapping. In FY 2021, these codes were coded as primary diagnoses for 14,808 SNF stays (0.84 percent). Table 3, Proposed Clinical Category Changes for Unacceptable Principal Diagnosis Codes is available on the PDPM website.

CMS also proposes to make future updates to align the PDPM ICD-10 code mapping with the MCE Unacceptable Principal Diagnosis edit code list on a subregulatory basis. **CMS solicits comments on also aligning the PDPM ICD-10 code mapping with both the MCE Manifestation codes not allowed as principal diagnosis codes and the Questionable admission codes edit code lists.**

V. SNF Quality Reporting Program (QRP)

CMS proposes, beginning with the FY 2025 SNF QRP, to:

- Adopt one new measure: The Discharge Function Score (DC Function) measure;
- Modify one existing measure: The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure; and
- Remove three measures:
    - The Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (Application of Functional Assessment/Care Plan) measure;
    - The Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure; and
    - The Application of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure.

CMS proposes, beginning with the FY 2026 SNF QRP, to adopt two new measures:

- The CoreQ: Short Stay Discharge (CoreQ: SS DC) measures; and
- The COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date (Patient/Resident COVID-19) Vaccine.

Additionally, CMS requests information on principles to be used to select and prioritize SNF quality measures in future years; provides an update on health equity efforts; proposes several

administrative changes, including a change to the SNF QRP data completion thresholds for the Minimum Data Set (MDS) Data Items; and proposes to begin public reporting of 4 measures.

CMS invites public comment on all of the proposals.

A. Background and Statutory Authority

The SNF QRP is authorized under section 1888(e)(6) of the Act and is a pay-for-reporting program. SNFs submit specified data elements and quality measure data for each resident using the SNF resident assessment instrument known as the Minimum Data Set (MDS). Completed assessments are sent to CMS through the Internet Quality Improvement & Evaluation System (iQIES). Freestanding SNFs, SNFs affiliated with acute care hospitals, and all non-CAH 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 SNF PPS annual update factor. FY 2018 was the first year in which the QRP affected payments.

B. General Considerations Used for Selection of Measures

CMS refers readers to section 413.360(b)(2) of title 42, CFR, for details on factors used to evaluate whether a measure should be removed from the SNF QRP and to the FY 2016 SNF (PPS) final rule (80 FR 46429 through 46431) for considerations CMS uses for selecting quality, resource use, and other measures.[10]

The table below (Table 11 reproduced from the proposed rule with minor modifications) shows the current quality measures for the FY 2024 SNF QRP.

Table 11: Quality Measures Currently Adopted for the FY 2024 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of 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 Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
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).

[10] More information about SNF QRP measures is available on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.

Table 11: Quality Measures Currently Adopted for the FY 2024 SNF QRP	
Short Name	**Measure Name & Data Source**
Change in Self-Care Score	Application of the 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).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider*	Transfer of Health Information to the Provider – PAC Measure
TOH-Patient*	Transfer of Health Information to the Patient – PAC Measure
Data Source: Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
Data Source: NHSN	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage amount Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)
***In response to the public health emergency (PHE) for COVID-19, the Interim Final Rule (85 FR 27595 through 27597) delayed the compliance date for collection and reporting of the Transfer of Health (TOH) Information measures for at least 2 full fiscal years after the end of the PHE. The compliance date for the collection and reporting of the TOH Information measures was revised to October 1, 2023 in the FY 2023 SNF PPS final rule (87 FR 47547 through 47551)	

C. SNF QRP Quality Measures Proposals

1. SNF QRP Quality Measure Proposals Beginning with the FY 2025 SNF QRP

a. Proposed Modification of the COVID-19 Vaccination Coverage among HCP Measure Beginning with the FY 2025 SNF QRP

Background: The COVID–19 Vaccination Coverage among HCP measure was adopted[11] into the SNF QRP measure set beginning with FY 2023, and requires each SNF to submit data on the percentage of HCP eligible to work in the SNF for at least one day during the reporting period who have received a complete vaccination course against SARS-CoV-2 (excluding persons with contraindications to the COVID-19 vaccine). CMS describes that since adoption of the measure, the agency continues to believe vaccination is a critical component to effectively countering the spread of COVID-19, and that it's important to incentivize and track HCP vaccination in SNFs. However, CMS states it is important to update the specifications of the HCP COVID-19 Vaccine measure to reflect the most current guidance that specifies for HCP to receive primary series and booster vaccine doses in a timely manner.

[11] FY 2022 SNF PPS final rule; 86 FR 42480 through 42489.

Proposed modification: The HCP COVID-19 Vaccine measure is a process measure (that is not risk-adjusted) developed by the CDC to track COVID-19 vaccination coverage among HCP in facilities such as SNFs. CMS proposes, beginning with the FY 2025 SNF QRP measure set, to modify the HCP COVID-19 Vaccine measure to:

- Replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition; and
- Update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses.

Pre-rulemaking: The current version of the HCP COVID-19 Vaccine ("Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel") measure received endorsement by NQF on July 26, 2022 (NQF #3636), but the measure so endorsed does not capture information about whether HCP are "up to date" with their COVID-19 vaccinations (as proposed in the CMS modifications to the measure). The CDC is pursuing NQF endorsement for the modified version of the measure and is considering an expedited review process as the current version of the measure has already received endorsement.

CMS included an updated version of the HCP COVID-19 Vaccine measure on the Measures Under Consideration (MUC) List for December 1, 2022. Comments by interested parties were mixed, and raised the concern about the difficulty of defining "up to date" for purposes of the measure. The Measure Applications Partnership (MAP) conditionally supported the rulemaking pending testing that indicates the measure is reliable and valid, and pending endorsement by the NQF.
CMS proposes to adopt the measure for FY 2025, consistent with the exception under section 1899B(e)(2)(B) of the Act, having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical.

Measure Calculation: The measure would be calculated as follows:

- Denominator of Measure: The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCPs include employees of the facility, licensed independent practitioners, and adult students/trainees and volunteers. There are no proposed changes to the denominator from that of the current measure.
- Numerator of Modified Measure: The number of HCP in the denominator population who are considered up to date[12] with CDC recommended COVID-19 vaccines.

Proposed compliance requirements and calculations:

- For SNF QRP compliance in FY 2025, SNFs would collect the numerator and denominator for the modified measure for at least one self-selected week during each month of the reporting quarter, report individuals who are up to date beginning in quarter

[12] The definition of up to date is as of the first day of the quarter, and can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. HCP would be considered up to date during Q4 of the CY 2022 reporting period if the individual received an updated bivalent booster dose; received their last booster dose less than 2 months ago; or completed their primary series less than 2 months ago.

4 of CY 2023, and submit the data to the NHSN Healthcare Personnel Safety (HPS) Component before the quarterly deadline.
- Each quarter, the CDC would calculate a single quarterly COVID-19 HCP vaccination coverage rate for each SNF, by taking the average of the data from the three weekly rates submitted by the SNF for that quarter.
- Beginning with the FY 2026 SNF QRP, SNFs would be required to submit data for the entire calendar year.
- Public reporting of the modified measure would begin with the October 2024 Care Compare refresh or as soon as technically feasible.

Burden assessment: Data would be collected through the CDC's NHSN, which SNFs already use to meet other SNF QRP requirements (including for the current HCP COVID-19 Vaccine measure). Since no changes are proposed to the form, manner, and timing of submission, there would be no increase in burden.

b. Proposed Adoption of the Discharge Function Score Measure Beginning with the FY 2025 SNF QRP

Background: Section 1888(e)(6)(B)(i) of the Act requires CMS to develop and implement standardized quality measures from five quality measure domains, including the domain of functional status, cognitive function, and changes in function and cognitive function, across post-acute care settings. CMS emphasizes the need for a cross-setting functional outcome measure to align measure specifications across settings, including the use of a common set of standardized functional assessment data elements. CMS also describes the importance of implementing interventions that improve functional outcomes as a part of patient-centered care, and states that assessing functional status as a health outcome in SNFs would be useful in determining treatment decisions throughout the care continuum.

Proposed measure: CMS proposes to adopt the Discharge Function Score (DC Function) measure beginning with the FY 2025 SNF QRP. The DC Function measure is an assessment-based outcome measure that evaluates functional status by calculating the percentage of SNF residents who meet or exceed an expected discharge function score during the reporting period.

The proposed measure would replace the topped-out Application of Functional Assessment/Care Plan cross-setting process measure proposed in section VI.C.1.c. for removal. CMS describes that the DC Function measure uses a set of cross-setting assessment items which would facilitate data collection, quality measurement, outcome comparison, and interoperable data exchange among PAC settings; whereas existing functional outcome measures do not use a set of cross-setting assessment items. CMS also explains that the DC Function measure considers two dimensions of function (self-care and mobility activities) and accounts for missing data by recoding missing functional status data to the most likely value had the status been assessed (i.e., using statistical imputation). In contrast, the topped-out measure treats residents with missing values the same as residents who were coded to the lowest functional status.

Measure testing: Validity was assessed for the measure performance[13], the risk adjustment model[14], face validity[15], and statistical imputation models.[16]

Pre-Rulemaking: This measure went through the standard pre-rulemaking process. Interested parties expressed support of the measure's reliability, validity, and feasibility. In accordance with the CMS pre-rulemaking process, the DC Function measure was included on the MUC list for December 1, 2022. The MAP recommended conditional support for the rulemaking. The measure is not NQF-endorsed, but CMS proposes to adopt the measure under the exception at section 1899B(e)(2)(B) of the Act, which allows the Secretary select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical. CMS intends to submit the proposed measure to NQF for consideration of endorsement when feasible.

Measure Calculation: The measure would be calculated as follows:

- Numerator: The number of SNF stays with an observed discharge function score that is equal to or greater than the calculated expected discharge function score.
    - Observed discharge function score is the sum of individual function item values at discharge.
    - Calculated expected discharge function score is computed by risk-adjusting (for resident characteristics, such as admission function score, age, and clinical conditions) the observed discharge function score for each SNF stay.
- Denominator: The total number of SNF stays with an MDS record in the measure target period (four rolling quarters) that do not meet the measure exclusion criteria.[17]

Burden assessment: Since the measure would be calculated using data that are already reported to CMS for payment and quality reporting purposes, there would be no additional burden.

c. Proposed Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function Beginning with the FY 2025 SNF QRP

Proposed Removal: CMS proposes to remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure from the SNF

[13] Validity testing of measure performance tested the strength and directional correlations between the proposed measure's performance for providers with 20 or more stays and the performance of other publicly reported SNF quality measures. Results indicated that the proposed DC Function measure captures the intended outcome, as detailed in Table 12 of the Proposed Rule.
[14] Validity testing of the risk adjustment model showed the measure model has the predictive ability to distinguish residents with low expected functional capabilities from those with high expected functional capabilities.
[15] Cross-Setting Discharge Function Technical Expert Panels and resident-family feedback showed strong support for the face validity and importance of the proposed measure as an indicator of quality of care.
[16] Validity testing of the measure's statistical imputation models indicated that the models demonstrate good discrimination and produce more precise and accurate estimates of function scores for items with missing scores when compared to the current imputation approach..
[17] For additional details regarding the numerator, denominator, risk adjustment, and exclusion criteria, refer to the Discharge Function Score Skilled Nursing Facilities (SNFs) Technical Report. https://www.cms.gov/files/document/snf-discharge-function-score-technical-report-february-2023.pdf.

QRP beginning with the FY 2025 SNF QRP. Public reporting of the Application of Functional Assessment/Care Plan measure would end by the October 2024 Care Compare refresh or as soon as technically feasible when public reporting of the proposed DC Function measure would begin (see section VI.G.3. of the proposed rule). Beginning for the FY 2025 SNF QRP:

- SNFs would not be required to report a Self-Care Discharge Goal (GG0130, Column 2) or a Mobility Discharge Goal (GG0170, Column 2) beginning with residents admitted on October 1, 2023.
- CMS would remove the items for Self-Care Discharge Goal (GG0130, Column 2) and Mobility Discharge Goal (GG0170, Column 2) with the next release of the MDS.

Basis for Removal: CMS explains that the proposed removal is based on the measure satisfying 2 of the 8 factors considered for removal of a measure.[18]

- Measure removal factor one: The measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made. The average performance rates on the measure since 2019 have been near 100 percent, indicating the measure has "topped out", and the measure no longer provides for any variation that would show distinction among SNFs.[19]
- Measure removal factor six: There is an available measure that is more strongly associated with desired resident functional outcomes. CMS points to the proposed DC Function measure discussed in section VIII.C.1.b. of the proposed rule as a measure that better measures functional outcomes.

Burden Assessment: CMS estimates the removal of this measure would result in a reduction of total burden for complying with the SNF QRP requirements decrease of 12,032 hours for all SNFs annually and $1,037,261 for all SNFs annually.

d. Proposed Removal of the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and Removal of the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients Beginning with the FY 2025 SNF QRP

Proposed Removal: CMS proposes to remove the two measures of IRF Functional Outcomes. : Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) from the SNF QRP beginning with the FY 2025 SNF QRP.

Background: At the time the Change in Self-Care Score and Change in Mobility Score measures were adopted[20], CMS also adopted 2 other measures addressing the functional status, cognitive function, and changes in function and cognitive function domain. Those additional measures are the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (Discharge Self-Care Score) and the Application of IRF Functional

[18] Section 413.360(b)(2) of title 42, CFR, specifies eight factors considered for measure removal from the SNF QRP.
[19] The proposed rule states the average performance scores ranged from 99.1 percent to 98.9 percent during CYs 2019-2021; were 98.8 percent for July 1, 2020 through June 30, 2021 (with nearly 70 percent of SNFs scoring 100 percent); and were 98.9 percent for CY 2021 (with nearly 63 percent of SNFs scoring 100 percent).
[20] Adopted in the FY 2018 SNF PPS final rule (82 FR 36578 through 36593).

Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (Discharge Mobility Score). By monitoring the measures since 2018 CMS concludes that the 2 self-care functional outcome measures, and similarly the 2 mobility score measures, provide almost identical information about the quality domain to SNFs and are therefore duplicative.

Basis for Removal: CMS reasons that removal of the Change in Self-Care Score measure and the Change in Mobility Score measure satisfy measure removal factor eight: the costs associated with each of the measures outweighs the benefits of the measures' uses in the SNF QRP program. CMS reasons that the costs to SNFs associated with tracking similar or duplicative measures in the SNF QRP outweigh any benefit that might be associated with the measures, and the costs to CMS associated with program oversight of the measures outweigh the benefit of information obtained from the measures.

Burden Assessment: Since the data elements used to calculate the measures would still be collected by SNFs for other quality measures under the SNF QRP, CMS does not believe the proposal would change burden for SNFs.

2. SNF QRP Quality Measure Proposal Beginning with the FY 2026 SNF QRP

a. Proposed Adoption of the CoreQ: Short Stay Discharge Measure (NQF #2614) Beginning with the FY 2026 SNF QRP

Background: CMS defines person-centered care as integrated healthcare services delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences, and describes such care as enabling residents and providers to make care plans together. Person-centered care is often assessed by self-reported measures, such as questionnaires assessing experience and satisfaction of the resident in receiving care. However, there is currently no national standardized satisfaction questionnaire that measures a resident's satisfaction with the quality of care received by SNFs.[21] CMS describes that resident satisfaction data is collected using Consumer Assessment of Healthcare Providers and Systems (CAHPS) resident experience surveys in other settings, such as home health, hospice, and hospital, and that specifically the CAHPS Nursing Home survey: Discharged Resident Instrument (NHCAHPS-D) was developed for short-stay SNF residents but because of its length (50 questions) and potential burden was not adopted for the SNF QRP.

CMS describes the CoreQ suite of questionnaires was developed by nursing home providers and researchers to assess satisfaction among SNF and assisted living residents and families, and includes 5 measures. Unlike the NHCAHPS-D, the CoreQ questionnaire includes only 4 questions and the CoreQ measures provide one score. CMS describes that SNFs are familiar with the CoreQ measures instruments, and many SNFs already voluntarily use the CoreQ: Short Stay Discharge (CoreQ: SS DC) survey.

[21] CMS identified resident satisfaction with the quality of care received by SNFs as a measurement gap in the SNF QRP (see section VI.D. of this proposed rule), as did the MAP in its report MAP 2018 Considerations for Implementing Measure in Federal Programs: Post-Acute Care and Long-Term Care

Proposed Measure: CMS is proposing to adopt the CoreQ: SS DC measure for the SNF QRP beginning with the FY 2026 SNF QRP.[22] The proposed measure is a resident-reported outcome measure based on the CoreQ: SS DC questionnaire that calculates the percentage of residents discharged in a 6-month period from a SNF, within 100 days of admission, who are satisfied with the SNF. The measure is not risk-adjusted by sociodemographic status. Unless exempt from collecting and reporting on the CoreQ: SS DC measure (as discussed in section VI.F.3.b.), each SNF would need to contract with an independent CMS-approved CoreQ survey vendor to administer the CoreQ: SS DC measure questionnaire, and to report the results to CMS (as specified in sections VI.F.3.a. and VI.F.3.c.).

Measure Testing: Extensive testing conducted by the American Health Care Association (the measure steward) on the CoreQ:SS DC measure, both prior to its initial NQF endorsement in 2016 and re-endorsement in 2020, found the measure to be highly reliable, valid, and reportable.

Pre-Rulemaking: In accordance with the CMS pre-rulemaking process, the CoreQ:SS DC measure was included on the MUC list for December 1, 2017, for the SNF QRP. The MAP recommended support for the rulemaking, supporting the value of resident-reported outcomes, but cautioning about the potential burden of collecting the information. The measure, consistent with the requirement under section 1899B(e)(2)(A) of the Act, is NQF-endorsed. CMS did not find other NQF-endorsed measures that assess satisfaction of residents discharged within 100 days of their admission to the SNF.

Quality Measure Calculation and Specifications:

- Component questions: The CoreQ: SS DC measure questionnaire utilizes four questions (referred to as the 4 Primary Questions) and uses a 5-point scale (as shown in the below table). CMS proposes to add 2 questions (shown in italics in the table) to determine if the questionnaire should be counted as completed for the denominator of the measure calculation or excluded.

Table 13 reproduced from the Proposed Rule, with Minor Modifications	
Primary questions used in the CoreQ: Short Stay Discharge Questionnaire	**Response options for the CoreQ primary questions**
1. In recommending this facility to your friends and family, how would you rate it overall?	Poor (1) Average (2) Good (3) Very Good (4) Excellent (5)
2. Overall, how would you rate the staff?	
3. How would you rate the care you received?	
4. How would you rate how well your discharge needs were met?	
5. Did someone help you [the resident] complete the survey?	
6. How did that person help you [the resident]?	

- Numerator of Measure: The sum of the resident respondents in the denominator that submitted an average satisfaction score of greater than or equal to 3 for the 4 Primary Questions on the CoreQ: SS DC questionnaire. If a questionnaire is missing one

[22] More information about the CoreQ questionnaire is available at *http://www.coreq.org*.

response out of the 4 Primary Questions, imputation would be used to represent the average value from the other three available response.

- Denominator: The sum of all of the questionnaire-eligible residents, regardless of payer, who (1) are admitted to the SNF and discharged within 100 days, (2) receive the CoreQ: SS DC questionnaire, and (3) respond to the CoreQ: SS DC questionnaire within two months of discharge from the SNF.
- Exclusions from Denominator: The following residents (and questionnaires) would be excluded from the denominator:
    - Residents discharged to another hospital, another SNF, a psychiatric facility, an IRF, an LTCH, or hospice;
    - Residents who die during their SNF stay;
    - Residents with court-appointed legal guardians with authority to make decisions on behalf of the resident;
    - Residents who have dementia impairing their ability to answer the questionnaire;
    - Residents who left the SNF against medical advice;
    - Residents with a foreign address;
    - If the CMS approved CoreQ survey vendor received the CoreQ: SS DC completed questionnaire more than two months after the resident was discharged from the SNF or the resident did not respond to attempts to conduct the interview by phone within two months of their SNF discharge date;
    - If the proposed question 6 (shown in the above table) indicates the questionnaire answers were answered by someone other than the resident; and
    - If the received CoreQ: SS DC questionnaire is missing more than one response to the 4 Primary Questions.

Burden Assessment: CMS estimates, in aggregate, a burden of 1,898 hours at a cost of $88,181 for all SNFs requesting an exemption from the CoreQ: SS DC measure survey requirement. For non-exempt SNFs, CMS estimates for FY 2026, a total increase in burden of 214,751 hours for all SNFs and an increase of $60,801,499 for all SNFs. For non-exempt SNFs, CMS estimates for years beginning with FY 2027, a total increase in burden of 318,147 hours for all SNFs annually and an increase of $63,344,417 for all SNFs annually.[23]

b. Proposed Adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning with the FY 2026 SNF QRP

Background: CMS describes how COVID remains a major challenge to PAC facilities, including SNFs, and emphasizes that older persons are at a significantly higher risk of mortality and severe disease following infection. CMS details that studies have shown COVID vaccines provide strong protection against severe disease, hospitalization, and death in adults. The agency also describes that since the emergence of the Omicron variants and availability of boosters, multiple studies have shown protection is higher among individuals receiving booster doses (specifically the bivalent booster in the case of Omicron subvariants) than among those only receiving the primary series.

[23] See Table 30 in the Proposed Rule for a detailed breakdown on estimated burden.

CMS also details significant gaps and disparities in vaccination rates between those receiving the primary vaccination series and the boosters. Variations are also present when examining vaccination rates by race, gender, and geographic location.

Proposed Measure: CMS is proposing to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure for the SNF QRP beginning with the FY 2026 SNF QRP. The proposed measure is an assessment-based process measure that reports the percent of stays in which residents in a SNF are up to date on their COVID-19 vaccinations per the CDC's latest guidance. The measure has no exclusions and is not risk adjusted. CMS explains the measure's potential to:

- Increase the rate of COVID vaccination of residents in SNFs to prevent the spread of COVID within the SNF population;
- Support the goal of CMS' Meaningful Measure Initiative 2.0 to "Empower consumers to make good health care choices through patient-directed quality measures and public transparency objectives";
- Provide residents and caregivers with information for informed decision-making (since the measure would be reported on Care Compare), including by providing residents with data to make side-by-side SNFs as well as comparisons across facility types;
- Allow for education of residents at time of discharge from the SNF as to why they should be vaccinated; and
- Promote measure harmonization across quality reporting programs.

Pre-rulemaking: CMS conducted the usual pre-rulemaking process for stakeholder input, with mixed comments received about whether there should be a measure addressing COVID-19 vaccination coverage among SNF residents, and with some concerns raised, such as regarding the evolving recommendations related to boosters and the definition of "up to date." The proposed measure was included on the 2022 MUC List for the SNF QRP.[24] The MAP workgroups were mostly supportive of the measure and recognized the importance of resident COVID-19 vaccination, but concerns raised included duplication with data collection required with NHSN reporting, provider actionability, lack of denominator exclusions, requirements for assessing resident vaccination status, evolving COVID-19 vaccination recommendations, and data reporting frequency for this measure. CMS responded that the measure is to promote transparency of data for residents to make informed decisions regarding care and is not intended to be a measure of SNF action. However, the MAP Coordinating Committee recommended not adopting the measure, with 3 potential mitigation strategies presented:

- Reconsider exclusions for medical contraindications;
- Complete reliability and validity measure testing; and
- Seek NQF endorsement.

The measure is not NQF-endorsed, but CMS proposes (despite the MAP recommendation) to adopt the measure under the exception at section 1899B(e)(2)(B) of the Act, which allows the

[24] Centers for Medicare & Medicaid Services. (2022). Overview of the List of Measures Under Consideration for December 1, 2022. https://mmshub.cms.gov/sites/default/files/2022-MUC-List-Overview.pdf.

Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical.[25] CMS proposes the measure adoption stating (1) exclusions for medical contraindications were not included because of the belief capturing the raw vaccination rate would be most helpful in resident and family/caregiver decision-making; (2) CMS plans to conduct reliability and validity measure testing once there is enough data; and (3) CMS intends to submit the proposed measure to NQF for endorsement when feasible.

Measure calculation and Specifications: The measure would be calculated as follows:

- Numerator: The total number of Medicare Part A-covered SNF stays in the denominator in which residents are up to date with their COVID-19 vaccination per CDC's latest guidance.
- Denominator: The total number of Medicare Part A-covered SNF stays discharged during the reporting period.
- Data Source: The MDS assessment instrument for SNF residents.

Burden Assessment: One data element would be added to the MDS at discharge, which CMS believes would result in an increase of 0.3 minutes of clinical staff time at discharge; estimating an increase of 12,032 hours in burden for all SNFs; and estimating the total cost of complying with the SNF QRP requirements would increase by $778,591 for all SNFs annually.

D. Request for Information (RFI): Principles for Selecting and Prioritizing SNF Quality Measures and Concepts

After discussing a framework of principles CMS could use to identify future SNF QRP measures, and the identification of measurement gaps in the current SNF QRP and measures that could be used to fill such gaps, **CMS solicits public comment on**:

- The set of principles for selecting measures for the SNF QRP;
- The identified measurement gaps; and
- Measures that are available for immediate use, or that may be adapted or developed for use in the SNF QRP.

CMS states the agency will not be responding to specific comments submitted in response to this RFI in the FY 2024 SNF PPS final rule, but intends to use the comments to inform future policies.

1. Background

CMS describes the established National Quality Strategy (NQS) for supporting a high-value health care system promoting quality outcomes, safety, equity and accessibility for all

[25] CMS describes there are no other available NQF measures, and reasons that the SNF COVID-19 vaccination rates posted on Care Compare are aggregated at the facility level, and with the data being reported through the CDC's NHSN not requiring beneficiary-level data. This is in contrast to the proposed Patient/Resident COVID-19 Vaccine measure which would be calculated using data collected on the MDS at the beneficiary level.

individuals. CMS describes the "Universal Foundation"[26] of quality measures as a building-block approach to support these goals by streamlining quality measures across quality programs for adult and pediatric populations. The Universal Foundation is intended to reduce provider burden, identify disparities in care, prioritize development of interoperable digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps.

In furtherance of these goals, this RFI seeks to gather information on existing gaps in SNF QRP measures and solicit public comment, for purposes of filling such gaps.

2. Guiding Principles for Selecting and Prioritizing Measures

CMS identifies guiding principles for inclusion and maintenance of measures in the future SNF QRP measure set. These principles intend for the measures to be meaningful to beneficiaries and caregivers, not impose undue burden on SNFs, align with PAC program goals, and be readily operationalized. The following 4 objectives are specified as follows:

- Actionability: SNF QRP measures should focus on structural elements, health care processes, and outcomes of care that have been demonstrated (through clinical evidence or other best practices) to be amenable to improvement and feasible for SNFs to implement.
- Comprehensiveness and Conciseness: SNF QRP measures should assess performance of all SNF core services using the smallest number of measures that comprehensively assess the value of care provided in SNF settings.
- Focus on Provider Response to Payment: SNF performance measures should neither exacerbate nor induce unwanted responses to the payment system, and as feasible mitigate adverse incentives of the system.
- Compliance with Statutory Requirements: SNF QRP measures must comply with the governing statutory authorities and CMS' policy to align QRP measures with broader policy initiatives, such as the Meaningful Measures Framework.

3. Gaps in SNF QRP Measure Set and Potential New Measures

Using the above principles, CMS identified measurement gaps in the domains of cognitive function, behavioral and mental health, resident experience and resident satisfaction, and chronic conditions and pain management.

a. Cognitive Function

Section 1888(e)(6)(B)(i) of the Act requires SNFs to submit data on quality measures under section 1899B(c)(1) of the Act. CMS identifies cognitive function and changes in cognitive function as key dimensions of clinical care that are not currently represented in the SNF QRP. CMS describes that SNFs currently collect and report to CMS data on cognitive function using the Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM), both of which are incorporated in the MDS as standardized resident assessment data elements, but

[26] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS – The Universal Foundation. N Engl J Med. 2023 Mar 2; 338:776-779. doi: 10.1056/NEJMp2215539. PMID: 36724323.

neither of which have been developed into quality measures for the SNF QRP. CMS also identifies Patient-Reported Outcomes Measurement Information Set (PROMIS) Cognitive Function forms and the PROMIS Neuro-Quality of Life (Neuro-QoL) measures as alternative sources of information on cognitive functioning, from which quality measures may be construed.

CMS is requesting comment on:

- The availability of cognitive functioning measures outside of the SNF QRP that may be available for immediate use in the SNF QRP, or that may be adapted or developed for use in the SNF QRP, using instruments such as the BIMS, CAM, PROMIS Cognitive Function forms, and PROMIS Neuro-QoL;
- The feasibility of measuring improvement in cognitive functioning during a SNF stay;
- The cognitive skills that are more likely to improve during a SNF stay;
- Conditions for which measures of maintenance (rather than improvement in cognitive functioning) are more practical; and
- The types of intervention that have been demonstrated to assist in improving or maintaining cognitive functioning.

b. Behavioral and Mental Health

CMS states that information on the availability and appropriateness of behavioral health measures in PAC settings is limited, and the 2021 National Impact Assessment of CMS Quality Measures Report identified PAC program measurement gaps in behavioral and mental health.

Looking at mental health quality measures used in other quality reporting programs, CMS identified the Home Health QRP measure, which assesses the extent to which patients have been screened for depression, but notes the measure doesn't assess performance in management of depression and related mental health concerns. CMS also identifies possible instruments that may be adapted in PAC settings to assess management of mental health, including CAHPS Experience of Care and Health Outcomes Survey (ECHO), the PROMIS suite of instruments, the NIH Toolbox for the Assessment of Neurological and Behavioral Health Function, and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach developed by SAMHSA.

CMS seeks feedback on:

- Measures and instruments (including those described in the proposed rule and above) that may be directly applied, adapted, or developed for use in the SNF QRP;
- The degree to which measures have been or will require validation and testing prior to application in the SNF QRP; and
- The availability of data, the manner in which data could be collected and reported to CMS, and the burden on SNFs.

c. Resident Experience and Resident Satisfaction

Resident experience measures focus on how residents experienced aspects of care; resident satisfaction measures focus on if residents' expectations were met. These measures are often

reported through instruments that use resident self-reported data, such as the CAHPS surveys. CMS mentions the Nursing Home Discharged Resident CAHPS, intended for use with residents who had a length of stay less than 100 days, as an example. CMS also refers to the CoreQ: Short Stay Discharge (CoreQ: SS DC) measure proposed for adoption for the SNF QRP under section VI.C.2.a.

CMS seeks comment on:

- The feasibility and challenges of adapting, for use in the SNF QRP, existing resident experience and resident satisfaction measures and instruments, and benefits to adapting or developing resident experience and satisfaction measures beyond the CoreQ: SS DC measure;
- The extent to which resident experience measures offer SNFs sufficient information to assist in quality improvement; and
- The challenges of collecting and reporting resident experience and resident satisfaction data.

d. Chronic Conditions and Pain Management

CMS describes that existing SNF QRP measures do not directly address aspects of care rendered to populations with chronic conditions (such as chronic respiratory conditions) nor address SNFs' management of residents' pain. CMS notes that beginning October 1, 2023, SNFs will begin to collect standardized resident assessment data elements, including items that assess pain interference with (1) daily activities, (2) sleep, and (3) participation in therapy.

CMS seeks comments on:

- Measures of chronic condition and pain management for residents that may be used to assess SNF performance; and
- The feasibility and challenges of measuring and reporting SNF performance on existing QRP measures, such as Discharge Self-Care Score for Medical Rehabilitation Patients and Discharge Mobility Score for Medical Rehabilitation Patients measures, for subgroups of residents defined by type of chronic condition.

4. Solicitation of Comments

CMS specifically solicits comments on the following questions:

- *Principles for identifying QRP measures*: To what extent do you agree with the principles for selecting and prioritizing measures? Are there principles that you believe CMS should eliminate from or add to the measure selection criteria?
- *Measurement Gaps*: CMS requests input on the identified measurement gaps, including in the areas of cognitive function, behavioral and mental health, resident experience and resident satisfaction, and chronic conditions and pain management. Specifically, are there gaps in the SNF QRP measures that have not been identified in this RFI?
- *Suitable Measures for Filling Gaps*: Are there measures that are either currently available for use or that could be adapted or developed for use in the SNF QRP program to assess performance in the areas of (1) cognitive functioning, (2)

behavioral and mental health, (3) resident experience and resident satisfaction, (4) chronic conditions, (5) pain management, or (6) other areas not mentioned in this RFI?

- *Data:* Input on data available to develop measures, approaches for data collection, perceived barriers or challenges, and approaches for addressing challenges.

E. Health Equity Update

1. Background

CMS notes that health inequity, manifested by significant disparities in healthcare outcomes, persists in the United States, particularly for individuals belonging to underserved communities. CMS describes health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

The agency describes goals outlined in the CMS *Framework for Health Equity 2022-2023* as consistent with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."

CMS seeks to advance health equity and whole-person care as one of eight goals comprising the CMS NQS. The NQS identifies potential methods of supporting the advancement of equity, including by: (1) establishing a standardized approach for resident-reported data and stratification; (2) employing quality and value-based programs to address closing equity gaps; and (3) developing equity-focused data collections, regulations, oversight strategies, and quality improvement initiatives.

CMS solicited public comment in the FY 2023 SNF PPS proposed rule (87 FR 22754 through 22760) regarding principles for measuring equity and healthcare quality disparities across CMS quality programs and will take comments into account as they continue work in this area.

2. Anticipated Future State

CMS is considering including social determinants of health (SDOH) as part of new SNF QRP quality measures. Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. CMS is considering whether health equity measures adopted for other settings, such as hospitals, could be adopted in post-acute care settings. CMS describes the possibility of specifying a health equity measure using the same SDOH data items as is currently collected as standardized resident assessment data elements under the SNF. The agency emphasizes the value in aligning SDOH items across all care settings, consistent with the Universal Foundation.

F. Form, Manner, and Timing of Data Submission

1. Background

See regulatory text at 42 CFR 413.360(b) for information regarding the policies for reporting SNF QRP data.

2. Proposed Reporting Schedule for the Minimum Data Set (MDS) Assessment Data for the Discharge Function Score Measure Beginning with the FY 2025 SNF QRP

- For the FY 2025 SNF QRP, SNFs would submit MDS assessment data beginning with residents admitted and discharged on October 1, 2023.
- Beginning with the FY 2026 SNF QRP, SNFs would be required to (starting in CY 2024) to submit data for the entire calendar year.

3. Proposed Method of Data Submission and Reporting Schedule for the CoreQ: Short Stay Discharge Measure Beginning with the FY 2026 SNF QRP

a. Proposed Method of Data Submission

To help ensure comparable data across all SNFs, CMS proposes that SNFs would be required to contract with a third-party vendor that is CMS-trained and approved to administer the CoreQ: SS DC survey. The vendor would be the business associate of the SNF[27]. Interested vendors may apply to become a CMS-approved CoreQ survey vendor beginning in Fall 2023. CMS proposes that vendors and SNF participate in oversight activities to ensure compliance with protocols, guidelines, and requirements outlined in the Draft CoreQ: SS DC Survey Protocols and Guidelines Manual, and that vendors develop a quality assurance plan for survey administration.

b. Proposed Exemptions

- Low volume exemption: SNFs with fewer than 60 residents, regardless of payer, discharged within 100 days of SNF admission in the prior calendar year would be exempt from the CoreQ: SS DC measure data collection and reporting requirements.
- New provider exemption: SNFs certified for Medicare participation on or after January 1 of the reporting year would be excluded from reporting on the CoreQ: SS DC measure for the applicable SNF QRP program year. A SNF certified on or after January 1, 2024, would be excluded from the CoreQ: SS DC measure reporting requirement for CY 2024 (with respect to the FY 2026 SNF QRP program).

c. Proposed Reporting Schedule

- SNFs would send a resident information file to the CMS-approved CoreQ survey vendor on a weekly basis.[28]

[27] The vendor would be required to follow the minimum business requirements. See https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/Downloads/CAHPS-for-MIPS-vendor-business-requirements.pdf.
[28] See Table 14 in the Proposed Rule for data elements to be included in the CoreQ: SS DC Measure Resident Information File.

- To avoid the 2-percentage point reduction to the annual payment update, a SNF would need to submit resident information files, on a weekly basis, that includes at least 90 percent of the required data fields to their CMS approved CoreQ survey vendors for at least 75 percent of the weeks in a reporting year.
- To meet the pay-for-reporting requirement of the SNF QRP for the first half of the FY 2026 program year, SNFs would submit one resident information file to the vendor for at least one week during either the Q1 or Q2 data submission quarter.
- Beginning July 1, 2024, SNFs would be required to submit weekly resident information files for at least 75 percent of the weeks remaining in CY 2024.
- Beginning for the FY 2027 SNF QRP program year, SNFs would be required to submit (staring with the 2025 reporting period) resident information files no less than weekly for the entire calendar year.

d. Proposed Participation Requirements for FY 2026 and FY 2027 SNF QRP (Showing a Table that Combines Tables 16 and 17 in the Proposed Rule)

Data Submission Quarters	Proposed Data Submission Frequency	Quarterly Data Submission Deadlines	SNF Annual Payment Update Compliance Thresholds
Q1 2024: Jan. 1, 2024-March 31, 2024	At least one week during either data submission quarter	August 15, 2024	At least one weekly resident information file containing at least 90% of the required resident information for one resident discharged within 100 days of admission.
Q2 2024: April 1, 2024-June 30, 2024		November 15, 2024	
Q3 2024: July 1, 2024-Sept. 30, 2024	No less than weekly	February 18, 2025	A minimum of 18 weekly resident information files that contain at least 90% of required resident information
Q4 2024: Oct. 1, 2024-Dec. 31, 2024	No less than weekly	May 15, 2025	
Q1 2025: Jan. 1, 2025-March 31, 2025	No less than weekly	August 15, 2025	A minimum of 35 weekly resident information files that contain at least 90% of required resident information
Q2 2025: April 1, 2025-June 30, 2025	No less than weekly	November 17, 2025	
Q3 2025: July 1, 2025-Sept 30, 2025	No less than weekly	February 16, 2026	
Q4 2025: Oct. 1, 2025-Dec. 31, 2025	No less than weekly	May 15, 2026	

1. Proposed Reporting Schedule for the Data Submission of Minimum Data Set (MDS) Assessment Data for the COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date Measure Beginning with the FY 2026 SNF QRP

- For purposes of the FY 2026 SNF QRP, SNFs would be required to report the measure beginning with Medicare Part A residents discharged on October 1, 2024.
- Beginning with the FY 2027 SNF QRP, SNFs would be required (starting in the CY 2025 reporting year) to submit data for the entire CY.
- In order for SNFs to report on the proposed measure, CMS proposes to add to the MDS a new item to collect information on whether a resident is up to date with their COVID-19 vaccine at the time of discharge from the SNF.

2. Proposal to Increase the SNF QRP Data Completion Threshold for the MDS Data Items Beginning with the FY 2026 SNF QRP

Beginning with the FY 2026 SNF QRP, SNFs would be required to report (starting in the CY 2024 reporting year) 100 percent of the required quality measure data and standardized resident assessment data collected using the MDS on at least 90 percent of the assessments SNFs submit. If a SNF does not meet the proposed requirement, the SNF would be subject to a reduction of 2 percentage points to the applicable FY annual payment update beginning with the FY 2026 SNF QRP.

G. Public Display of Measure Data for the SNF QRP

1. Background

The Secretary must establish procedures for making the SNF QRP data available to the public after SNFs have the opportunity to review data specific to the SNF involved, in accordance with section 1899B(g) of the Act.

2. Proposed Public Reporting of the Transfer of Health (TOH) Information to the Provider – Post-Acute Care (PAC) Measure and Transfer of Health Information to the Patient – PAC Measure Beginning with the FY 2025 SNF QRP

These 2 assessment-based measures were adopted in the FY 2020 SNF final PPS rule. After delayed compliance dates for collecting and reporting due to the COVID-19 PHE, data collection for the measures will begin with residents discharged on or after October 1, 2023. CMS proposes to publicly display four rolling quarters of the data received, initially using data on discharges from January 1, 2024, through December 31, 2024. CMS would begin publicly displaying data for the measures beginning with the October 2025 Care Compare refresh or as soon as technically feasible. CMS would not publicly report a SNF's performance on a measure if the SNF had fewer than 20 eligible cases in any four consecutive rolling quarters for that measure.

3. Proposed Public Reporting of the DC Score Measure Beginning with the FY 2025 SNF QRP

CMS proposes to begin public display of data for the DC Function measure beginning with the October 2024 refresh of Care Compare or as soon as technically feasible, and will use data collected from January 1, 2023, through December 31, 2023. Provider preview reports would be

provided to SNFs in July 2024, or as soon as feasible; thereafter, SNFs measure scores would be publicly displayed based on 4 quarters of data and updated quarterly. CMS would not publicly report a SNF's performance on a measure if the SNF had fewer than 20 eligible cases in any quarter for that measure.

4. Proposed Public Reporting of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning with the FY 2026 SNF QRP

CMS proposes to begin public display of data for the measure with the October 2025 refresh of Care Compare or as soon as technically feasible, and will use data collected from the fourth quarter of 2024. Provider preview reports would be distributed to SNFs in July 2025 for data collected in Q4 of 2024 and thereafter the data would be publicly displayed based on one quarter of data updated quarterly. A SNF's performance on the measure would not be publicly reported if the SNF had fewer than 20 eligible cases in the quarter.

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

In this rule, CMS proposes substantial changes to the SNF VBP Program. Most stem from provisions of the Consolidated Appropriations Act, 2021 (CAA, 2021) that permit the Secretary to expand the Program measures. All proposals in this section of the rule are open to comment.

> The SNF VBP Program was implemented for discharges beginning in FY 2019 and applies to all SNFs paid under the SNF PPS: freestanding, affiliated with acute care facilities, and non-CAH swing-bed rural facilities. Measures for the program and a performance scoring methodology were adopted in the FY 2016 and 2017 SNF PPS final rules. An Extraordinary Circumstances Exception (ECE) policy was finalized for FY 2019; the FY 2019 and FY 2020 final rules added scoring adjustments and data suppression policies for low-volume facilities. In response to the COVID-19 PHE, in the FY 2022 and 2023 final rules, CMS implemented a cross-program measure suppression policy for the duration of the PHE,[29] accompanied by a special scoring policy for the SNF VBP Program for the FY 2022 and 2023 program years. In the FY 2023 final rule, CMS modified the SNF 30-Day All-Cause Readmission Measure beginning with the FY 2023 program year by adding a risk-adjustment variable for both patients with COVID-19 during the prior proximal hospitalization (PPH) and patients with a history of COVID-19.

Currently, the SNF VBP Program withholds 2.0 percent of the payments that would be made to SNFs and redistributes approximately 60 percent of the money withheld for redistribution based on performance on a readmission measure. Specifically, amounts redistributed are delivered by applying a value-based incentive adjustment at the individual claim-level to each SNF's adjusted FY federal per diem rate. The remaining 40 percent is returned as savings to the Medicare program, minus funds used for adjustments made according to low-volume facility policies. CMS estimates that if all of the changes proposed for the Program are finalized, approximately $462.12 million will be withheld from SNFs and $277.27 million will be redistributed among

[29] The cross-program measure suppression policy is applicable across CMS' VBP programs (SNF VBP, Hospital VBP, Hospital Readmissions Reduction, Hospital-Acquired Condition Reduction, and ESRD Quality Incentive).

SNFs as value-based incentive payments in FY 2024. Approximately $184.85 million will be returned through the SNF VBP Program to the Medicare Program as savings in FY 2024.

More information on the SNF VBP Program can be found on the CMS web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.

A. SNF VBP Program Measures

Section 1888(g) mandates the adoption of certain measures, and section 111 of CAA, 2021 amended section 1888(h) of the Act to permit CMS to add up to 10 additional measures to the SNF VBP Program, as the agency determines to be appropriate. These new measures could be applied to payments beginning on or after October 1, 2023. Measures adopted thus far into the SNF VBP Program are as follows:

- The SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510), which is required under section 1888(g)(1) of the Act.
- The Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure (SNFPPR), which is required under section 1888(g)(2) of the Act.
- The Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) measure was finalized beginning with the FY 2026 Program Year.
- The Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure was finalized beginning with the FY 2026 Program Year.
- The Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF) measure was finalized beginning with the FY 2027 Program Year.

Currently, only the SNFRM is in use. CMS plans to comply with the statutory mandate to replace the SNFRM with the SNFPPR once the latter is NQF-endorsed.

CMS invites comment on all of the following measure proposals.

1. SNFPPR Measure Specifications Refinement and Measure Name Update

CMS proposes to refine the SNFPPR measure specifications as follows:

- Change the outcome observation window from a fixed 30-day window following acute care hospital discharge to within the SNF stay; and
- Change the length of time allowed between a qualifying prior proximal inpatient discharge (i.e., the inpatient discharge that occurs before admission to the index SNF stay) and SNF admission from one day to 30 days.

To align with those measure refinements, CMS would update the measure name to the "Skilled Nursing Facility **Within-Stay** Potentially Preventable Readmission (SNF **WS** PPR) Measure" [emphasis added].

a. Overview of Proposed Updated Measure

The SNF WS PPR outcome measure would estimate the risk-standardized rate of unplanned, potentially preventable readmissions (PPR) that occur during SNF stays among Medicare FFS beneficiaries. It reflects readmission rates for residents readmitted to a short-stay acute-care hospital or long-term care hospital (LTCH) with a principal diagnosis considered to be unplanned and potentially preventable while within SNF care.

The measure is risk-adjusted and calculated using 2 consecutive years of Medicare FFS claims data. Specifically, the stay construction, exclusions, and risk-adjustment model use data from Medicare eligibility files and inpatient hospital claims. CMS does not believe adoption of the measure would impose any additional data collection or submission burden for SNFs because it is calculated entirely using administrative data.

CMS tested the updated measure for reliability and validity. It was found to have good reliability, and validity tests showed it can accurately predict PPRs while controlling for differences in resident case-mix. For the updated measure's technical specifications, see https://www.cms.gov/files/document/snfvbp-snfwsppr-draft-technical-measure-specification.pdf. The Measure Applications Partnership (MAP) conditionally supported the measure contingent on NQF endorsement.[30]

b. Measure Specifications

Denominator. The measure denominator is the risk-adjusted "expected" number of residents with a PPR that occurred during the SNF stay. The estimate includes risk adjustment for certain resident characteristics without the facility effect (see below). The "expected" number of residents with a PPR is derived from the predicted number of residents with a PPR if the same residents were treated at the average SNF; an average SNF means a SNF whose facility effect is zero.

Inclusions. Medicare FFS beneficiaries who are admitted to a SNF during a 2-year measurement period who are not excluded. Each stay of a SNF resident with multiple stays during the 2-year readmissions window is separately eligible for inclusion. The index SNF admission must have occurred within 30 days of discharge from a prior proximal hospital (PPH) stay (an inpatient stay in an IPPS hospital, a CAH, or an inpatient psychiatric facility).
Exclusions. There are 11 exclusions (e.g., age, enrollment, more than 30-day gap between PPH discharge and SNF admission, certain cancer treatment, pregnancy, care furnished by provider outside the U.S.) that are fully described in the measure's specifications.

Numerator. The measure numerator is the risk-adjusted "predicted" estimate of the number of residents with an unplanned PPR that occurred during a SNF stay. The unadjusted, observed count of the measure outcome (i.e., the number of residents with an unplanned PPR during a SNF stay) is risk-adjusted for resident characteristics and a statistical estimate of the SNF's

[30] https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.

facility effect. An unplanned PPR is a readmission from a SNF to an acute care hospital or a LTCH, with a diagnosis considered to be unplanned and potentially preventable.

The numerator only includes unplanned PPRs that occur during the within-SNF stay period (i.e., from the date of the SNF admission through and including the date of discharge), which can be a hospital readmission that occurs within the SNF stay or a direct transfer to a hospital on the date of the SNF discharge. Planned readmissions and readmissions to inpatient psychiatric facilities are not included in the numerator.

c. Risk Adjustment

The updated measure is risk adjusted; it uses a hierarchical logistic regression risk model to estimate the effect of resident characteristics on the probability of readmission across all SNFs and the effect of each SNF on readmissions that differs from that of the average SNF ("facility effect"). The denominator is risk-adjusted only for resident characteristics, and the numerator is risk-adjusted for both resident characteristics and the facility effect. The preamble lists 9 specific risk adjustment variables, which include age and sex category, disability, ESRD, surgical category, principal PPH inpatient diagnosis, comorbidities from secondary diagnoses on PPH inpatient claim, PPH length of stay, prior ICU or CCU use, and number of prior acute care hospital discharges in the preceding year.

d. Measure Calculation

The provider-level risk-standardized readmission rate (RSRR) of unplanned PPRs is calculated by multiplying the standardized risk ratio (SRR) by the mean readmission rate in the population (i.e., all Medicare FFS residents included in the measure). CMS would calculate the standardized risk ratio by dividing the predicted number of readmissions at the SNF by the expected number of readmissions for the same residents if treated at the average SNF. A lower score on this measure indicates better performance. For more details on the calculation, see https://www.cms.gov/files/document/snfvbp-snfwsppr-draft-techical-specification.pdf.

e. Proposed Scoring of SNF Performance on the SNF WS PPR Measure

Because a lower score might be interpreted by the public to be an indicator of poor performance, the agency proposes to apply its measure rate inversion scoring policy that is used for the SNFRM to the updated SNF WS PPR measure. It would calculate the score as follows so a higher score reflects better performance:

SNF WS PPR Inverted Rate = 1 – Facility's SNF WS PPR Risk Standardized Rate

h. Confidential Feedback Reports and Public Reporting for the Proposed SNF WS PPR Measure

Starting with program year 2028, CMS proposes to apply requirements for confidential feedback reports and public reporting of measures under §413.338(f) to the SNF WS PPR measure.

2. Proposal to Replace the SNFRM with the SNF WS PPR Measure Beginning with the FY 2028 SNF VBP Program Year

CMS proposes to replace the SNFRM with the proposed SNF WS PPR measure beginning with the FY 2028 program year. The proposed SNF WS PPR would have a 2-year performance period, and CMS believes the earliest the first performance period could occur is FY 2025 and FY 2026 (October 1, 2024 through September 30, 2026). The proposed first performance period would afford the agency adequate time to calculate and announce the performance standards for the proposed SNF WS PPR measure at least 60 days before the beginning of that performance period. Additionally, net payment adjustments for SNFs must be announced no later than 60 days before the start of the applicable fiscal year.

3. Quality Measure Proposals for the SNF VBP Expansion Beginning with the FY 2026 Program Year

As noted above, in the FY 2023 final rule, CMS adopted the SNF HAI measure; the Total Nurse Staffing measure; and the DTC PAC SNF measure. The SNF HAI and Total Nurse Staffing measures were adopted beginning with the FY 2026 program year/FY 2024 performance period. The DTC PAC SNF measure was adopted beginning with the FY 2027 program year, and FY 2024 and FY 2025 is the first performance period.

CMS proposes to adopt 1 new measure to the SNF VBP measure set beginning with the FY 2026 program year and 3 new measures for the FY 2027 program year as follows:

- FY 2026 program year/FY 2024 performance period: Total Nursing Staff Turnover ("Nursing Staff Turnover") measure.
- FY 2027 program year/FY 2025 performance period:
    - Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) ("Falls with Major Injury (Long-Stay)") measure.
    - Discharge Function Score for SNFs ("DC Function measure").
    - Number of Hospitalizations per 1,000 Long Stay Resident Days ("Long Stay Hospitalization") measure.

Table 17 in the proposed rule (reproduced below) lists the SNF VBP measures—current and proposed—and the first program year and performance period. Data on five measures would be collected starting with the FY 2024 performance period and data on another four measures, for a total of 9, would be collected starting with the FY 2025 performance period.

Measure Name	Measure Short Name	Measure Status	First Program Year	First Performance Period*
SNF 30-Day All-Cause Readmission Measure	SNFRM	Adopted, implemented	FY 2017**	FY 2015
SNF Healthcare-Associated Infections Requiring Hospitalization Measure	SNF HAI Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nurse Staffing Hours per Resident Day Measure	Total Nurse Staffing Measure	Adopted, not implemented	FY 2026	FY 2024

Measure Name	Measure Short Name	Measure Status	First Program Year	First Performance Period*
Total Nursing Staff Turnover Measure	Nursing Staff Turnover Measure	Proposed	FY 2026+	FY 2024
Discharge to Community – Post-Acute Care Measure for SNFs	DTC PAC SNF Measure	Adopted, not implemented	FY 2027	FY 2024 and FY 2025
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure	Falls with Major Injury (Long-Stay) Measure	Proposed	FY 2027+	FY 2025
Discharge Function Score for SNFs Measure	DC Function Measure	Proposed	FY 2027+	FY 2025
Number of Hospitalizations per 1,000 Long Stay Resident Days Measure	Long Stay Hospitalization Measure	Proposed	FY 2027+	FY 2025
SNF Within-Stay Potentially Preventable Readmissions Measure	SNF WS PPR Measure	Proposed	FY 2028+	FY 2025 and FY 2026

*For each measure, CMS has adopted or is proposing to adopt a policy to automatically advance the beginning of the performance period by 1 year from the previous program year. See section VII.C.3 of the proposed rule for additional information.
** Proposed to be replaced with the SNF WS PPR measure beginning with the FY 2028 program year.
+ Proposed first program year in which the measure would be included in the Program.

a. Total Nursing Staff Turnover Measure

Citing several studies, CMS expresses concern that higher turnover rates of nursing staff is associated with poorer quality of care for SNF residents. The agency believes adding a nursing staff turnover measure to the SNF VBP Program would provide a comprehensive assessment of the quality of care provided to residents and drive improvements in nursing staff turnover, which CMS views will likely translate into positive resident outcomes. It also believes this measure would complement the Total Nurse Staffing measure and proposes to adopt it beginning with the FY 2026 program year. The Nursing Staff Turnover measure is measured and publicly reported for nursing facilities on the Care Compare website and is used in the Five-Star Quality Rating System.[31] The MAP offered conditional support of the Nursing Staff Turnover measure for rulemaking, contingent upon endorsement by the consensus-based entity.[32]

Description. The measure is a structural measure that uses auditable electronic data reported to CMS' Payroll-Based Journal (PBJ) system to calculate annual turnover rates for nursing staff, including RNs, LPNs, and nurse aides. The measure is constructed using daily staffing information submitted through the PBJ system by nursing facilities; turnover is identified based on gaps in days worked and individuals are identified by the employee ID and SNF identifiers in the PBJ data. The PBJ staffing data are electronically submitted and auditable back to payroll and other verifiable sources.

[31] https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
[32] https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.

Denominator. All eligible employees (i.e., RNs, LPNs, and nurse aides who are regular employees and agency staff) who work at a Medicare certified SNF and use the same job category codes as other nurse staffing measures that are reported on the Care Compare website. To be counted in the denominator, eligible employees must work at least 120 hours in a 90-day period. CMS sates that the timeframe for the 90-day period begins on the first workday observed during the quarter prior to the start of the performance period (the "baseline quarter") and ends on the last workday of the last month of the second quarter of the performance period.

Exclusions. SNFs would be excluded in the following circumstances:

- A SNF with 100 percent total nursing staff turnover for any day in the six-quarter period during which there were at least five eligible nurse staff. (CMS states that a 100 percent daily turnover is typically the result of changes in the employee IDs used by SNFs and does not reflect actual staff turnover.)
- A SNF that does not submit staffing data or submitted data that are considered invalid (using the current exclusion rules for the staffing domain) for one or more of the quarters used to calculate the Nursing Staff turnover measure.
- A SNF that does not have resident census information (derived from MDS assessments).
- A SNF with fewer than five eligible nurses (RNs, LPNs and nurse aides) in the denominator.

Numerator. Eligible employees included in the denominator and who are not identified in the PBJ data as having worked at the SNF for at least 60 consecutive days during the performance period. The 60-day gap must start during the period covered by the turnover measure, and the turnover date is defined as the last workday prior to the start of the 60-day gap.

Measure Calculation. CMS proposes to calculate the Nursing Staff Turnover measure rate for the SNF VBP Program using the following formula:

$$\textit{Total Nursing Staff Turnover Rate} = \frac{Total\ number\ of\ employment\ spells\ that\ ended\ in\ turnover}{Total\ number\ of\ eligible\ employment\ spells}$$

The measure would be calculated using six consecutive quarters of PBJ data. Data from a baseline quarter[33] (Q0) and the first two quarters of the performance period are used to identify employees in the denominator. Data from the four quarters of the performance period (Q1 through Q4) are used to identify the number of employment spells that ended in turnover for the numerator. An employment spell is a continuous period of work. Data from the sixth quarter (Q5), which occurs after the four-quarter numerator (performance) period, are used to identify gaps in days worked that started in the last 60 days of the fifth quarter (Q4) used for the measure. To calculate the measure score, CMS would first determine the measure denominator by identifying the total number of employment spells, and then calculate the numerator as the total number of employees who had a 60-day gap during the performance period.

[33] The baseline quarter is specific to this measure calculation and not related to the SNF VBP Program's measure baseline period, which is part of the performance standards used to score the measure. The baseline quarter is the quarter prior to the first quarter of either the baseline period or the performance period for a program year.

Scoring of Measure. Because a lower score might be interpreted by the public to be an indicator of poor performance, the agency proposes to apply its measure rate inversion scoring policy and would calculate the score as follows so a higher score reflects better performance:

Nursing Staff Turnover Inverted Rate = 1 – Nursing Staff Turnover Rate

Confidential Feedback Reports and Public Reporting (§413.338(f)). Starting with program year 2026, CMS proposes to apply requirements for confidential feedback reports and public reporting of measures to the Nursing Staff Turnover measure.

b. Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure

Noting that falls are the leading cause of injury-related death among persons aged 65 years and older, CMS proposes to add this outcome measure to the SNF VBP Program's measure set beginning with program year FY 2027.

Description. The measure is a patient safety measure reported at the facility level reports. It reports the percentage of long-stay residents in a nursing home who have experienced one or more falls with major injury using 1 year of data from the Minimum Data Set (MDS) 3.0 that is collected through the Resident Assessment Instrument (RAI). A major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural. A long-stay resident is one who has received 101 or more cumulative days of nursing home care by the end of the measure reporting period (performance period). For the measure's specifications, see https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqiqualitymeasures.

CMS adopted a similar measure for the SNF QRP, titled Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (80 FR 46440 through 46444), but that measure excludes long-stay residents. CMS believes the measure will help keep SNFs accountable for the quality of care provided to long-stay residents given that the majority of long-term care facilities are dually certified as SNFs and nursing facilities. Input from a TEP was supportive of such a measure, and the MAP supported the Falls with Major Injury (Long-Stay) measure for rulemaking, noting that the measure would add value to the Program because of the lack of an existing falls measure and that it would help improve patient safety. Because the measure is calculated using data from the MDS which is already required to be reported by SNFs and NFs, CMS states the measure would not impose any additional data collection or submission burden for SNFs.

Denominator. All long-stay residents with one or more look-back scan assessments no more than 275 days prior to the target assessment. Residents returning to SNF following a hospital discharge would not have their cumulative days in the facility reset to zero; thus, the days of care from a previous admission would be added to any subsequent admissions.

CMS notes that the MDS includes a series of assessments and tracking documents, such as Omnibus Budget Reconciliation Act (OBRA) Comprehensive Assessments, OBRA Quarterly Assessments, OBRA Discharge Assessments, or PPS assessments. A target assessment, which presents the resident's status at the end of the episode of care or their latest status if their episode

of care is ongoing, is selected for each long-stay resident. Target assessments may be (i) an Omnibus Budget Reconciliation Act (OBRA) admission, quarterly, annual, or significant change/correction assessment; (ii) PPS 5-day assessments; or (iii) discharge assessment with or without anticipated return.

Exclusions.

- Residents if the number of falls with major injury was not coded for all of the look-back scan assessments.
- A SNF would not be scored on this measure if it does not have long-stay residents, or residents with 101 or more cumulative days of care.
- All SNF swing beds because swing beds are not used for long-stay residents.

Numerator. Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.

The selection period for the look-back scan is the target assessment and all qualifying earlier assessments in the scan. CMS indicates that an assessment should be included in the scan if it meets all of the following conditions: (i) it is contained within the resident's episode, (ii) it has a qualifying Reason for Assessment (RFA), (iii) its target date is on or before the target date for the target assessment, and (iv) its target date is no more than 275 days prior to the target date of the target assessment. The term "target date" means the event date of an MDS record (i.e., entry date for an entry record or discharge date for a discharge record or death-in-facility record) or the assessment reference date for all other records.

Risk adjustment. There is no risk adjustment for this measure.

Measure calculation. The Falls with Major Injury (Long-Stay) measure is calculated and reported at the facility level.[34] CMS proposes to determine the measure denominator by identifying the total number of long-stay residents who have a qualifying target assessment, who have one or more look-back scan assessments, and who do not meet the exclusion criteria. To calculate the numerator, CMS would identify the total number of those residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury. The numerator would then be divided by the denominator and multiplied by 100 for the percentage of long-stay residents who experience one or more falls with major injury. A lower measure rate indicates better performance on the measure.

Scoring of Measure. Because a lower score might be interpreted by the public to be an indicator of poor performance, the agency proposes to apply its measure rate inversion scoring policy and would calculate the score as follows so a higher score reflects better performance:

Falls with Major Injury (Long Stay) Inverted Rate = 1 – (Facility's Falls with Major Injury (Long Stay) Rate / 100)

[34] For more detail on the measure calculation, see https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqiqualitymeasures.

Confidential Feedback Reports and Public Reporting (§413.338(f)). Starting with program year 2026, CMS proposes to apply requirements for confidential feedback reports and public reporting of measures to the Falls with Major Injury (Long Stay) measure.

c. Discharge Function Score

As noted in section VI.C.1.b of the summary above describing proposals for the SNF QRP, CMS proposes to adopt the Discharge Function Score ("DC Function") measure beginning with the FY 2025 SNF QRP. The agency also proposes to adopt this same measure for the SNF VBP Program beginning with the FY 2027 program year. Please see section VI.C.1.b of the summary above for a description of this measure, its calculation, and other relevant matters.

CMS believes SNFs have had sufficient time to ensure successful reporting of the data elements needed for the DC Function measure. CMS believes there would be no additional burden for SNFs because the measure would be calculated using data that are already reported to CMS for payment and quality reporting purposes.

d. Number of Hospitalizations per 1,000 Long Stay Resident Days

CMS cites studies that have found that many unplanned hospitalizations could have been safely avoided by early intervention by the facility, and notes that data on Care Compare show considerable variation in performance across nursing homes regarding unplanned hospitalizations. It proposes to adopt the Number of Hospitalizations per 1,000 Long Stay Resident Days Measure ("Long Stay Hospitalization measure") beginning with the FY 2027 SNF VBP Program. CMS observes that the use of the measure may raise concerns about its use in the SNF VBP program, but it nonetheless believes the Long Stay Hospitalization measure to be a better way to capture the quality of care provided to the entirety of the population that resides in facilities that are dually certified as SNFs and NFs. The MAP offered conditional support of the measure for rulemaking, contingent upon endorsement by the consensus-based entity.[35]

Description. This risk-adjusted, outcome measure calculates the number of unplanned inpatient admissions to an acute care hospital or critical access hospital, or outpatient observation stays (regardless of diagnosis), that occurred among long-stay residents per 1,000 long-stay resident days, using one year of FFS claims data. CMS would use inpatient hospital claims data to determine the hospital admission, outpatient hospital claims data to determine the outpatient observation stay, and items from the MDS for resident stays and for risk-adjustment.

A day would be counted as a long-stay day if it occurs after a resident's one-hundredth cumulative day in the nursing home, or the beginning of the 12-month target period (whichever is later), until the day of discharge, the day of death, or the end of the 12-month target period (whichever is earlier).

Denominator. A Medicare beneficiary enrolled in both Parts A and B with a single stay, or sequence of stays, during which the individual resides in the nursing home for a total of 101 days or more without a gap of 30 contiguous days living in the community or other institution. The

[35] https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.

denominator is the total number of days (in thousands) during the target period that all long-stay residents were in the nursing home facility after they obtained long-term resident status.

Exclusions.

- Residents enrolled in Medicare managed care during any portion of their stay.
- Days and any hospital admissions during which the resident was enrolled in hospice.

The measure does not count long-stay days before the beginning of the applicable performance period or any days before the resident's 101st cumulative day. Any days a resident was not in the facility for any reason are not counted. For example, days the resident is admitted to another inpatient facility or residing in the community if the facility with NF beds that are also certified as SNF beds submits an MDS discharge assessment for the temporary discharge.

A resident who spends 31 or more consecutive days residing outside the facility with NF beds that are also certified as SNF beds would be considered discharged. If that resident were admitted to the same facility within 30 days, they would still be considered in long-stay status and the days in this admission would be counted in the denominator.

Numerator. The numerator includes all inpatient hospital admissions or outpatient observation stays for Medicare beneficiaries who:

- met the inclusion criteria for the denominator;
- were admitted to an acute care or critical access hospital for an inpatient stay or outpatient observation stay while they were residing in the nursing home and not enrolled in hospice; and
- were not admitted for a planned hospital inpatient admission (identified using principal discharge diagnosis and procedure codes on Medicare claims for the inpatient stay).

Risk adjustment. CMS proposes to use a negative binomial regression risk adjustment model for this measure. It would risk adjust the observed number of hospitalizations after the resident met the long-stay status to determine the expected number of hospitalizations for each long-stay resident given the resident's clinical and demographic profile. Using data derived from Medicare inpatient claims, the measure would risk adjust for age, sex, number of hospitalizations in the 365 days before the day the resident became a long-stay resident or the beginning of the 1-year measurement period (whichever is later), and an outcome-specific comorbidity index. The MDS-based covariates span multiple domains including functional status, clinical conditions, clinical treatments, and clinical diagnoses. For more details, see https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Nursing-Home-Compare-Claims-based-Measures-Technical-Specifications-April-2019.pdf.

Measure calculation. The risk adjusted rate is calculated by dividing the observed Long Stay Hospitalization rate by the expected Long Stay Hospitalization rate, which is multiplied by the national Long Stay Hospitalization rate.

To calculate the observed Long Stay Hospitalization rate, CMS would divide the risk-adjusted expected number of hospital admissions or observation stays by the actual total number of long-stay days that met the inclusion criteria; that quotient would then be divided by 1,000 days.

To calculate the national Long Stay Hospitalization rate, CMS would divide the total number of hospital admissions or observation stays that met the numerator criteria by the total number of long-stay days that met the denominator criteria; that quotient would then be divided by 1,000.

Scoring of Measure. Because a lower score might be interpreted by the public to be an indicator of poor performance, the agency proposes to apply its measure rate inversion scoring policy and would calculate the score as follows so a higher score reflects better performance:

Long Stay Hospitalization Inverted Rate = 1 – (Long Stay Hospitalization Risk Standardized Rate / 1000)

Confidential Feedback Reports and Public Reporting (§413.338(f)). Starting with program year 2026, CMS proposes to apply requirements for confidential feedback reports and public reporting of measures to the Long Stay Hospitalization measure.

B. SNF VBP Performance and Baseline Periods

1. Background

Under established policy, CMS automatically adopts the performance period and baseline period for a SNF VBP program year by advancing the performance period and baseline period by 1 year from the previous program year. In the FY 2023 SNF PPS final rule CMS applied this policy for three new quality measures (i.e., the SNF HAI measure, the Total Nurse Staffing measure, and the DTC PAC SNF measure) beginning with the FY 2026 program year.

2. SNFRM Performance and Baseline Periods for the FY 2024 Program Year

CMS reminds readers that, due to the impact of the COVID-19 PHE, the baseline and performance periods for the SNFRM for the FY 2024 program year were updated as follows:

- the baseline period is FY 2019, and
- the performance period is FY 2022.

3. Proposed Performance Periods and Baseline Periods for the Nursing Staff Turnover, Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization Measures

CMS believes that the performance periods for these measures should occur two fiscal years before the applicable fiscal program year and that baseline periods that occur 4 fiscal years prior to the applicable fiscal program year, and 2 fiscal years prior to the performance periods, are most appropriate for these measures. Thus, it proposes the following performance and baseline periods:

Measure	Performance Period	Baseline period
Nursing Staff Turnover	FY 2024	FY 2022
Falls with Major Injury (Long-Stay)	FY 2025	FY 2023
DC Function	FY 2025	FY 2023
Long Stay Hospitalization	FY 2025	FY 2023

CMS also proposes to apply its policy to automatically adopt the performance period for a SNF VBP program year by advancing the beginning of the performance periods and baseline periods by 1 year from the previous program year for these measures.

4. Proposed Performance Periods and Baseline Periods for the SNF WS PPR Measure Beginning with the FY 2028 SNF VBP Program Year

Because the proposed SNF WS PPR measure is calculated using 2 consecutive years of Medicare FFS claims data, CMS proposes to adopt a 2-year performance period and a 2-year baseline period for this measure. Thus, the performance period for this measure for the FY 2028 SNF VBP program year would be FY 2025 and FY 2026, and the baseline period for the measure would be FY 2022 and FY 2023 for the FY 2028 SNF VBP program year.

CMS also proposes to apply its policy to automatically adopt the performance period for a SNF VBP program year by advancing the beginning of the performance periods and baseline periods by 1 year from the previous program year for these measures.

As noted above, CMS proposes to replace the SNFRM measure with the SNF WS PPR measure beginning with the FY 2028 program year. Because the SNF WS PPR measure is a 2-year measure and the SNFRM is a 1-year measure, the data used to calculate the baseline and performance period for the SNF WS PPR measure for the FY 2028 program year would include data that is also used to calculate the baseline and performance period for the SNFRM for the FY 2027 program year. CMS believes the overlap is necessary to ensure that that the transition from the SNFRM to the SNF WS PPR is seamless, without any gaps in the use of either measure.

C. Performance Standards

CMS is not proposing any changes to the performance standards policies previously established, including the numerical values established for FY 2024 and FY 2025.

CMS proposes SNF VBP estimated performance standards for program year FY 2026, shown below in Table 19 reproduced from the rule.

Estimated FY 2026 SNF VBP Program Performance Standards		
Measure Short Name	**Achievement Threshold**	**Benchmark**
SNFRM	0.78526	0.82818
SNF HAI Measure	0.91468	0.94766
Total Nurse Staffing Measure	3.33289	5.98339
Nursing Staff Turnover Measure	0.37500	0.72925

The baseline and performance periods for the DTC PAC SNF measures, adopted for the FY 2027 program year, are 2 consecutive years; FY 2024 and FY 2025 is the performance period for the DTC PAC SNF measure for the FY 2027 program year. The estimated numerical performance standards for the DTC PAC SNF measure for the FY 2027 program year are as follows:

Estimated FY 2027 SNF VBP Program DTC PAC Performance Standards		
Measure Short Name	**Achievement Threshold**	**Benchmark**
DTC PAC SNF Measure	0.44087	0.68956

D. SNF VBP Performance Scoring

1. Proposed Case Minimum and Measure Minimum Policies

As noted above, CMS proposes to adopt the Nursing Staff Turnover measure beginning with the FY 2026 program year; the Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures beginning with the FY 2027 program year; and the SNF WS PPR measure beginning with the FY 2028 program year. Thus, it proposes to adopt case minimums for the new measures and to update the previously finalized measure minimum for the FY 2027 program year.

a. Case Minimums by Measure and Program Year

CMS proposes the following case minimums:

Measure Short Name	Program Year	Case Minimum
Nursing Staff Turnover	FY 2026	(i) at least 1 eligible stay during the 1-year performance period, and (ii) at least 5 eligible nursing staff (RNs, LPNs, and nurse aides) during the 3 quarters of PBJ data included in the measure denominator

Measure Short Name	Program Year	Case Minimum
Falls with Major Injury (Long-Stay)	FY 2027	At least 20 residents in the measure denominator during the 1-year performance period
DC Function	FY 2027	At least 20 eligible stays during the 1-year performance period
Long Stay Hospitalization	FY 2027	At least 20 eligible stays during the 1-year performance period
SNF WS PPR	FY 2028	At least 25 eligible stays during the 2-year performance period

CMS believes the proposed case minimums appropriately a balance quality measure reliability with the agency's goal to score as many SNFs as possible on the measures.

b. Measure Minimums by Program Year

FY 2026. For program year FY 2026, CMS previously finalized that an eligible SNF must meet the case minimums for 2 of the 3 measures applicable for that year to receive performance scores and value-based incentive payments. Even though CMS proposes to adopt the new Nursing Staff Turnover measure for program year FY 2026, it would retain the 2-measure minimum. This policy is intended to ensure swing-bed facilities, which do not submit PBJ data, could still be included in the SNF VBP program.

FY 2027. For program year FY 2027, CMS previously finalized that an eligible SNF must meet the case minimums for 3 of the 4 measures applicable for that year. Because CMS proposes to adopt 3 additional measures for the FY 2027 program year, resulting in a measure set of eight, an eligible SNF would have to meet the case minimums for 4 of the 8 measures applicable for that year. Under the proposed case minimums, CMS estimates that roughly 8 percent of SNFs would be excluded from the SNF VBP for the FY 2027 program year.

2. Proposed Application of the SNF VBP Scoring Methodology to Proposed Measures

CMS proposes to award up to 10 points based on achievement, and up to nine points based on improvement, for the each of the proposed new measures described above, so long as the SNF meets the case minimum for the measure. Under previously established policies, the higher of the two scores (achievement or improvement) would be the SNF's score for the measure for the program year involved, except where the SNF does not meet the case minimum for the measure during the applicable baseline period, in which case that SNF would only be scored on achievement for the measure. Each SNF's raw point total would be normalized, based on the number of measures for which that SNF met the case minimum, to get a SNF Performance Score that is on a 100-point scale. Performance scores would only be awarded to SNFs that meet the measure minimum.

The raw point total would be 40 points for the FY 2026 program year and 80 points for the FY 2027 program year.

CMS also proposes a Health Equity Adjustment, which would allow a "top tier performing" SNF to earn up to two bonus points for each measure. See immediately below for more details.

3. Proposal to Incorporate Health Equity into the SNF VBP Program Scoring Methodology Beginning with the FY 2027 Program Year (§413.338(k))

a. Overview

Extensive background is provided on the need to address health disparities and the actions the agency has undertaken to do so. CMS believes the SNF VBP program can incentivize SNFs who serve a high proportion of underserved individuals to deliver high quality care.

Starting with the FY 2027 program year, CMS proposes to add a Health Equity Adjustment (HEA) to the normalized sum of a SNF's measure points on SNF VBP program measures. It would calculate the HEA using a methodology that considers both the SNF's performance on the SNF VBP Program measures, and the proportion of residents with dual eligibility status (DES) out of the total resident population in a given program year at each SNF. Skilled nursing facilities that serve a higher proportion of DES residents and that perform well on quality measures would receive a larger adjustment.

An analysis that used FY 2018-2021 measure data for the previously finalized and proposed measures, including a simulation of performance from all 8 finalized and proposed measures for the FY 2027 program year, found that the HEA significantly increased the proportion of SNFs with high proportions of DES residents that received a positive value-based incentive payment adjustment. CMS believes that its approach would modify the SNF VBP program to improve quality of care for underserved populations by providing needed resources.

b. Proposed HEA Beginning with the FY 2027 Program Year

For purposes of the HEA, CMS proposes to define underserved population as residents with DES and would only use DES data to identify SNF residents who are underserved. **It seeks comment on other indicators (e.g., LIS, ADI) to identify those who are underserved in future HEA proposals for the SNF VBP Program.**

A SNF would be assigned 2 points for each measure for which it is a "top tier performing" SNF. CMS proposes to define "top tier performing" SNF to mean a SNF whose score on the measure for the program year is in the top third of performance ($\geq 66.67^{th}$ percentile) on a given measure, and whose resident population during the performance period that applies to the program year includes at least 20 percent of residents with DES.

Each measure would be assessed independently, and HEA bonus points for one measure would not be conditioned on receiving HEA bonus points for another one. CMS would assign a measure performance scaler for each SNF that would equal the total number of assigned points

the SNF earns on each measure. Thus, if a SNF were top tier performer for each of the 8 measures, it would receive the maximum measure performance scaler of 16.

CMS proposes to define the term "underserved multiplier" for a SNF to mean the number representing the SNF's proportion of residents with DES out of its total resident population in the applicable program year, translated using a logistic exchange function. Underserved multipliers would be calculated for those SNFs with at least 20 percent of residents with DES during the applicable performance period.

CMS proposes to define the total resident population at each SNF as Medicare beneficiaries identified from the SNF's Part A claims during the performance period of the 1-year measures. The term residents with DES (or DES residents) would mean the percentage of Medicare SNF residents who are also eligible for Medicaid. Dual eligibility status would be assigned for any Medicare beneficiary who was deemed by Medicaid agencies to be eligible to receive Medicaid benefits for any month during the performance period of the 1-year measures.[36]

The agency proposes to define HEA bonus points for a SNF as the product of the SNF's measure performance scaler and the SNF's underserved multiplier. The HEA bonus points would then be added to the normalized sum of all points a SNF is awarded for each measure. The new definitions would be added to the regulations at §413.338(a).

c. Proposed Calculation Steps

As noted above, the HEA bonus points for a SNF would be calculated as follows:

$$\textit{HEA bonus points} = \textit{measure performance scaler} \times \textit{underserved multiplier}$$

CMS proposes the following four-step process for this calculation:

1. Calculate a measure performance scaler based on a SNF's score on each of the SNF VBP program measures. Top tier performing SNFs on that measure (i.e., those in the top third across all SNFs for that measure) would be assigned 2 points.

Top tier performance on each measure would be calculated by determining the percentile that the SNF falls in based on their score on the measure as compared to the score earned by other SNFs who are eligible to receive a score on the measure. If the SNF performs in the bottom two-thirds of performance on all measures, that SNF would be assigned a point value of 0 for each measure, resulting in a measure performance scaler of 0.

2. Calculate the underserved multiplier.

As noted above, CMS proposes to utilize a logistic exchange function to calculate the underserved multiplier for scoring SNFs such that there would be a lower rate of increase at the

[36] More information is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile and https://resdac.org/cms-data/variables/monthly-medicare-medicaid-dual-eligibility-code-january.

beginning and the end of the curve. The formula for the underserved multiplier using a logistic exchange function would be as follows:

$$underserved\ multiplier = \frac{1}{1 + e^{-12.5(percent\ of\ residents\ with\ DES - 0.6)}}$$

Due to the structure of the logistic exchange function, those SNFs with lower proportions of DES residents have smaller underserved multipliers than their actual proportion of residents with DES and those SNFs with higher proportions of SNF DES residents have underserved multipliers higher than their proportion of SNF residents with DES. Additional detail and examples are provided in the preamble.

A SNF that has a proportion of SNF residents with DES of less than 20 percent would be assigned an underserved multiplier of 0. CMS believes that the vast majority of SNFs would be able to earn HEA bonus points despite this 20 percent floor.

3. Calculate the HEA Bonus Points

CMS proposes to multiply the measure performance scaler by the underserved multiplier to calculate the HEA bonus points that may be awarded for a measure. Table 22 has examples of how the measure performance scaler and underserved multiplier would be used to calculate the bonus points.

4. Add HEA Bonus Points to the Normalized Sum of all Points Awarded for each Measure

CMS would add a SNF's HEA bonus points (calculated in Step Three) to the normalized sum of all points awarded to a SNF for each measure, which would be the SNF Performance Score earned by the SNF for the program year. However, CMS proposes to cap the SNF's Performance Score at 100 points.

d. Proposal to Increase the Payback Percentage to Support the HEA

CMS previously finalized 60 percent as the SNF VBP Program's payback percentage for FY 2019 and subsequent fiscal years, subject to increases needed to implement the Program's Low-Volume Adjustment policy for SNFs without sufficient data on which to base measure scores. Stakeholders over the years have urged CMS to increase the payback percentage. In conjunction with the HEA bonus point proposal, CMS proposes to increase the total amount available for a fiscal year to fund the value-based incentive payment amounts beginning with the FY 2027 program year.

CMS considered a fixed payback percentage (e.g., 65 percent) varying the payback percentage to ensure that SNFs that receive the HEA would not experience a decrease in their value-based incentive payment amount. After consideration of a number of variables described in the preamble, with examples shown in table 24, CMS proposes to vary the payback percentage by program year to account for the application of the HEA so that SNFs that do receive the HEA would not experience a decrease in their value-based incentive payment amount, to the greatest extent possible, relative to no HEA in the Program and maintaining a payback percentage of 60 percent.

For a program year, CMS would first calculate SNF value-based incentive payment amounts with a payback percentage of 60 percent without the application of the proposed HEA. Then it would identify which SNFs receive the HEA based on the proportion of DES residents and measure performance. Third, while maintaining the value-based incentive payment amounts calculated in the first step for those SNFs that do not receive the HEA, it would calculate the payback percentage needed to apply the HEA.

CMS notes that its proposal to add 2 bonus points per measure should not result in a payback increase beyond the statutory maximum of 70 percent. See table 25 of the rule for examples. **Comment is sought on the proposal for the variable payback percentage.**

e. Alternatives Considered

In lieu of an HEA, CMS considered the addition of risk adjustment to the payment methodology, peer grouping, or providing an opportunity to earn additional improvement points. CMS declined to pursue these options in favor of the HEA for various reasons. It reiterates that the HEA proposal would effectuate program goals of rewarding SNFs that overcome the challenges of caring for higher proportions of SNF residents with DES and incentivizing SNFs that have not achieved such high-quality care to work towards improvement. As the Program greatly expands beyond one measure, the agency hopes HEA will support high-quality care for all populations and recognize top tier performing SNFs serving residents with DES. **It seeks comment on the following issues**:

- Using the proportion of SNF residents with DES as a measure of the proportion of residents who are underserved.
- The requirement that a SNF be in the top third of performance for a measure to receive any points for the measure performance scaler.
- Assigning a point value of 2 for each measure as opposed to a higher point value such as 3.
- Using a logistic exchange function based off the proportion of SNF residents with DES to calculate the underserved multiplier.
- The requirement that a SNF's proportion of residents with DES be at least 20 percent for a SNF to be eligible for HEA bonus points.
- Increasing the payback percentage and allowing for it to vary such that SNFs that do receive the HEA would not experience a decrease in their value-based incentive payment amounts, to the greatest extent possible, relative to no HEA in the Program and maintaining a payback percentage of 60 percent.
- Adoption of the HEA proposal beginning with the FY 2027 program year.

4. <u>Health Equity Approaches Under Consideration for Future Program Years: Request for Information (RFI)</u>

In addition to its HEA proposal, CMS seeks to incentivize the achievement of health equity in the SNF VBP Program in other ways, such as focusing specifically on reducing disparities to ensure it is incentivizing improving care for all populations, including residents who may be

underserved, and ways to assess improvements in health equity in SNFs. In this RFI, **CMS seeks input** in four main topic areas:

a) Resident-level demographic and social risk indicators, as well as geographic-level indices that could be used to assess health equity gaps.

Comment is sought on which demographic variables, social risk indicators, or combination of indicators would be most appropriate for assessing disparities and measuring improvements in health equity in the SNF VBP Program for the health equity approaches described in the RFI.

b) Health equity advancement approaches that could be added to the Program and questions that should be considered for each.

CMS seeks to incentivize the advancement of health equity for all SNFs, focusing on improving care for all residents, including those who may currently face disparities in their care. Input is requested on potential approaches, including (i) applying points to current measures to assess health equity; (ii) new health equity focused measure(s), whether process, outcome or structural; (iii) composite measures; and (iv) different conceptual approaches to calculating disparities to assess health equity gaps.

c) Other approaches that could be considered for inclusion in the SNF VBP Program in conjunction with the approaches described in the second section.

CMS explored risk adjustment, stratification/peer grouping, and adding improvement points when developing the proposed HEA but had concerns with each of those approaches. However, it is considering one or more of these approaches in conjunction with the potential approaches described above in the second topic area.

d) Adopting domains that could incorporate health equity.

As the number of measures under the SNF VBP are increased, CMS is considering whether it should group the measures into measure domains, which would align the SNF VBP with the Hospital Value-Based Purchasing (VBP) Program. Comment is sought on whether quality domains should be added for future program years and whether those domains should be used to advance health equity in the Program.

E. Proposed Update to the Extraordinary Circumstances Exception Policy Regulation Text

The Extraordinary Circumstances Exception (ECE) policy for the SNF VBP Program under §413.338(d)(4) applies to the SNF Readmission Measure. To apply the ECE policy to additional quality measures, CMS proposes to modify the regulation text at §413.338(d)(4)(v) by removing specific references to the SNF Readmission Measure and substituting a more general statement that CMS would calculate a SNF performance score for a program year that does not include the SNF's "performance during the calendar months affected by the extraordinary circumstance." Comment is invited on this proposal.

F. Proposal to Update SNF VBP Program Validation Process

Section 1888(h)(12) of the Act requires the Secretary to apply a validation process to the SNF VBP Program measures and relevant data. In light of the number of previously finalized adopted measures and the additional measures proposed for adoption in this rule, CMS reviewed its existing validation process and the data sources for the new measures, and it makes the following proposals:

- To apply the validation process it adopted for the SNFRM to all claims-based measures;
- To adopt a validation process that would apply to SNF VBP measures for which the data source is PBJ data; and
- To adopt a validation process that would apply to SNF VBP measures for which the data source is MDS data.

The proposals only apply to the SNF VBP; CMS intends to propose a validation process for the SNF QRP in future rulemaking.

1. Application of the Existing Validation Process for the SNFRM to All Claims-Based Measures Reported in the SNF VBP Program

CMS proposes to expand the previously adopted SNFRM validation process and apply it to all claims-based measures, including the SNF HAI, Long Stay Hospitalization, DTC PAC SNF, and SNF WS PPR measures, as well as any other claims-based measures it may adopt for the SNF VBP in the future.

MACs validate information reported through claims for accuracy through software to determine whether billed services are medically necessary and should be covered by Medicare, review claims to identify any ambiguities or irregularities, and use a quality assurance process to help ensure quality and consistency in claim review and processing. They conduct prepayment and post-payment audits of Medicare claims, using both random selection and targeted reviews based on analyses of claims data. CMS would codify this proposal at §413.338(j).

2. Adoption of Validation Process that Applies to SNF VBP Measures Calculated Using PBJ Data

The Total Nurse Staffing measure and the Nursing Staff Turnover measure would be calculated using PBJ data that nursing facilities with SNF beds are already required to report to CMS. CMS proposes to adopt the existing PBJ data audit process for purposes of validating SNF VBP measures that are calculated using PBJ data. CMS would also codify this proposal at §413.338(j).

3. Adoption of Validation Process that Applies to SNF VBP Measures Calculated Using MDS Data

There is no current process to verify that the MDS data submitted by providers to CMS for quality measure calculations is accurate for use in SNF quality reporting and value-based purchasing programs. CMS proposes to adopt a new validation method for the SNF VBP

measures that are calculated using MDS data; the proposed method is similar to the one used to validate measures reported by hospitals under the Hospital IQR Program.

Under the proposed validation process:

(a) Each year, CMS would randomly select up to 1,500 active and current SNFs, including non-critical access hospital swing bed facilities providing SNF-level services, that submit at least one MDS record in the calendar year 3 years prior to the fiscal year of the relevant program year or were included in the SNF VBP Program in the year prior to the relevant program year.
(b) The validation contractor would request up to 10 randomly selected medical charts (either digital or paper copies) from each of the selected SNFs for each quarter that applies to validation.
(c) The SNF would have 45 days from the date of the request to submit the records to the validation contractor. If the SNF has not complied within 30 days, the validation contractor would send the SNF a reminder.

In future rulemaking, CMS intends to propose a penalty for SNFs that either do not submit the requested number of charts or that have not achieved a certain validation threshold as well as a process by which it would evaluate the submitted medical charts against the MDS to determine the validity of the MDS data used to calculate the measure results. **Comment is sought on the proposal.**

G. SNF Value-Based Incentive Payments for the FY 2024 Program Year

For the FY 2024 SNF VBP Program Year, CMS indicates that it will reduce SNFs' adjusted Federal per diem rates for the fiscal year by 2 percent (i.e., the applicable percentage specified under section 1888(h)(6)(B) of the Act), and will remit value-based incentive payments to each SNF based on their SNF Performance Score, which is calculated based on their performance on the Program's quality measure.

H. Public Reporting on the Provider Data Catalog Website

CMS does not make any proposals related to public reporting, but the preamble includes a description of the agency's past regulatory actions on this topic.

VII. Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount

Section 488.436 permits a facility to waive its right to a hearing and receive a 35 percent reduction in the amount of civil money penalties (CMPs) owed in lieu of contesting the enforcement action. The facility must submit a written waiver request to avail itself of this opportunity. CMS notes very high rates of waiver requests and extremely low rates of facilities that use the full hearing process over the years (roughly 4 percent).

CMS proposes to remove the requirement that a facility must submit a written request and substitute a constructive waiver process that would operate by default when a timely request for hearing is not received; the current 35 percent penalty reduction would continue to apply. Specifically, section 488.436(a) would be revised to state that a facility is deemed to have

waived its rights to a hearing if the 60-day time period for requesting a hearing has expired and timely request for a hearing has not been received. The regulation text would specify that the 35 percent reduction would be applied after the 60-day timeframe.

The agency would still have the opportunity (under §488.444) to settle CMP cases at any time before a final administrative decision for Medicare-only SNFs, State-operated facilities, or other facilities for which an agency enforcement action prevails, in accordance with §488.30. CMS does not believe its proposal to eliminate the requirement for a written waiver will negatively impact facilities; however, it welcomes comments from the public addressing any potential circumstances in which facilities' needs or the public interest could best be met or only be met by the use of an express, written waiver.

VIII. Economic Analyses

CMS estimates that under the proposed rule in FY 2024, SNFs would experience an increase of $1.2 billion in payments or an average increase of 3.7 percent across all SNFs. This impact reflects a $2.0 billion (6.1 percent) increase from the update to the payment rates and a $745 million decrease (2.3 percent) as a result of the second phase of the parity adjustment recalibration. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $184.85 million.

Table 35 of the proposed rule (reproduced below) shows the estimated impact of the proposed rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the parity adjustment recalibration and the budget neutral updates to the wage index data. The combined effects of all of these changes vary by specific type of providers and by location. For example, CMS estimates that due to the changes in this proposed rule, payment rates for SNFs in rural areas would increase by 3.0 percent overall compared with 3.8 percent for SNFs in urban areas.

Table 35: Impact to the SNF PPS for FY 2024

Impact Categories	Number of Facilities	Parity Adjustment Recalibration	Update Wage Data	Total Change
Group	-	-	-	
Total	15,435	-2.3%	0.0%	3.7%
Urban	11,206	-2.3%	0.1%	3.8%
Rural	4,229	-2.2%	-0.7%	3.0%
Hospital-based urban	359	-2.3%	0.1%	3.7%
Freestanding urban	10,847	-2.3%	0.1%	3.8%
Hospital-based rural	375	-2.2%	-0.4%	3.3%
Freestanding rural	3,854	-2.2%	-0.7%	3.0%
Urban by region	-	-	-	
New England	734	-2.3%	-0.7%	2.9%
Middle Atlantic	1,468	-2.4%	1.4%	5.1%
South Atlantic	1,935	-2.3%	0.0%	3.7%
East North Central	2,176	-2.3%	-0.7%	3.0%
East South Central	555	-2.2%	0.0%	3.7%

Impact Categories	Number of Facilities	Parity Adjustment Recalibration	Update Wage Data	Total Change
West North Central	957	-2.3%	-0.7%	3.0%
West South Central	1,432	-2.3%	0.0%	3.7%
Mountain	545	-2.3%	-0.8%	2.9%
Pacific	1,398	-2.4%	0.2%	3.7%
Outlying	6	-2.0%	-2.5%	1.4%
Rural by region	-	-	-	
New England	114	-2.3%	-1.0%	2.6%
Middle Atlantic	205	-2.2%	-0.4%	3.3%
South Atlantic	484	-2.2%	-0.1%	3.7%
East North Central	906	-2.2%	-0.8%	2.9%
East South Central	490	-2.2%	-1.0%	2.8%
West North Central	1,009	-2.2%	-0.9%	2.8%
West South Central	732	-2.2%	-0.5%	3.3%
Mountain	197	-2.3%	-0.6%	3.1%
Pacific	91	-2.3%	-2.0%	1.5%
Outlying	1	-2.3%	0.0%	3.6%
Ownership	-	-	-	
For profit	10,884	-2.3%	0.0%	3.7%
Non-profit	3,550	-2.3%	0.0%	3.6%
Government	1,001	-2.3%	-0.4%	3.3%

Note: The Total column includes the FY 2024 6.1 percent market basket update factor. The values presented in Table 35 may not sum due to rounding. CMS uses a multiplicative formula to derive total percentage change. This formula is (1 + Parity Adjustment Percentage) * (1 + Wage Index Update Percentage) * (1 + Payment Rate Update Percentage) – 1 = Total Percentage Change.

Appendix: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes

CMS notes that under PDPM providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim in order to bill for covered SNF services. The first character of the HIPPS code represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group "TA", then the first character in the patient's HIPPS code would be an A. Similarly, if the patient is classified into the SLP group "SB", then the second character in the patient's HIPPS code would be a B. The third character represents the Nursing group into which the patient classifies. The fourth character represents the NTA group into which the patient classifies. Finally, the fifth character represents the assessment used to generate the HIPPS code.

Tables 5 and 6 in the proposed rule (recreated below) show the case-mix adjusted federal rates and associated indexes for PDPM groups for urban and rural SNFs, respectively. In each table, Column 1 represents the character in the HIPPS code associated with a given PDPM component. Columns 2 and 3 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant PT group. Columns 4 and 5 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant OT group. Columns 6 and 7 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant SLP group. Column 8 provides the nursing case-mix group (CMG) that is connected with a given PDPM HIPPS character. For example, if the patient qualified for the nursing group CBC1, then the third character in the patient's HIPPS code would be a "P." Columns 9 and 10 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant nursing group. Finally, columns 11 and 12 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant NTA group.

Table 5: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN (Includes the Parity Adjustment Recalibration)

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$101.62	1.41	$91.97	0.64	$16.74	ES3	3.84	$469.06	3.06	$282.01
B	1.61	$112.83	1.54	$100.4 5	1.72	$45.00	ES2	2.90	$354.24	2.39	$220.26
C	1.78	$124.74	1.60	$104.3 7	2.52	$65.92	ES1	2.77	$338.36	1.74	$160.36
D	1.81	$126.84	1.45	$94.58	1.38	$36.10	HDE2	2.27	$277.28	1.26	$116.12
E	1.34	$93.91	1.33	$86.76	2.21	$57.81	HDE1	1.88	$229.64	0.91	$83.87
F	1.52	$106.52	1.51	$98.50	2.82	$73.77	HBC2	2.12	$258.96	0.68	$62.67
G	1.58	$110.73	1.55	$101.1 1	1.93	$50.49	HBC1	1.76	$214.98	-	-
H	1.10	$77.09	1.09	$71.10	2.7	$70.63	LDE2	1.97	$240.64	-	-
I	1.07	$74.99	1.12	$73.06	3.34	$87.37	LDE1	1.64	$200.33	-	-
J	1.34	$93.91	1.37	$89.37	2.83	$74.03	LBC2	1.63	$199.10	-	-
K	1.44	$100.92	1.46	$95.24	3.5	$91.56	LBC1	1.35	$164.90	-	-
L	1.03	$72.18	1.05	$68.49	3.98	$104.1 2	CDE2	1.77	$216.21	-	-
M	1.20	$84.10	1.23	$80.23	-	-	CDE1	1.53	$186.89	-	-
N	1.40	$98.11	1.42	$92.63	-	-	CBC2	1.47	$179.56	-	-
O	1.47	$103.02	1.47	$95.89	-	-	CA2	1.03	$125.81	-	-
P	1.02	$71.48	1.03	$67.19	-	-	CBC1	1.27	$155.13	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
Q	-	-	-	-	-	-	CA1	0.89	$108.71	-	-
R	-	-	-	-	-	-	BAB2	0.98	$119.71	-	-
S	-	-	-	-	-	-	BAB1	0.94	$114.82	-	-
T	-	-	-	-	-	-	PDE2	1.48	$180.78	-	-
U	-	-	-	-	-	-	PDE1	1.39	$169.79	-	-
V	-	-	-	-	-	-	PBC2	1.15	$140.47	-	-
W	-	-	-	-	-	-	PA2	0.67	$81.84	-	-
X	-	-	-	-	-	-	PBC1	1.07	$130.70	-	-
Y	-	-	-	-	-	-	PA1	0.62	$75.73	-	-

Table 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL (Includes the Parity Adjustment Recalibration)

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$115.83	1.41	$103.44	0.64	$21.09	ES3	3.84	$448.17	3.06	$269.43
B	1.61	$128.61	1.54	$112.97	1.72	$56.69	ES2	2.90	$338.46	2.39	$210.44
C	1.78	$142.19	1.60	$117.38	2.52	$83.06	ES1	2.77	$323.29	1.74	$153.21
D	1.81	$144.58	1.45	$106.37	1.38	$45.48	HDE2	2.27	$264.93	1.26	$110.94
E	1.34	$107.04	1.33	$97.57	2.21	$72.84	HDE1	1.88	$219.41	0.91	$80.13
F	1.52	$121.42	1.51	$110.77	2.82	$92.95	HBC2	2.12	$247.43	0.68	$59.87
G	1.58	$126.21	1.55	$113.71	1.93	$63.61	HBC1	1.76	$205.41	-	-
H	1.10	$87.87	1.09	$79.96	2.7	$88.99	LDE2	1.97	$229.92	-	-
I	1.07	$85.47	1.12	$82.16	3.34	$110.09	LDE1	1.64	$191.40	-	-
J	1.34	$107.04	1.37	$100.50	2.83	$93.28	LBC2	1.63	$190.24	-	-
K	1.44	$115.03	1.46	$107.11	3.5	$115.36	LBC1	1.35	$157.56	-	-
L	1.03	$82.28	1.05	$77.03	3.98	$131.18	CDE2	1.77	$206.58	-	-
M	1.20	$95.86	1.23	$90.23	-	-	CDE1	1.53	$178.57	-	-
N	1.40	$111.83	1.42	$104.17	-	-	CBC2	1.47	$171.56	-	-
O	1.47	$117.42	1.47	$107.84	-	-	CA2	1.03	$120.21	-	-
P	1.02	$81.48	1.03	$75.56	-	-	CBC1	1.27	$148.22	-	-
Q	-	-	-	-	-	-	CA1	0.89	$103.87	-	-
R	-	-	-	-	-	-	BAB2	0.98	$114.38	-	-
S	-	-	-	-	-	-	BAB1	0.94	$109.71	-	-
T	-	-	-	-	-	-	PDE2	1.48	$172.73	-	-
U	-	-	-	-	-	-	PDE1	1.39	$162.23	-	-
V	-	-	-	-	-	-	PBC2	1.15	$134.22	-	-
W	-	-	-	-	-	-	PA2	0.67	$78.20	-	-
X	-	-	-	-	-	-	PBC1	1.07	$124.88	-	-
Y	-	-	-	-	-	-	PA1	0.62	$72.36	-	-