Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025
[CMS-1802-P]

Summary

On April 3, 2024, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (89 FR 23424) a proposed rule updating for fiscal year (FY) 2025 the Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). Among other proposals, the proposed rule would update the federal per diem rates under the SNF Prospective Payment System (PPS); rebase and revise the SNF Market Basket; and adopt revised Core-Based Statistical Areas that are the basis of the labor market areas that CMS uses for the wage index adjustment. CMS also proposes changes to CMS' enforcement policies to allow for more consistent civil monetary penalties (CMP) imposed and expand the current enforcement for SNFs related to health and safety violations.

For the SNF QRP, CMS proposes adopting four new social determinants of health (SDOH) and modifying one SDOH assessment item. CMS also proposes requiring SNFs participating in the SNF QRP to participate in a Minimum Data Set validation process. It also seeks feedback on future measure concepts for the SNF QRP with a Request for Information (RFI). For the SNF Value-Based Purchasing (VBP) Program, CMS proposes a measure retention and removal policy that aligns with the policy currently in effect in the SNF QRP program. In addition, CMS proposes a technical measure updates policy, a measure minimum for FY 2028 and subsequent years, updates to the review and correction policy, and updates to the Extraordinary Circumstances Exception policy.

CMS estimates that the overall impact of the proposed rule will be an increase of $1.3 billion (+4.1 percent) in Medicare payments to SNFs during FY 2025. 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 May 28, 2024.

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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. The Consolidated Appropriations Act, 2021 (CAA, 2021) authorized the Secretary to apply up to nine additional measures to the VBP program for SNFs. 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.

II. SNF PPS Rate Setting Methodology and FY 2025 Update

A summary of key data under the proposals for the SNF PPS for FY 2025 is presented below with additional details in the subsequent sections.

Summary of Key Data under Proposed SNF PPS for FY 2025	
Market basket update factor	
Market basket increase	+2.8%
Forecast error adjustment for FY 2023	+1.7%
Total Factor Productivity (TFP) adjustment	-0.4%
Net TFP-adjusted update	**+4.1%**
Wage index budget neutrality adjustment	1.0002
Labor-related share	71.9%

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 2025 of 2.8 percent based on the fourth quarter 2023 forecast from IHS Global Insight, Inc. (IGI), with historical data through the fourth quarter of 2023. The forecast is based on the proposed 2022-based SNF market basket before application of the forecast error adjustments and productivity adjustment.

For FY 2023—the most recent year for which actual data are available—CMS applied a market basket of 3.9 percent, but the actual increase was 5.6 percent. As the difference (1.7 percentage points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposes to apply a 1.7 percentages point adjustment to the proposed FY 2025 SNF market basket. The market basket of 2.8 percent would be increased by 1.7 percentage points to 4.5 percentage points with this proposal.

The total factor productivity (TFP) adjustment required under the Affordable Care Act (ACA) is estimated to be -0.4 percentage points. CMS uses the TFP adjustment as calculated by the Bureau of Labor Statistics (BLS).[1] 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, 2025, based on IGI's fourth quarter 2023 forecast.

Thus, the resulting productivity-adjusted FY 2025 SNF market basket increase is equal to 4.1 percent (market basket increase of 2.8 percent plus 1.7 percentage point forecast error adjustment less the 0.4 percentage point productivity adjustment).

[1] Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP).

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 2025 SNF QRP.

Based on the proposed productivity-adjusted update, CMS proposes FY 2025 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables below. Under the Patient Driven Payment Model (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 2024 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$70.27	$80.10
Occupational Therapy	$65.41	$73.56
Speech-Language Pathology	$26.23	$33.05
Nursing	$122.48	$117.03
Non-Therapy Ancillaries	$92.41	$88.29
Non-case mix adjusted	$109.69	$111.72

Proposed FY 2025 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$73.16	$83.39
Occupational Therapy	$68.10	$76.59
Speech-Language Pathology	$27.31	$34.41
Nursing	$127.52	$121.83
Non-Therapy Ancillaries	$96.21	$91.92
Non-case mix adjusted	$114.20	$116.31

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 2025 payment rates reflect the use of the PDPM classification system from October 1, 2024 through September 30, 2025. 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 listed separately for urban and rural SNFs. These rates do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP Program.

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 2025, CMS proposes to use updated wage data for hospital cost reporting periods in FY 2021. 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 FY 2025, CMS has determined that the only rural area without wage index data available is North Dakota; it imputes a rural wage index of 0.8334 based on the average wage index values of 8 urban counties contiguous with the 18 rural counties. 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.

For FY 2025 CMS proposes to adopt the revised Office of Management and Budget (OMB) delineations identified in OMB Bulletin No. 23-01.[2] This is described in more detail in Section IV.B of this summary. These revisions contain a number of significant changes including, for example, new CBSAs, urban counties that would become rural, rural counties that would become urban and existing CBSAs that would split apart.

CMS applies the wage index adjustment to the labor-related portion of the Federal rate. The labor-related share 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 (proposed 2022) weights to FY 2025 price levels. This process includes computing the FY 2025 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 71.9 percent, compared to a FY 2024 final labor-related share of 70.1 percent. Table 7 in the proposed rule summarizes the proposed labor-related share for FY 2025

[2] See https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf

(based on the IGI fourth quarter 2023 forecast) compared with FY 2024 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 2025 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 2024 to the weighted average wage adjustment factor for FY 2025. For this calculation, CMS uses the same FY 2023 claims utilization data for both the numerator and denominator of this ratio. The proposed budget neutrality factor for FY 2025 is 1.0002.

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 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".[3]

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 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

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

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.[4]

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, 2024. The latest list of excluded codes can be found on the SNF Consolidated Billing website.[5]

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 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.

IV. Other SNF PPS Issues

A. Rebasing and Revising the SNF Market Basket

For FY 2025 and subsequent fiscal years, CMS is proposing to rebase the market basket to reflect 2022 Medicare-allowable total cost data (routine, ancillary, and capital-related) from freestanding SNFs and to revise applicable cost categories and price proxies used to determine the market basket. The proposed rule includes a lengthy and technical explanation of this process. CMS is proposing to continue the same overall methodology it used for the 2018-based

[4] 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.))

[5] https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling.

SNF market basket to develop the capital related cost weights of the proposed 2022-based SNF market basket. It uses price proxies to measure operating cost and capital cost category growth and relies on the same methodology and price proxies used for the 2018-based SNF market basket. The resulting change to the final SNF index and the individual weights for each category is minimal and illustrated below:

Fiscal Year (FY)	2022-based SNF Market Basket	2018-based SNF Market Basket
Historical Data:		
FY 2020	2.0	2.1
FY 2021	3.6	3.6
FY 2022	6.5	6.3
FY 2023	5.6	5.6
Average FY 2020-2023	4.4	4.4
Forecast:		
FY 2024	3.7	3.7
FY 2025	2.8	2.9
FY 2026	2.7	2.7
Average FY 2024-2026	3.1	3.1

Source: IHS Global, Inc. 4th quarter 2023 forecast with historical data through the 3rd quarter 2023.

The change to the labor-related share from rebasing and revising the SNF market basket is 0.8 percentage points (71.9 percent in FY 2025 to 71.1 percent in FY 2024). The components of the labor share and their change is illustrated below:

	Relative Importance, Labor-Related Share, FY 2024 22:2 Forecast[1]	Relative Importance, Labor-Related Share, FY 2025 23:4 Forecast[2]
Wages and Salaries[3]	52.5	53.2
Employee Benefits	9.3	9.1
Professional Fees: Labor-Related	3.4	3.5
Administrative & Facilities Support Services	0.6	0.4
Installation, Maintenance & Repair Services	0.4	0.5
All Other: Labor-Related Services	2.0	2.0
Capital-Related	2.9	3.2

	Relative Importance, Labor-Related Share, FY 2024 22:2 Forecast[1]	Relative Importance, Labor-Related Share, FY 2025 23:4 Forecast[2]
Total:	71.1	71.9

[1]Published in the Federal Register (88 FR 53213); based on the second quarter 2023 IHS Global Inc. forecast of the 2018-based SNF market basket, with historical data through first quarter 2023.
[2] Based on the fourth quarter 2023 IHS Global Inc. forecast of the proposed 2022-based SNF market basket, with historical data through third quarter 2023.
[3] The Wages and Salaries and Employee Benefits cost weight reflect contract labor costs.

The proposed FY 2025 SNF labor-related share is 0.8 percentage points higher than the FY 2024 SNF labor-related share (based on the 2018-based SNF market basket). The major reason for the higher labor-related share is the higher compensation cost weight and the higher relative importance of the capital cost category as a result of incorporating the 2022 Medicare cost report data.

B. Changes to SNF PPS Wage Index

As discussed above, since the inception of the SNF PPS, CMS has used hospital inpatient wage data in developing a wage index to be applied to SNFs. The applicable SNF PPS wage index value is assigned to a SNF on the basis of the labor market area in which the SNF is geographically located. 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.

For FY 2025, CMS proposes to adopt the revised Office of Management and Budget (OMB) delineations identified in OMB Bulletin No. 23-01. These revisions OMB published on July 21, 2023 contain a number of significant changes: new CBSAs, urban counties that would become rural, rural counties that would become urban and existing CBSAs that would split apart. It believes that the delineations reflected in this update better reflects the local economies and wage levels of the areas in which hospitals are currently located.

Overall, it believes that implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Based on its analysis, CMS determined that 43 percent of SNFs would experience decreases in their area wage index values; less than 1 percent, however, would experience a significant decrease (that is, greater than 5 percent) in their area wage index value. The remaining 57 percent of SNFs would have higher area wage index values. CMS notes it will apply the permanent 5 percent cap policy (adopted in FY 2023) on decreases in a hospital's wage index compared to its wage index for the prior fiscal year (FY 2024) to assist providers in adapting to these revised OMB delineations. It does not believe any additional transition is necessary. These wage index adjustment, as required by statute, will be made in a budget neutral manner and that the applied 5 percent cap would not result in any change in estimated aggregate SNF PPS payment

CMS details the following changes related to adoption of these revised OMB geographic delineations.

(1) Micropolitan Statistical Areas

CMS discusses how it uses the Micropolitan Statistical Area definition in the calculation of the wage index. OMB defines these areas as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. Consistent with the treatment of Micropolitan areas under the IPPS, CMS proposes to continue to treat Micropolitan Areas as "rural" and to include Micropolitan Areas in the calculation of the state's rural wage index.

(2) Urban Counties That Would Become Rural Under the Revised OMB Delineations

CMS' analysis shows that a total of 54 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural area, for SNF PPS payment beginning in FY 2025, if its adopts the new OMB delineations. Table 22 in the proposed rule lists the 54 urban counties that would be rural if it finalizes its proposal to implement the new OMB delineations. For these counties, CMS would utilize the rural unadjusted per diem rates as the basis for determining payment rates for these facilities beginning on October 1, 2024.

(3) Rural Counties That Would Become Urban Under the Revised OMB Delineations

CMS' analysis shows that a total of 54 counties (and county equivalents) that are currently located in rural areas would be located in urban areas if it finalizes its proposal to implement the revised OMB delineations. Table 23 in the proposed rule lists the 54 rural counties that would be urban. For these counties, if finalized, CMS would utilize the urban unadjusted per diem rates as the basis for determining payment rates for these facilities beginning on October 1, 2024.

(4) Urban Counties That Would Move to a Different Urban CBSA Under the Revised OMB Delineations

Several urban counties would shift from one urban CBSA to another CBSA under its proposal to adopt the new OMB delineations. In other cases, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. Table 24 in the proposed rule lists the 88 urban counties that would move from one urban CBSA to another urban CBSA under the new OMB delineations. For these counties, there may be impacts, both negative and positive, upon their specific wage index values. There are also cases where adopting the revised OMB delineation would involve a change only in CBSA name and/or number but no change to the counties that constitute the CBSA. Table 25 in the proposed rule details these CBSAs.

(5) Changes to County-Equivalents in the State of Connecticut

CMS notes that the June 6, 2022 Census Bureau Notice (87 FR 34235 - 34240), OMB Bulletin No. 2301 replaced the 8 counties in Connecticut with 9 new "Planning Regions." Planning regions now serve as county-equivalents within the CBSA system. CMS proposes to adopt the planning regions as county equivalents for wage index purposes. Table 26 in the proposed rule provides a crosswalk with the current and proposed FIPS county and county-equivalent codes and CBSA assignments.

CMS invites comments on its proposed implementation of revised labor market area delineations. The proposed wage index applicable to FY 2025 is set forth in Table A available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/wage-index

C. 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.[6]

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[7], 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 2025.

CMS proposes changing the clinical category assignment for four new ICD-10 codes that were effective on October 1, 2023 (detail in table below). These four new ICD-10 codes were remapped from "Medical Management" as this clinical category was not appropriate as a primary diagnosis or as a treatment for a Part A-covered SNF stay.

ICD-10 Code	Diagnosis	CMS Proposal
E88.10	Metabolic syndrome a cluster of risk factors for cardiovascular disease and type 2 diabetes mellitus.	Remap from "Medical Management" to "Return to Provider"
E88.811	Insulin Resistance Syndrome	Remap from "Medical Management" to "Return to Provider."
E88.818	Other Insulin Resistance	Remap from "Medical Management" to "Return to Provider"
E88.819	Insulin Resistance	Remap from "Medical Management" to "Return to Provider"

[6] PDPM Website is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payments/SNFPP/PDPM
[7] 84 FR 38750

CMS solicits comments on the proposed substantive changes to the PDPM ICD-10 code mappings as well as comments on additional substantive and nonsubstantive changes that commenters believe are necessary.

D. Request for Information: Update to PDPM Non-Therapy Ancillary Component

1. Background

Under the PDPM, payment is determined through the combination of six payment components. Five of the components (PT, OT, SLP, NTA, and nursing) are case-mix adjusted. Additionally, there is a non-case-mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics.

The Non-Therapy Ancillary or NTA component utilizes a comorbidity score to assign the patient to an NTA component case-mix group, which is determined by the presence of conditions or the use of extensive services (henceforth also referred to as comorbidities) that were found to be correlated with increases in NTA costs for SNF patients. The presence of these conditions and extensive services is reported by providers on certain items of the Minimum Data Set (MDS) resident assessment. During the development of PDPM, CMS identified a list of 50 conditions and extensive services that were associated with increases in NTA costs. Each of the 50 comorbidities used under PDPM for NTA classification is assigned a certain number of points based on its relative costliness. To determine the patient's NTA comorbidity score, a provider would identify all the comorbidities for which a patient would qualify and then add the points for each comorbidity together. The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA component classification group.[8]

CMS is revisiting both the list of included NTA comorbidities and the points assigned to each condition or extensive service based on changes in the patient population and care practices over time. This request for information (RFI) solicits comment on the methodology CMS is currently considering for updating the NTA component.

2. Updates to the Study Population and Methodology

CMS states that it is considering several changes to the NTA study population as a foundation upon which to update the NTA component. First, it is considering updating the years used for data corresponding to Medicare Part A SNF stays, including claims, assessments, and cost reports. To develop PDPM, CMS used a study population of Medicare Part SNF stays with admissions from FY 2014 through FY 2017. The updated study population would use Medicare Part A SNF stays with admissions from FY 2019 through FY 2022. Given that much of this data was affected by the national COVID-19 PHE, CMS is considering using the same subset

[8] More information about the creation of the NTA component scoring method can be found in Section 3.7 of the SNF PDPM Technical Report, available at https://www.cms.gov/medicare/payment/prospective-paymentsystems/skilled-nursing-facility-snf/pps-model-research.

population used for the PDPM parity adjustment recalibration by excluding stays with either a COVID-19 diagnosis or stays using a COVID-19 PHE-related modification.

It is also considering making certain methodological changes to reflect more accurate and reliable coding of NTA conditions and extensive services on SNF Part A claims and the MDS after PDPM implementation. The NTA list was created using data from a variety of different sources, including Medicare inpatient, outpatient, and Part B claims to identify the presence of condition categories from the Medicare Parts C and D risk adjustment models (referred to as CCs and RxCCs, respectively). CMS now believes the NTA list would more accurately reflect the coding of conditions and extensive services under PDPM by relying exclusively upon SNF PPS Part A claims and the MDS. It is therefore considering updating the methodology to only utilize SNF Part A claims and the MDS, and not claim types from other Medicare settings.

CMS is also considering modifying the overlap methodology to rely more upon the MDS items that use a checkbox to record the presence of conditions and extensive services whenever possible, while allowing for potentially more severe or specific diagnoses to be indicated on MDS item I8000. Since the implementation of PDPM, it now believes patient conditions and extensive services are now more accurately and reliably reported by providers using MDS items. Thus, it is considering prioritizing the reporting of conditions on the MDS by raising the cost threshold for selecting the overlapping CC or RxCC definitions from any additional cost to 5 dollars in average NTA cost per day, which is the amount that is generally associated with a 1-point NTA increase.

3. Updates to Conditions and Extensive Services Used for NTA Classification

Table 27 in the proposed rule provides the list of conditions and extensive services that would be used for NTA classification following the various changes based on the methodology outlined above. For each condition or extensive service, CMS includes the frequency of stays, the average NTA cost per day, the ordinary least squares (OLS) estimate of its impact on NTA costs per day, and the assigned number of points based on its relative impact on a patient's NTA costs. Conditions and extensive services with a greater impact on NTA costs were assigned more points, while those with less of an impact were assigned fewer points. More information about this methodology can be found in Section 3.7 of the SNF PDPM Technical Report, available at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research

CMS invites comments on the updates that it is considering for the NTA component of PDPM.

V. SNF Quality Reporting Program (QRP)

CMS proposes, beginning for the FY 2027 SNF QRP:

- To collect through the Minimum Data Set (MDS) four new items as standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) category: one item for living situation, two items for food, and one item for utilities.
- To modify the current transportation item collected and submitted using the MDS.

- To require SNFs participating in the SNF QRP to participate in a validation process.

CMS also requests information on quality measure concepts under consideration for future SNF QRP program years.

The overall economic impact to SNFs of the proposed SNF QRP changes is an estimated cost of $2,322,541.48 annually beginning with the FY 2027 SNF QRP. The overall economic impact to SNFs of the proposal for participation in a validation process is an estimated cost of $813,067.95 annually beginning with the FY 2027 SNF QRP.

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.[9] 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 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 28 reproduced from the proposed rule with minor modifications) shows the current quality measures adopted for the SNF QRP. No changes to the measure set are proposed.

Quality Measures Currently Adopted for the 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)

[9] Program requirements are codified at §413.360.

[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. Also, see section 413.360(b)(2) of title 42, CFR, for factors used to evaluate whether a measure should be removed from the SNF QRP.

Quality Measures Currently Adopted for the SNF QRP	
Short Name	**Measure Name & Data Source**
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program
TOH-Provider	Transfer of Health Information to the Provider – PAC Measure
TOH-Patient	Transfer of Health Information to the Patient – PAC Measure
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
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)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
Data Source: National Healthcare Safety Network (NHSN)	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

C. Proposal to Collect Four New Items as SPADEs and to Modify One Item Collected as a SPADE Beginning with the FY 2027 SNF QRP

1. Definition of Standardized Patient Assessment Data

SNFs are statutorily required, as a post-acute care (PAC) provider,[11] to submit standardized patient assessment data under the SNF QRP with respect to the admission and discharge of an individual (or more frequently as specified by the Secretary) using a standardized patient assessment instrument, which for SNFs is the MDS. Standardized patient assessment data is data required with respect to the following categories: (1) functional status, such as mobility and self-care at admission to and before discharge from a PAC provider; (2) cognitive function, such as ability to express ideas and understand, and mental status, such as depression and dementia; (3) special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition; (4) medical conditions and

[11] Section 1888(e)(6)(B)(i)(III) of the Act requires SNFs to submit standardized patient assessment data required under section 1899B(b)(1) of the Act, which requires PAC providers to submit such data under applicable reporting provisions.

comorbidities, such as diabetes, congestive heart failure, and pressure ulcers; (5) impairments, such as incontinence and an impaired ability to hear, see, or swallow; and (6) other categories deemed necessary and appropriate by the Secretary.[12]

2. Social Determinants of Health (SDOH) Collected as SPADEs

CMS currently collects seven items in the SDOH category of SPADEs: ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation.[13] The agency states that standardized data relating to SDOH on national levels allows it to assess the data's appropriateness as risk adjustors or in future quality measures. The adopted SDOH items use common standards and definitions across the PAC provider settings to facilitate care coordination, continuity in care planning, and discharge planning from PAC settings. CMS further explains that health-related social needs (HRSNs) are adverse social conditions that negatively affect a person's health or health care, such as lack of access to food, housing, or transportation, and are associated with poorer health outcomes and higher health care costs.

3. Proposal to Collect Four New Items as SPADEs

CMS proposes to require SNFs to submit, beginning with the FY 2027 SNF QRP, the following four new items as SPADEs under the SDOH category using the MDS, all selected from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC Model.

a. One Living Situation Item Proposed

CMS describes the potential negative impacts that housing instability may have on health and believes that SNFs can use information from the Living Situation item during a resident's discharge planning, including to better coordinate with other providers, facilities, and agencies during transitions of care.

CMS therefore proposes to adopt the Living Situation item, which would ask "What is your living situation today?" The proposed response options would be: I have a steady place to live; I have a place to live today, but I am worried about losing it in the future; I do not have a steady place to live; Resident declines to respond; and Resident unable to respond.

b. Two Food Items Proposed

CMS describes food insecurity, which is not having enough food or having a diet that is not nutritious, as a factor for negative health outcomes and health disparities. The agency believes SNFs could use data on food insecurity to help them with resident transitions of care and referrals, including to Federal assistance initiatives. Therefore, CMS proposes two new food items:

- The first would state: "Within the past 12 months, you worried that your food would run out before you got money to buy more."

[12] These six categories are specified under section 1899B(b)(1)(B) of the Act.
[13] See the FY 2020 SNF PPS final rule (84 FR 38805-38817).

- The second would state: "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."
- The proposed response options for each would be: Often true; Sometimes true; Never true; Resident declines to respond; and Resident unable to respond.

c. One Utilities Item Proposed

CMS describes a lack of utility security as an inability to adequately meet basic household energy needs. The effects of a lack of utility security include vulnerability to environmental exposures which impact a person's health. The agency believes SNFs could use information on utility security to help refer residents to (and help them apply for) utility assistance programs for paying for their home energy costs.

CMS, therefore, proposes to adopt the Utilities item, which would ask "In the past 12 months has the electric gas, oil, or water company threatened to shut off services in your home?" The proposed response options would be: Yes; No; Already shut off; Resident declines to respond; and Resident unable to respond.

4. Proposal to Modify the Transportation Item

The Transportation item (A1250) is one of seven items SNFs began collecting as of October 1, 2023 on the MDS as SPADEs under the SDOH category.[14] It currently asks "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" The response options are: Yes, it has kept me from medical appointments or from getting my medications; Yes, it has kept me from non-medical meetings, appointments, work, or from getting things I need; No; Resident unable to respond; and Resident declines to respond.

As part of routine monitoring, CMS has determined that the Transportation item could be improved by revising the look-back period to a defined 12-month period (as opposed to the current look-back period of 6 to 12 months) and by simplifying the response options to reduce burden. The proposed modifications would align the item with a Transportation item collected on the AHC HRSN Screening Tool, which is a potential tool that the Inpatient Psychiatric Facility Quality Reporting and Hospital Inpatient Quality Reporting programs may use.

Beginning with the FY 2027 payment SNF QRP, therefore, CMS proposes to modify the Transportation item. The modified item would ask: "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?" The proposed response options would be: Yes; No; Resident declines to respond; and Resident unable to respond.

5. Burden Assessment

If the proposals to collect four new items as SPADEs and modify the Transportation item are finalized, CMS estimates that, beginning with the FY 2027 SNF QRP, per SNP there would be

[14] Adopted in the FY 2020 SNF PPS final rule (84 FR 38805-38809).

an annual increase of 2.31 hours in burden and of $150.88 in cost and for all SNPs there would be an annual increase of 35,561.81 hours in burden and of $2,322,541.48 in cost.

D. SNF QRP Quality Measure Concepts under Consideration for Future Years – Request for Information (RFI)

CMS seeks input on the following four concepts for the SNF QRP:

- A composite measure of vaccinations for the SNF QRP, which could represent overall immunization status of residents.[15]
- The concept of depression, which may be similar to the Clinical Screening for Depression and Follow-up measure in the Universal Foundation.[16]
- The concept of pain management.
- The concept of patient experience of care/patient satisfaction.

CMS will not respond to specific comments in the final rule, but intends to use input in response to this RFI for future measure development.

E. 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 Proposed New SPADEs and Modified Transportation Data Element

- For the FY 2027 SNF QRP, SNFs would submit MDS assessment data on the 4 proposed new items and the modified Transportation item beginning with residents admitted on October 1, 2025 through December 31, 2025.
- Beginning with the FY 2028 SNF QRP, SNFs would (starting in CY 2026) submit data for the entire calendar year.
- SNFs would be required to submit the new items (Living Situation, Food, and Utilities) with respect to admission only (and not also at discharge) because it is unlikely the status for those items would change between admission and discharge.[17]
- Beginning with October 1, 2025 SNF admissions, SNFs would be required to submit the proposed modified Transportation item at admission only (as opposed to the current submissions at admission and discharge).

[15] The Adult Immunization Status Measure in the Universal Foundation is provided as an example. Centers for Medicare and Medicaid Services Measures Inventory Tool (cms.gov).
[16] See Centers for Medicare and Medicaid Services Measures Inventory Tool (cms.gov).
[17] A draft of the proposed items is available in the Downloads section of the SNF QRP Measures and Technical Information webpage at https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.

3. Proposal to Participate in Validation Process Beginning with the FY 2027 SNF QRP

a. Proposal for Validation Process Participation for Assessment-Based Measures

CMS proposes, as a SNF QRP requirement beginning with the FY 2027 SNF QRP, to adopt a validation process that would apply to data submitted using the MDS (assessment-based measures).[18] The process would be similar to the validation process it adopted for the SNF Value-Based Purchasing (VBP) program.[19] CMS specifically proposes:

- The validation contractor would annually select up to 1,500 SNFs that submit at least one MDS record in the calendar year that is 3 years before the applicable FY SNF QRP. (For example, for the FY 2027 SNF QRP, the SNFs would be chosen based on those that submitted at least one MDS record in 2024.) SNFs chosen for the SNF QRP validation for a year would be the same ones randomly selected for the SNF VBP validation for the corresponding SNF VBP program year.
- Each selected SNF would be required to submit up to 10 medical records once in a FY. The same medical records would be submitted at the same time as those required from the same SNFs for the SNF VBP validation.
- The records would need to be submitted to the validation contractor within 45 days of the request from the contractor. SNFs would submit either digital or paper copies of the records.
- If a selected SNF does not submit the requested records within the specified time, then the SNF's otherwise applicable annual market basket percentage update would be reduced by 2 percent. For example, if validation records were requested for FY 2027 and the SNF does not comply then the market basket percentage update would be reduced by 2 percent for the FY 2029 SNF QRP.[20]

CMS intends to propose in future rulemaking the process by which it would evaluate the submitted medical records against the MDS to determine the accuracy of the reported MDS data. CMS invites comment on that potential process as well as the proposed validation process.

b. Proposal to Apply Existing Validation Process for Claims-Based Measures

Currently, data submitted through Medicare part A FFS claims are validated by MACs for accuracy, including to determine if billed services are medically necessary and through random selection and targeted review for prepayment and post-payment audits of claims.

CMS proposes, as a SNF QRP requirement beginning with the FY 2027 SNF QRP, to adopt the MAC's process of validating claims for medical necessity through targeted and random audits as a validation process for data submitted under the SNF QRP for claims-based measures.

CMS also proposes to amend the regulations at §413.360 consistent with the validation process proposals.

[18] Section 1888(h)(12)(A) of the Act requires a process to validate data submitted under the SNF QRP.
[19] The validation process for the SNF VBP was adopted in the FY 2024 SNF PPS final rule (88 FR 53323-53325).
[20] The proposed reduction would be made consistent with the authority under section 1888(e)(6)(A) of the Act.

c. Burden Assessment

CMS estimates that the change in burden associated with the proposed validation process would per selected SNF be an annual increase of 5.12 hours and of $542.05 and for all selected SNFs would be an average annual increase of 7,680 hours and $813.067.95.

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

In this rule, CMS proposes new requirements for the SNF VBP Program, including a measure selection, retention, and removal policy; a technical measure updates policy; a measure minimum for FY 2028 and subsequent years; updates to the review and correction policy; and updates to the Extraordinary Circumstances Exception policy.

All proposals are open to comment.

A. Background

The SNF VBP Program is authorized under section 1888(h) of the Act and awards incentive payments to SNFs to reward better quality of care, value, and outcomes.[21] It 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. CMS intends, to the extent feasible, to align the SNF VBP measure set with the measures in the Universal Foundation and the PAC add-on measure set.[22]

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 (currently the SNF 30-Day All-Cause Readmission Measure (SNFRM)). 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. SNFs that do not meet a case minimum specified for the SNFRM for the FY 2025 program year will be excluded from the Program and will receive their full Federal per diem rate for that fiscal year.

CMS estimates that approximately $281.53 million will be redistributed (of the estimated $469.22 million in withheld funds) in value-based incentive payments to SNFs in FY 2025, meaning that the SNF VBP Program is estimated to result in $187.69 million in savings to the Medicare program in FY 2025.

[21] 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. The SNF VBP Program regulations are at 42 CFR 413.337(f) and 413.338.
[22] See https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.

B. Proposed Regulation Text Technical Updates

CMS proposes several technical changes to the regulatory text at §§413.337(f) and 413.338, including (i) to correct cross references, (ii) to update the definition of SNF readmission measure to clarify that the SNF readmission measure will be updated to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure beginning October 1, 2027, (iii) to rename "performance score" with the term "SNF performance score"; and (iv) to include certain components of the MDS validation process that had been finalized in the FY 2024 SNF PPS final rule (88 FR 53324).

C. SNF VBP Program Measures

1. Background

Section 1888(g) mandates the adoption of certain measures (the SNF Readmission Measure), and section 111 of CAA, 2021 amended section 1888(h) of the Act to permit CMS to add up to 9 measures (in addition to the SNF Readmission Measure[23]) to the SNF VBP Program, as the agency determines to be appropriate, including measures of functional status, patient safety, care coordination, or patient experience. Table 30 in the rule lists the measures that have been adopted so far for the SNF VBP Program and the timeline for their inclusion.

SNF VBP Program Measures and Timeline for Inclusion in the Program (Based on Table 30 of the Rule)

Measure	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
SNF 30-Day All-Cause Readmission Measure (SNFRM)	X	X	X	
SNF Healthcare Associated Infections Requiring Hospitalization (SNF HAI) measure		X	X	X
Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure		X	X	X
Total Nursing Staff Turnover (Nursing Staff Turnover) measure		X	X	X
Discharge to Community—Post-Acute Care Measure for SNFs (DTC PAC SNF) measure			X	X
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure			X	X
Discharge Function Score for SNFs (DC Function) measure			X	X
Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure			X	X

[23] Currently the SNF Readmission measure is the SNFRM, which is to be replaced by the SNF WS PPR measure, beginning with the FY 2028 program year.

Measure	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
SNF Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measure				X

2. Proposal to Adopt Measure Selection, Retention, and Removal Policy

Beginning with the FY 2026 SNF VBB program year, CMS proposes to adopt the following measure selection, retention, and removal policy that would apply to all SNF VBP measures except the SNF readmission measure, which is statutorily required to be retained:

- When a measure is adopted for a program year, it would be automatically retained for subsequent program years unless CMS proposes to remove or replace it.
- Notice and comment rulemaking would be used to remove or replace a measure.
- Measure removal would be based on the following 8 removal factors:
    - SNF performance on the measure is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.
    - Performance and improvement on the measure do not result in better outcomes.
    - The measure no longer aligns with current clinical guidelines or practices.
    - A more broadly applicable measure for the particular topic is available.
    - A measure that is more proximal in time to the desired resident outcomes for the topic is available.
    - A measure that is more strongly associated with the desired resident outcomes for the topic is available.
    - The collection or public reporting of a measure leads to negative unintended consequences other than resident harm.
    - The costs associated with the measure outweigh the benefit of its continued use.
- CMS may immediately remove a measure if it determines the continued required submission of data on the measure raises specific resident safety concerns. Upon removal, the agency would provide notice to SNFs and the public with a statement of the patient safety concerns. Notice of the removal would be provided in the Federal Register.

3. Future Measure Considerations

Beginning in the FY 2027 program year, there will be seven measures, in addition to the statutorily-required SNF Readmission Measure, in the SNF VBP Program. CMS may adopt up to two additional measures beyond those measures. The agency is not proposing any new measures or measure set adjustments in this rule. However, it is assessing several options, including resident experience measures and other measures that address interoperability and health equity/social determinants of health, as well as considering measure set adjustments such as the feasibility of a staffing composite measure and whether measure domains and domain weighting would be appropriate for the Program. CMS welcomes feedback on potential new measure topics and measure set adjustments.

D. SNF VBP Performance Standards

1. Estimated Performance Standards for FY 2027 and FY 2028 Program Years

CMS adopted the final numerical values for the FY 2027 performance standards for the DTC PAC SNF measure in the FY 2024 SNF PPS final rule (88 FR 53300). In this rule it provides estimated numerical performance standards for the remaining measures applicable for the FY 2027 program year in Table 31 of the rule (shown below).

Estimated FY 2027 SNF VBP Program Performance Standards

Measure Short Name	Achievement Threshold	Benchmark
SNFRM	0.78800	0.82971
SNF HAI Measure	0.92315	0.95004
Total Nurse Staffing Measure	3.18523	5.70680
Nursing Staff Turnover Measure	0.35912	0.72343
Falls with Major Injury (Long-Stay) Measure	0.95327	0.99956
Long Stay Hospitalization Measure	0.99777	0.99964
DC Function Measure	0.40000	0.79764

The SNF WS PPR measure will replace the SNFRM beginning with the FY 2028 program year. The baseline and performance periods for that measure will each be 2 consecutive years. FYs 2025 and 2026 will be the performance period for the measure for the FY 2028 program year.[24]

CMS provides the estimated numerical performance standards for the FY 2028 program year for the SNF WS PPR measure and the DTC PAC SNF measure in Table 32 of the rule (shown below). It will provide the estimated numerical performance standards for the remaining measures in the FY 2026 SNF PPS proposed rule.

Estimated FY 2028 SNF VBP Program Performance Standards

Measure Short Name	Achievement Threshold	Benchmark
DTC PAC SNF Measure	0.42946	0.66370
SNF WS PPR Measure	0.86756	0.92527

2. Proposed Policy for Incorporating Technical Measure Updates into Measure Specifications and for Subsequent Updates to SNF VBP Performance Standards

Beginning with the FY 2025 program year, CMS proposes that the agency be able to use subregulatory processes to make technical measure updates to previously finalized SNF VBP measure specifications and to update the numerical values of the performance standards for a measure if that measure's specifications have been technically updated.[25] CMS would be able to update numerical values for the performance standards for a measure for a program year if the measure's specifications were technically updated between the time of publication of the performance standards and the time CMS calculates SNF performance on the measure at the end of the performance period. The agency would inform SNFs of technical measure updates and

[24] See the FY 2024 SNF PPS final rule (88 FR 53280-53281).
[25] These proposals align with policies adopted for the Hospital VBP Program in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50077 through 50079).

updates to the numerical values through postings on its SNF VBP website, listservs, and through educational outreach efforts. CMS would continue to use rulemaking to adopt substantive updates to the measures. It would determine if a change is substantive versus technical on a case-by-case basis.[26]

E. SNF VBP Performance Scoring Methodology[27]

1. Proposed Measure Minimum Policies

CMS proposes to apply the previously finalized FY 2027 measure minimum to the FY 2028 program year and subsequent years. Under that FY 2027 measure minimum policy, for a SNF to receive a SNF performance score and value-based incentive payment for the program year, it must report the minimum number of cases for 4 of the 8 measures during the applicable performance period. If a SNF does not meet the measure minimum requirement it would be excluded from the applicable program year and receive its adjusted Federal per diem rate for that fiscal year. CMS estimates that approximately 6 percent of SNFs would be excluded from the Program for the FY 2028 program year (and subsequent years that use the same measure set) as compared to the approximately 8 percent of SNFs it estimated would be excluded from the FY 2027 program year. This is because of the SNF WS PPR measure replacing the SNFRM beginning in FY 2028.

2. Potential Next Steps for Health Equity

CMS adopted a Health Equity Adjustment (HEA) that allows SNFs to earn bonus points if they provide high quality care and care for high proportions of SNF residents who are underserved.[28] The agency is considering different ways of measuring health equity that could be incorporated into the SNF VBP Program, such as a health-equity focused measure, composite measure, or metrics for SNFs to earn bonus points on their performance score. Considerations include:

- A high-social risk factor (SRF) measure that uses an existing Program measure but where the denominator of the measure would only include residents with a given SRF.
- A worst-performing group measure that uses an existing Program measure and compares the quality of care among residents with and without a given SRF on that measure.
- A within-provider difference measure that assesses performance differences between residents with and without a given SRF on an existing Program measure.

F. Proposed Updates to the SNF VBP Review and Corrections Process

CMS uses a two-phase review and corrections process for the SNF VBP Program. Under phase one it accepts corrections for 30 days after distributing the Full-Year Workbooks (one each for

[26] CMS provides examples of technical measure changes as including updates to the case-mix or risk adjustment methodology, changes in exclusion criteria, or updates required to accommodate changes in the content and availability of assessment data. It provides that changes it may consider to be substantive would be those that are so significant that the measure is no longer the same measure.

[27] The history of the performance scoring methodology may be found in the FY 2024 SNF PPS final rule (88 FR 53300-53304). The performance scoring methodology is codified at §§413.338(d) and (e). The health equity adjustment is codified at §413.338(k).

[28] See FY 2024 SNF PPS final rule (88 FR 53304-53318).

the baseline period and performance period) quarterly confidential feedback reports to SNFs (generally released in December and June, respectively). These corrections are limited to errors made by CMS or its contractors when calculating a measure rate. For corrections to the underlying administrative claims data to be reflected in the quarterly confidential feedback reports, SNFs must submit requests to their MAC before a "snapshot date" to ensure corrections are reflected in measure calculations. In phase two SNFs can submit corrections to SNF performance scores and rankings, and corrections are accepted for 30 days after distribution of the performance score report released in August.

CMS proposes, beginning with the 2026 SNF VBP program year, to apply the existing phase one review and corrections process to all SNF VBP measures, regardless of data source, and proposes snapshot dates for the new SNF VBP measures, which would be codified in a revised §413.338(f)(1).

For claims-based measures, for corrections to administrative claims data to be reflected in the quarterly confidential feedback reports, the SNF would need to submit corrections requests to their MAC before the following snapshot dates for the corrections to be reflected in measure calculations:

- For the SNF HAI, DTC PAC SNF, and SNF WS PPR measures, the snapshot date would be 3 months following the last SNF discharge in the applicable baseline period or performance period.
- For the Long Stay Hospitalization measure, the snapshot date would be 3 months following the final quarter of the applicable baseline period or performance period.

For Payroll-Based Journal (PBJ) measures (those measures calculated using electronic staffing data submitted through the PBJ system, which include the Total Nurse Staffing measure and Nursing Staff Turnover measure), corrections to the data would be able to be reflected in the quarterly confidential feedback reports only if the SNF makes corrections to the data within the PBJ system before the snapshot date. The snapshot date would the date that is 45 days after the last day in the given fiscal quarter.

For measures calculated using data reported on the MDS 3.0 (which include the Falls with Major Injury (Long-Stay) and DC Function measures), for corrections to the underlying MDS data to be reflected in the quarterly confidential feedback reports, the SNF would be required to make corrections to the data via the Internet Quality Improvement Evaluation System before the snapshot date, which would be the February 15th that is 4.5 months after the last day of the applicable baseline or performance period.[29]

G. Proposed Updates to the Extraordinary Circumstances Exception (ECE) Policy

The ECE policy for the SNF VBP Program under §413.338(d)(4) allows SNFs to request an exception to the Program requirements when there are certain extraordinary circumstances beyond the control of the SNF. Currently, a SNF may request an ECE if it is able to demonstrate that an extraordinary circumstance affected the care provided to its residents and subsequent

[29] If February 15 would fall on a Friday, weekend, or federal holiday then the deadline would be delayed until the next business day.

measure performance. If an ECE is granted, a SNF performance score is calculated so that it does not include performance on measures during the months that the SNF is affected by the extraordinary circumstance.

The agency proposes, beginning with the FY 2025 program year:

- To allow a SNF to request an ECE if the SNF can demonstrate that, as a result of the extraordinary circumstance, it cannot report SNF VBP data on one or more measures by the specified deadline.
- To allow a SNF to request an ECE by sending an email with the subject line "SNF VBP Extraordinary Circumstances Exception Request" to the SNF VBP Program Health Desk rather than by completing an ECE Request Form. The email would need to contain: (1) The SNF's CMS Certification Number; (2) The SNF's business name and address; (3) Contact information for the SNF's CEO or CEO-designated personnel; (4) A description of the extraordinary circumstance (including dates and duration); (5) Available evidence of the impact of the extraordinary circumstance on care provided to residents or the SNF's ability to report measure data; and (6) A date by which the SNF believes it will be able to fully comply with the Program's requirements and justification for that date.

CMS also proposes to redesignate that ECE policy currently at §413.338(d)(4) as a new §413.338(m) to ensure the policy remains effective beyond FY 2025.

VII. Nursing Home Enforcement

A. Background

To ensure that residents are receiving high quality, and safe care, long-term care facilities that participate in the Medicare or Medicaid program, or both must be certified as meeting Federal participation requirements. The Secretary is authorized by statute (Section 1864(a) of the Act) to enter into agreements with state survey agencies to conduct surveys (that is, inspections) to determine whether skilled nursing facilities meet the Federal participation requirements for Medicare. The results of these surveys are used by CMS and by the State Medicaid agency, respectively, as the basis for a decision to enter into, deny, or terminate a provider agreement with the facility. They are also used to determine whether one or more enforcement remedies should be imposed when noncompliance with requirements is identified.

One of the Federal statutory enforcement remedies available to the Secretary and the states to address facility noncompliance with the requirements is a civil money penalty (CMP) for health and safety violations. Under statute,[30] CMPs may be imposed to remedy noncompliance at amounts not to exceed $10,000 for each day of noncompliance (as annually adjusted by inflation by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015). The regulations that govern the imposition of CMPs and other remedies authorized by the statute were published on November 10, 1994 (59 FR 56116) and subsequently revised on September 28, 1995 (60 FR 50118), March 18, 1999 (64 FR 13354 through 13360), March 18, 2011 (76 FR 15106), and September 6, 2016 (81 FR 61538). The nursing home enforcement rules are set forth

[30] Sections 1819(h)(2)(B)(ii)(I) and 1919(h)(3)(C)(ii)(I) of the Act

in 42 CFR part 488, subpart F, and the provisions directly affecting CMPs imposed for noncompliance with the requirements are set forth in §§488.430 to 488.444.

The amount of CMPs increases based on the severity and/or extent of the harm, or potential for more than minimal harm that might result from noncompliance. Current regulations allow for penalties to be assessed in the upper range for $3,050 to $10,000 per day (PD) or $1,000 to $10,000 per instance (PI), as annually adjusted for inflation, for noncompliance that constitutes immediate jeopardy (IJ) to resident health and safety, while penalties in the lower range of $50 to $3,000 PD or $1,000 to $10,000 PI of noncompliance, as annually adjusted for inflation, may be imposed where immediate jeopardy does not exist.[31]

Under the current regulations, the State and/or CMS must decide whether to select either a PD or PI CMP when considering whether a CMP will be used as a remedy. A PD CMP is an amount that may be imposed for each day a facility is not in compliance until the facility corrects the noncompliance and achieves substantial compliance. A PI CMP is an amount that is imposed for each instance that a facility is not in substantial compliance. The current enforcement regulations do not authorize the use of both types of CMPs during the same survey, nor do they allow for multiple PI CMPs to be imposed for multiple instances within the same noncompliance deficiency that occurred on different days during a survey.

CMS proposes to make revisions to this limitation to enable more types of CMPs to be imposed during a survey once a CMP remedy is selected. By doing so, it believes this will allow for penalties to be better aligned with the noncompliance identified during the survey and for more consistency of CMP amount across the nation. Its analysis of the use of PD and PI CMPs and CMP impositions across states from January 1, 2022, to December 31, 2022 found national variations in the length of time PD CMPs are imposed based on when the noncompliance occurred, when the survey was performed, and when the facility was found to have corrected the noncompliance.

These proposed revisions discussed below are not intended to expand the type of deficiencies that are subject to PD and PI CMPs as the States and CMS would continue to follow the existing criteria for imposing a PD CMP or PI CMP. CMS believes that these proposed revisions would allow for more consistent CMP amounts imposed across the nation and expand the current enforcement to allow for additional CMPs that more closely align with the noncompliance that occurred. By doing so, CMS believes these actions will help to better ensure that compliance is quickly achieved and is lasting.

B. Provisions of the Proposed Regulations

1. Imposing Multiple Per Instance Civil Monetary Penalties for the Same Type of Noncompliance

The statute grants the Secretary broad discretion to determine how appropriate CMPs should be enforced and only limits the imposition to a maximum daily amount. CMS proposes to expand the circumstances in which a PI CMP can be imposed to allow for more than one PI CMP to be

[31] §488.408

imposed when multiple occurrences, or "instances" of a specific noncompliance are identified during a survey, regardless of whether they are cited at the same regulatory deficiency tag number in the statement of deficiencies. For example, if a surveyor identifies during a survey several instances of noncompliance within a particular regulatory requirement (such as §483.25, identified as tag F684 - quality of care,) that occurred on different days, CMS or the State survey agency would be able to impose a PI CMP for each occurrence of that noncompliance for those days, as long as the total facility CMP liability did not exceed the statutory and regulatory maximum amount on any given day.

To strengthen its enforcement policies, CMS proposes to revise §488.401 to define "instance" or "instance of noncompliance" as a separate factual and temporal occurrence when a facility fails to meet a participation requirement. It further proposes that each instance of noncompliance would be sufficient to constitute a deficiency and that a deficiency may be comprised of multiple instances of noncompliance. This will allow CMS and the States to impose multiple PI CMPs for the same type of noncompliance in a survey. It believes that this will incentivize facilities to take meaningful steps to permanently resolve their deficiencies and would provide more opportunities to impose CMPs in a manner that is consistent with the Congressional mandate to ensure that residents are protected from harm that often result in facilities with multiple occurrences of noncompliance.

2. Imposing Per Instance and Per Day Civil Money Penalties on the Same Survey

Under its current regulations, CMS is currently unable to impose both a PI CMP and a PD CMP to address two separate occurrences of noncompliance identified during the same survey. For example, if a survey identified numerous instances of medication administration errors as well as systemic noncompliance with infection control policies, CMS believes that imposing a PI CMP for the medication errors and a PD CMP for the infection control deficiencies could be a more effective enforcement response.

CMS proposes to revise §§488.408(e)(2)(ii) and 488.430(a) to expand its authority to impose both a PI CMP and a PD CMP, not to exceed the statutory and regulatory maximum amount on any given day even when combined, when surveyors identify noncompliance. It makes the following specific proposals:

- For each instance of noncompliance, CMS and the State may impose a PD CMP of $3,050 to $10,000 (as adjusted under 45 CFR part 102), a PI CMP of $1,000 to $10,000 (as adjusted under 45 CFR part 102), or both, in addition to the remedies specified in §488.408(e)(2)(i).
- Revise §488.430(a) to allow for each instance of noncompliance, a PD CMP, PI CMP, "or both" may be imposed, regardless of whether or not the deficiencies constitute immediate jeopardy. When a survey contains multiple instances of noncompliance, a combination of per instance and per day CMPs for each instance of noncompliance may be imposed within the same survey.

CMS believes these proposed revisions will enable PI CMPs to be imposed for noncompliance that was previously not able to be addressed once a PD CMP was selected. This would also

allow CMS or a State survey agency to impose multiple PI CMPs for noncompliance that occurred prior to the start of a survey and use the survey start date to begin the PD CMP, thereby enabling more consistent CMP amounts to be imposed while still incentivizing a swift return to compliance.

Additionally, CMS proposes to make conforming changes by revising §488.434(a)(2)(iii) to clarify that both PD and PI CMPs can be imposed on the same survey and thus is included in the penalty notice to the facility. Furthermore, it proposes to revise §488.434(a)(2)(v) to indicate that the date and instance of noncompliance is not a singular event, but rather can be multiple "date(s) of the instance(s) of noncompliance." Lastly, it proposes to revise § 488.440(a)(2) to remove the phrase, "for that particular deficiency," and replace with, "per instance," which will allow for more than one PI CMP to be imposed on the same type of noncompliance or "F tag" citation. **CMS seek public comment on these proposed revisions**.

3. Timing of Enforcement

CMS notes that due to an increase in the number of complaint surveys being conducted, the current regulation may result in an unanticipated limit on CMS's authority to impose remedies to the noncompliance deficiencies identified when the last standard survey was performed. The current regulations limit how far back CMS or the State may go when calculating a CMP amount: to the last standard survey.

To address this issue, CMS proposes to revise §488.430(b) by changing "since the last standard survey" to "since the last three standard surveys." It believes this proposed revision aligns with the statutory mandate that the Secretary ensure that enforcement remedies adequately protect the health and safety of nursing home residents in facilities where the Medicare and/or Medicaid programs pay for services. It also notes that the proposed three-standard survey lookback period is also consistent with current agency practices. For example, this same timeframe is also used to calculate each facility's health inspection rating for the Five-Star Quality Rating System.

CMS seeks public comments on this proposal and also seek comments on an alternative look-back period that would also ensure CMPs are imposed in a manner that is not dependent on when the next standard survey is conducted.

4. Impact of Nursing Home Enforcement

CMS estimates that the overall economic impact of the proposed changes to CMS' enforcement authority results in an estimated additional penalty amount totaling $25 million annually to long term care facilities, and $163,800 in annual administrative costs to CMS and States.

VIII. Economic Analyses

CMS estimates that under the proposed rule in FY 2025, SNFs would experience an increase of $1.3 billion in payments from the update to the payment rates or an average increase of 4.1 percent across all SNFs. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $187.69 million.

Table 38 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 adoption of revised CBSAs from updated census data 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 4.9 percent overall compared with 4.0 percent for SNFs in urban areas.

Table 38: Impact to the SNF PPS for FY 2025

Impact Categories	Number of Facilities	Census Data Update	Update Wage Data	Total Change
Group	-	-	-	
Total	15,393	0.0%	0.0%	4.1%
Urban	11,151	0.0%	-0.1%	4.0%
Rural	4,242	-0.1%	0.9%	4.9%
Hospital-based urban	360	0.1%	-1.0%	3.2%
Freestanding urban	10,791	0.0%	-0.1%	4.0%
Hospital-based rural	369	-0.1%	0.8%	4.8%
Freestanding rural	3,873	-0.1%	0.9%	4.9%
Urban by region	-	-	-	
New England	715	-0.3%	-0.9%	2.8%
Middle Atlantic	1,467	-1.0%	-0.8%	2.3%
South Atlantic	1,893	0.6%	0.8%	5.5%
East North Central	2,166	1.0%	-0.6%	4.4%
East South Central	566	0.4%	2.1%	6.7%
West North Central	950	0.0%	0.6%	4.7%
West South Central	1,454	0.2%	1.0%	5.3%
Mountain	539	0.1%	1.6%	5.8%
Pacific	1,396	-0.1%	-1.4%	2.6%
Outlying	5	0.0%	-2.3%	1.7%
Rural by region	-	-	-	
New England	119	0.6%	-1.3%	3.4%
Middle Atlantic	226	-0.7%	4.0%	7.5%
South Atlantic	527	-0.1%	-0.3%	3.7%
East North Central	890	-0.1%	0.2%	4.2%
East South Central	471	-0.1%	1.5%	5.6%
West North Central	988	0.0%	1.5%	5.6%
West South Central	740	-0.1%	1.2%	5.2%
Mountain	193	0.0%	2.1%	6.2%
Pacific	87	0.0%	-0.6%	3.4%
Outlying	1	0.0%	0.0%	4.1%
Ownership	-	-	-	
For profit	10,893	0.0%	0.0%	4.0%
Non-profit	3,492	0.1%	0.1%	4.3%
Government	1,008	-0.1%	0.6%	4.7%

Note: The Total column includes the FY 2025 4.1 percent market basket update. Values may not sum due to rounding.

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

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	$106.08	1.41	$96.02	0.64	$17.48	ES3	3.84	$489.68	3.06	$294.40
B	1.61	$117.79	1.54	$104.87	1.72	$46.97	ES2	2.90	$369.81	2.39	$229.94
C	1.78	$130.22	1.60	$108.96	2.52	$68.82	ES1	2.77	$353.23	1.74	$167.41
D	1.81	$132.42	1.45	$98.75	1.38	$37.69	HDE2	2.27	$289.47	1.26	$121.22
E	1.34	$98.03	1.33	$90.57	2.21	$60.36	HDE1	1.88	$239.74	0.91	$87.55
F	1.52	$111.20	1.51	$102.83	2.82	$77.01	HBC2	2.12	$270.34	0.68	$65.42
G	1.58	$115.59	1.55	$105.56	1.93	$52.71	HBC1	1.76	$224.44	-	-
H	1.10	$80.48	1.09	$74.23	2.7	$73.74	LDE2	1.97	$251.21	-	-
I	1.07	$78.28	1.12	$76.27	3.34	$91.22	LDE1	1.64	$209.13	-	-
J	1.34	$98.03	1.37	$93.30	2.83	$77.29	LBC2	1.63	$207.86	-	-
K	1.44	$105.35	1.46	$99.43	3.50	$95.59	LBC1	1.35	$172.15	-	-
L	1.03	$75.35	1.05	$71.51	3.98	$108.69	CDE2	1.77	$225.71	-	-
M	1.20	$87.79	1.23	$83.76	-	-	CDE1	1.53	$195.11	-	-
N	1.40	$102.42	1.42	$96.70	-	-	CBC2	1.47	$187.45	-	-
O	1.47	$107.55	1.47	$100.11	-	-	CA2	1.03	$131.35	-	-
P	1.02	$74.62	1.03	$70.14	-	-	CBC1	1.27	$161.95	-	-
Q	-	-	-	-	-	-	CA1	0.89	$113.49	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
R	-	-	-	-	-	-	BAB2	0.98	$124.97	-	-
S	-	-	-	-	-	-	BAB1	0.94	$119.87	-	-
T	-	-	-	-	-	-	PDE2	1.48	$188.73	-	-
U	-	-	-	-	-	-	PDE1	1.39	$177.25	-	-
V	-	-	-	-	-	-	PBC2	1.15	$146.65	-	-
W	-	-	-	-	-	-	PA2	0.67	$85.44	-	-
X	-	-	-	-	-	-	PBC1	1.07	$136.45	-	-
Y	-	-	-	-	-	-	PA1	0.62	$79.06	-	-

Table 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

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	$120.92	1.41	$107.99	0.64	$22.02	ES3	3.84	$467.83	3.06	$281.28
B	1.61	$134.26	1.54	$117.95	1.72	$59.19	ES2	2.90	$353.31	2.39	$219.69
C	1.78	$148.43	1.60	$122.54	2.52	$86.71	ES1	2.77	$337.47	1.74	$159.94
D	1.81	$150.94	1.45	$111.06	1.38	$47.49	HDE2	2.27	$276.55	1.26	$115.82
E	1.34	$111.74	1.33	$101.86	2.21	$76.05	HDE1	1.88	$229.04	0.91	$83.65
F	1.52	$126.75	1.51	$115.65	2.82	$97.04	HBC2	2.12	$258.28	0.68	$62.51
G	1.58	$131.76	1.55	$118.71	1.93	$66.41	HBC1	1.76	$214.42	-	-
H	1.10	$91.73	1.09	$83.48	2.7	$92.91	LDE2	1.97	$240.01	-	-
I	1.07	$89.23	1.12	$85.78	3.34	$114.93	LDE1	1.64	$199.80	-	-
J	1.34	$111.74	1.37	$104.93	2.83	$97.38	LBC2	1.63	$198.58	-	-
K	1.44	$120.08	1.46	$111.82	3.50	$120.44	LBC1	1.35	$164.47	-	-
L	1.03	$85.89	1.05	$80.42	3.98	$136.95	CDE2	1.77	$215.64	-	-
M	1.20	$100.07	1.23	$94.21	-	-	CDE1	1.53	$186.40	-	-
N	1.40	$116.75	1.42	$108.76	-	-	CBC2	1.47	$179.09	-	-
O	1.47	$122.58	1.47	$112.59	-	-	CA2	1.03	$125.48	-	-
P	1.02	$85.06	1.03	$78.89	-	-	CBC1	1.27	$154.72	-	-
Q	-	-	-	-	-	-	CA1	0.89	$108.43	-	-
R	-	-	-	-	-	-	BAB2	0.98	$119.39	-	-
S	-	-	-	-	-	-	BAB1	0.94	$114.52	-	-
T	-	-	-	-	-	-	PDE2	1.48	$180.31	-	-
U	-	-	-	-	-	-	PDE1	1.39	$169.34	-	-
V	-	-	-	-	-	-	PBC2	1.15	$140.10	-	-
W	-	-	-	-	-	-	PA2	0.67	$81.63	-	-
X	-	-	-	-	-	-	PBC1	1.07	$130.36	-	-
Y	-	-	-	-	-	-	PA1	0.62	$75.53	-	-