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Medicare Program; Fiscal Year 2022
Skilled Nursing Facilities Prospective Payment System Final Rule
Summary

On July 29, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating fiscal year (FY) 2022 Medicare skilled nursing facility (SNF) payment rates and the requirements for the SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing (VBP) Program. The rule was published in the *Federal Register* on August 4, 2021.

The federal per diem rates under the SNF Prospective Payment System (PPS) are increased by 1.2 percent. A measure suppression policy and special scoring rules are adopted for the SNF VBP Program, and payment adjustments are made for FY 2022 in response to the COVID-19 Public Health Emergency. No structural changes are being made to the Patient Driven Payment Model (PDPM) patient classification system. CMS extensively discusses a methodology, referred to as a parity adjustment, to recalibrate the PDPM's budget neutrality adjustment. Finally, CMS summarizes public comments on several requests for information (RFIs) on future quality measures, digital quality measurement system development, and addressing health disparities in CMS programs.

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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. 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 those services.

Beginning in FY 2020, CMS implemented a new case-mix classification system to classify SNF patients under the SNF PPS: the PDPM (83 FR 39162). While the previous Resource Utilization Groups, Version IV (RUG-IV) classification model primarily used the volume of therapy services provided to the patient as the basis for payment, PDPM classifies patients into payment groups based on specific, data-driven patient characteristics. CMS notes that it continues to monitor the impact of PDPM implementation on patient outcomes and program outlays.

Adoption of the PDPM was intended to be budget neutral. However, CMS provided data analysis in the proposed rule indicating that Medicare is paying more under the PDPM than if the RUG-IV classification model had continued. At that time, CMS indicated that an adjustment of -5 percent would be necessary to restore budget neutral payments. While CMS did not finalize an adjustment for FY 2022, it notes that any delays in making the full adjustment allow excess payments to continue. CMS also reviews public comments received in response to the agency's request for information about parity adjustment options.

II. SNF PPS Rate Setting Methodology and FY 2022 Update

A summary of key data under the SNF PPS final rule for FY 2022 is presented below with additional details in the subsequent sections.

Summary of Key Data under SNF PPS for FY 2022	
Market basket update factor	
Market basket increase	+2.7%
Forecast error adjustment for FY 2020	-0.8%
Required multifactor productivity (MFP) adjustment	-0.7%
Net MFP-adjusted update	**+1.2%**
Wage index budget neutrality adjustment	1.0006
Labor-related share	70.4%

A. Federal Base Rates

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

B. SNF Market Basket Update

For FY 2022, the final market basket increase is 2.7 percent (2.3 percent in the proposed rule). The reduction for multifactor productivity (MFP), as required by law, is 0.7 percentage points (0.2 percentage points in the proposed rule). The market basket is based on the 2nd quarter 2021 forecast from IHS Global Insight, Inc. (IGI), using historical data through the 1st quarter of 2021. The MFP adjustment is based on IGI's 2nd quarter 2021 forecast of the 10-year moving average of economy-wide, non-farm MFP for the period ending September 30, 2022.

For FY 2020—the most recent year for which actual data are available—CMS applied a market basket increase of 2.8 percent but the actual increase was 2.0 percent. As the difference (0.8 percentage points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposed to apply a -0.8 percentage point adjustment to the FY 2022 SNF market basket. CMS invited comments on whether it should eliminate the forecast error adjustment or raise the threshold from 0.5 to 1.0 percentage points in future rulemaking.

Public comments supported options including keeping the current 0.5 percentage point threshold for doing a forecast error correction, raising the threshold to 1.0 percentage point, or eliminating the forecast error correction adjustment entirely. Other comments were concerned with the timing of a reduction to the update for forecast error correction during the COVID-19 public health emergency (PHE). CMS is not making any changes in policy in response to these comments and is finalizing a forecast error adjustment to the update of -0.8 percentage points. The resulting SNF market basket update equals 1.2 percent (2.7 percent less the 0.8 percentage points for forecast error and 0.7 percentage points for MFP reduction).

CMS also applies a 2.0 percentage point reduction to the update for SNFs that do not satisfy the reporting requirements for the FY 2022 SNF QRP. The rate update for SNFs that do not meet the

SNF QRP reporting requirements will be -0.8 percent. (The rate update is applied to the unreduced FY 2021 SNF federal per diem rates).

For FY 2022, CMS notes an additional adjustment to the unadjusted per diem base rates. Section 134 in Division CC of the Consolidated Appropriations Act (CAA), 2021 included a provision to exclude blood clotting factors, indicated for treatment of patients with hemophilia and other bleeding disorders, from the list of items and services included in the Part A SNF PPS per diem payment. The exclusion becomes effective for items and services furnished on or after October 1, 2021. The law further requires that the Secretary make a proportional reduction in SNF rates to account for blood clotting factors being excluded from the SNF per diem payments. In the proposed rule, CMS provided a detailed explanation of how it determined the SNF per diem rate adjustment of -$0.02 to the nursing and non-therapy ancillary rates only. Public commenters supported CMS' methodology. Therefore, CMS is finalizing the adjustment to SNF PPS rates for excluding blood clotting factors. The adjustment remains -$0.02 for the final rule.

Under the PDPM case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five components are case-mix adjusted: 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. Including all of the above-described adjustments, CMS calculates final FY 2022 SNF PPS rates, shown below compared to FY 2021 (not adjusted for case-mix):

Final Unadjusted Federal Rates Per Diem-FY 2021 and FY 2022				
	Urban		**Rural**	
Rate component – PDPM	**FY 2021**	**FY 2022**	**FY 2021**	**FY 2022**
Physical Therapy	$62.04	$62.82	$70.72	$71.61
Occupational Therapy	$57.75	$58.48	$64.95	$65.77
Speech-Language Pathology	$23.16	$23.45	$29.18	$29.55
Nursing	$108.16	$109.51	$103.34	$104.63
Non-Therapy Ancillaries	$81.60	$82.62	$77.96	$78.93
Non-case mix adjusted	$96.85	$98.07	$98.64	$99.88

C. Case-Mix Adjustment

Table 6 and table 7 of the final rule (reproduced in the appendices of this summary) show the PDPM case-mix adjusted federal rates and associated indexes for October 1, 2021 through September 30, 2022.

D. Wage Index Adjustment

CMS proposed to continue to apply the wage index adjustment to the labor-related portion of the federal rate as the basis for the SNF PPS wage index. To do this, the agency uses the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, but without applying the IPPS' occupational mix, rural floor, or outmigration adjustments. For FY 2022, CMS proposed to use updated wage data for hospital cost reporting periods ending in FY 2018.

The agency states that using 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.

As CMS is using the IPPS wage index to adjust SNF payments for area differences in labor costs, the agency must have a policy for the circumstance when a SNF is located in an urban or rural area that has no hospitals, and thereby no applicable wage index. CMS is continuing prior year policies, listed below. For 2022, these policies are only applicable in one urban area—CBSA 25980, Hinesville-Fort Stewart, Georgia.

- For rural areas without hospitals, CMS uses the average wage index from all contiguous urban areas as the SNF proxy wage index.
- For urban areas without hospitals, CMS uses the average wage index of all urban areas within the state as the SNF proxy wage index.

The Office of Management and Budget (OMB) provides the Core-Based Statistical Area (CBSA) delineations that are the basis of the labor market areas used by CMS for wage index adjustment. In the FY 2021 SNF PPS final rule, CMS indicated its intent to adopt the latest OMB revision for purposes of the FY 2022 SNF wage index. OMB published Bulletin 20-01 on March 6, 2020, in which one micropolitan area was added to the CBSA delineations. The addition will have no effect on the SNF wage index.

The wage index adjustment is applied to the labor-related share of the SNF payment rate. Effective with FY 2022, CMS proposed to rebase and revise the SNF market basket from 2014 to 2018 and the resulting labor-related share. The proposed 2018-based labor-related share summed 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 portion of Capital-Related expenses.

CMS uses a four-step process to trend forward the 2018 base year weights to FY 2022 price levels. The process includes computing the FY 2022 price index level for the total market basket and for each cost category of the market basket. Based on this update, CMS calculates a final rule labor-related share of 70.4 percent (70.1 percent in the proposed rule), compared to a FY 2020 final labor-related share of 71.3 percent. Table 8 in the final rule summarizes the labor-related share for FY 2022 (based on the IGI 2nd quarter 2021 forecast) compared with FY 2021 for each of the cost categories.

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 2021 to the weighted average wage adjustment factor for FY 2022. For this calculation, CMS uses the same FY 2020 claims utilization data for both the numerator and denominator of this ratio. The final budget neutrality factor for FY 2022 is 1.0006.

Public commenters requested that CMS consider 1) creating a SNF-specific wage index instead of relying on hospital data, and 2) provide its SNF cost report and wage data publicly so

commenters can conduct their own analyses related to refining the SNF wage index methodology. CMS repeats responses that it has provided many times before: collection of SNF-specific wage data would be highly burdensome and the resulting data would be volatile. The rule indicates that the use of proxy data from hospitals remains appropriate in the absence of SNF-specific wage data. CMS will examine additional data that could be publicly released to help stakeholders better understand its rationale for continued use of the hospital data.

To calculate the labor portion of the case-mix adjusted per diem rate, CMS multiplies the total case-mix adjusted per diem rate -- the sum of all five case-mix adjusted components into which a patient is classified -- and the non-case-mix component rate by the FY 2022 labor-related share percentage (provided in Table 8). The remaining portion of the rate would be the non-labor portion. Tables 9-11 of the final rule provide a hypothetical rate calculation to illustrate the methodology, including the wage index adjustment and case mix adjustment.

Wage index tables are no longer published in the *Federal Register*. Instead, these tables are available exclusively at: [Wage Index | CMS]

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

CMS proposed to continue using an administrative presumption: 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. The automatic presumption applies up to and including the assessment reference date for the 5-day 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 level of care determination using 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:

- The case-mix classifiers in the following nursing categories: Extensive Services, Special Care High, Special Care Low, and Clinically Complex;
- The following PT and OT classifiers: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- The following SLP classifiers: SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost comorbidity group (which is finalized as 12+).

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 not to be 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 proposed rule reviewed the consolidated billing requirements for SNFs, including billing for PT, OT, and SLP services that the resident receives during a non-covered stay. CMS also reviewed the specific exclusions from those requirements that remain separately billable. The exclusions include a number of "high cost, low probability" services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, that fall into 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 furnishing these products (effective October 1, 2021 as a result of the CAA, 2021 as explained above in summary section II.B.).

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 invited comments to identify specific HCPCS codes in any of these five service categories representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. To be excluded from consolidated billing, the services must be included in one of the above five categories and also must meet criteria as being of high cost and low probability in the SNF setting.[1]

Public commenters provided two HCPCS codes billed for blood clotting factor (J7204 and J7212) and a chemotherapy drug (Q5123) that they believe meet the criteria for exclusion from the consolidated billing requirements. CMS agreed. Other commenters requested that non-dialysis uses of EPO, orthotics, specific prosthetic codes and monoclonal antibodies be excluded from the consolidated billing requirements. For each of these requests, CMS reiterates prior responses. For EPO and monoclonal antibodies, these drug classes do not meet the requirements for exclusion from consolidated billing. The orthotics and prosthetic codes were in existence at the time the consolidated billing exclusions were enacted into law but not designated for exclusion. CMS, therefore, believes that the statute meant for these products to be included in consolidated billing.

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 tool in order to support implementation of the PDPM. The latest changes to the minimum data

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

set for swing-bed rural hospitals can be found at the SNF PPS website at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps.

IV. Other SNF PPS Issues

A. Rebasing and Revising the SNF Market Basket

For FY 2022 and subsequent fiscal years, CMS proposed to rebase the market basket to reflect 2018 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 final rule repeats the lengthy and technical explanation of this process. Public commenters supported CMS' proposal to rebase and revise the SNF market basket reflective of 2018 Medicare allowable total cost data.

The resulting change to the SNF index and the individual weights for each category is minimal and illustrated below:

Fiscal Year (FY)	2014-based SNF Market Basket	2018-based SNF Market Basket
Historical Data:		
FY 2017	2.7	2.7
FY 2018	2.6	2.6
FY 2019	2.3	2.3
FY 2020	2.0	2.0
Average FY 2017-2020	2.4	2.4
Forecast:		
FY 2021	3.2	3.1
FY 2022	2.7	2.7
FY 2023	2.7	2.7
Average FY 2021-2023	2.9	2.8
Source: IHS Global, Inc. 2nd quarter 2021 forecast with historical data through the 1st quarter 2021.		

The change to the labor-related share from rebasing and revising the SNF market basket is -0.9 percentage points (71.3 percent in FY 2021 to 70.4 percent in FY 2022). The components of the labor share and their changes are illustrated below:

	Relative Importance, Labor-Related Share, FY 2021 20:2 Forecast[1]	Relative Importance, Labor-Related Share, FY 2022 21:2 Forecast[2]
Wages and Salaries	51.1	51.4
Employee Benefits	9.9	9.5
Professional Fees: Labor-Related	3.7	3.5
Administrative & Facilities Support Services	0.5	0.6
Installation, Maintenance & Repair Services	0.6	0.4
All Other: Labor-Related Services	2.6	2.0
Capital-Related	2.9	3.0
Total:	71.3	70.4
[1] Published in the Federal Register (85 FR 47605); based on the 2nd quarter 2020 IHS Global Inc. forecast of the 2014-based SNF market basket, with historical data through first quarter 2020. [2] Based on the 2nd quarter 2021 IHS Global Inc. forecast of the final 2018-based SNF market basket with historical data through the 1st quarter of 2021.		

The major reason for the lower labor-related share is the decrease in the All Other: Labor-related services and professional fees cost weight.

A few commenters wrote in support of the revised labor share while one commenter opposed, stating the revision does not reflect the experiences of SNFs during the PHE. CMS declined to make any changes to its proposal other than to use revised data in the final rule to calculate a labor-related share of 70.4 percent instead of 70.1 percent.

B. Technical Updates to PDPM ICD-10 Mappings

CMS finalizes as proposed substantive changes to the PDPM code mappings of several ICD-10 diagnosis codes and groups of codes for FY 2022. The codes and their finalized revised mappings are listed below.

ICD-10 diagnosis codes are used to assign ("map") SNF patients to clinical categories in the physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) components of the PDPM and to assign certain comorbidities for classification under the SLP and non-therapy ancillary (NTA) components. The ICD-10 code set also is incorporated into other aspects of SNF operations such as application of the SNF GROUPER.

The code set undergoes routine annual review, after which any changes made are considered for inclusion in the PDPM. Public comments about changes are also routinely requested by CMS. Changes in ICD-10 codes may affect the accuracy of patient classification (and payment) under the PDPM. Changes with limited effects, termed nonsubstantive, are handled through a subregulatory process, while substantive changes are addressed through notice and comment rulemaking.

CMS reviews comments received, most of which supported the ongoing efforts by CMS to improve accuracy and clarity within the PDPM. One commenter disagreed with the revised mapping of two sickle-cell disease codes, but CMS was not persuaded to retain the original code mappings as requested. Another commenter requested remapping of multiple codes that had not been included in the proposed rule for consideration of remapping. CMS identifies these remapping requests as potentially substantive changes and therefore out of scope of this final rule but may consider them for future mapping updates.

Codes: D57.42 and D57.44: Sickle-cell thalassemia zero and beta without crisis
Revised Mapping: Return to Provider

Codes: K20.81, K20.91, and K21.0: Esophageal diseases with bleeding
Revised Mapping: Medical Management

Codes: M35.81: Multisystem inflammatory disease
Revised Mapping: Medical Management

Codes: P92.821, P91.822, and P91.823: Neonatal cerebral infarction, sites specified

Revised Mapping	Acute Neurologic
Codes	U07.0: Vaping disorder
Revised Mapping	Pulmonary
Codes	G93.1: Anoxic brain damage, not elsewhere classified
Revised Mapping	Acute Neurologic

C. Recalibrating the PDPM Parity Adjustment

1. Background

On October 1, 2019, CMS implemented the PDPM, a new case-mix classification model that replaced the prior case-mix classification model, the RUG-IV. Implementation of the PDPM was not intended to result in an increase or decrease in the aggregate amount of Medicare payment to SNFs, referred to by CMS as maintaining "parity." To achieve parity, CMS multiplied each of the PDPM case mix index (CMI) components by an adjustment factor. The factors were calculated by comparing total payments under RUG-IV to expected payments under the PDPM using FY 2017 claims and assessment data (the most recent final claims data available at the time). This analysis resulted in CMS multiplying each of the PDPM CMIs by an adjustment factor of 1.46.

Similar to what occurred in FY 2011 with the transition from RUG III to RUG-IV, CMS has observed a significant increase in overall payment levels under the SNF PPS during the transition from RUG-IV to PDPM. CMS believes a recalibration of the PDPM parity adjustment is warranted to ensure that the transition between RUG-IV and PDPM remains budget neutral. However, CMS also acknowledges that the PHE for COVID-19, which began during the first year of PDPM implementation and has continued into at least part of FY 2021, likely has impacted SNF PPS utilization data. Further, CMS is concerned that using the existing methodology to calculate a recalibrated PDPM parity adjustment could lead to a potentially inaccurate recalibration, given the significant differences in both patient assessment requirements and payment incentives between RUG-IV and PDPM.

For these reasons, CMS presents the results of its PDPM data monitoring efforts and a potential recalibration methodology intended to address the issues presented above.

2. FY 2020 Changes in SNF Case-Mix Utilization

CMS indicates that SNF case-mix utilization changed significantly in FY 2020 because of the transition to the PDPM. It also evaluates the impact of the COVID-19 PHE on case-mix utilization. As a result of the PHE, CMS issued waivers that would allow for SNF coverage without a 3-day prior inpatient hospitalization and allowed a beneficiary to renew SNF benefits without first having to start a new benefit period. The potential for patients not otherwise qualified for SNF coverage to gain coverage as a result of the PHE could have changed SNF case-mix utilization in FY 2020.

As compared to prior years, when approximately 98 percent of SNF beneficiaries had a qualifying prior hospital stay, approximately 87 percent of SNF beneficiaries had a qualifying prior hospitalization in FY 2020. Approximately 9.8 percent of SNF stays included a COVID-19 ICD-10 diagnosis code (either as a primary or secondary diagnosis) while 15.6 percent of SNF stays utilized a COVID-19 PHE waiver (with the majority of these cases using the prior hospitalization waiver).

These general statistics highlight that while the PHE for COVID-19 certainly impacted many aspects of nursing home operations, the overwhelming majority of SNF beneficiaries entered into Part A SNF stays in FY 2020 without using a PHE-related waiver, with a prior hospitalization, and without a COVID-19 diagnosis. Even when removing those cases using a PHE-related waiver and those with COVID-19 diagnoses from the dataset, the observed increase in SNF payments since PDPM was implemented is approximately the same. That is, patients using a COVID-19 PHE waiver are not causing the increased SNF case mix from the transition between RUG IV and the PDPM.

Moreover, CMS believes that there is clear evidence that PDPM alone is impacting certain aspects of SNF patient classification and care provision. For example, through FY 2019, the average number of therapy minutes SNF patients received per day was approximately 91 minutes. Beginning almost immediately with PDPM implementation (and well before the onset of the pandemic), the average number of therapy minutes SNF patients received per day dropped to approximately 62, a decrease of over 30 percent. Given both the immediacy and ubiquity of this change in the SNF data without any concurrent change in the SNF population, it is clear that the overall decrease in the amount of therapy services provided to SNF patients is a result of PDPM implementation, not other factors.

Similarly, CMS also observed the percentage of SNF stays which included concurrent or group therapy was approximately 1 percent for each of these therapy modes prior to FY 2020; these numbers rose to approximately 32 percent and 29 percent, respectively, beginning in the first month of PDPM implementation. Coincidentally, these numbers then dropped to 8 percent and 4 percent, respectively, beginning in April 2020, close to when the PHE for COVID-19 was declared (highlighting at least one impact of the PHE for COVID-19 on SNF care provision and utilization). CMS believes these utilization patterns are explained by the change to the payment system, as the agency could not identify any significant changes in health outcomes for SNF patients that would otherwise explain these utilization patterns.

The changes in therapy provision highlight the reasons why CMS believes that the typical methodology for recalibrating a parity adjustment would not be appropriate in the context of PDPM. CMS would typically utilize claims and assessment data from a given period under the new payment system, classify patients under both the current and prior payment model using this same set of data, compare aggregate payments under each payment model, and calculate an appropriate adjustment factor to achieve budget neutrality. However, given the significant reduction in the overall amount of therapy provided to SNF patients since PDPM implementation, as well as changes in the way that the therapy is provided (e.g., increases in group and concurrent therapy delivery), classifying SNF patients into RUG-IV payment groups using data collected under PDPM would lead to a RUG-IV case-mix distribution that differs

significantly with historical trends under RUG-IV. This finding clearly illustrates why CMS does not believe that the typical methodology for recalibrating the PDPM parity adjustment would result in an accurate calculation and may lead to an overcorrection.

3. Methodology for Recalibrating the PDPM Parity Adjustment

Identifying the scope and magnitude of the case-mix increase due solely to the change in the payment system begins with looking at the type of case-mix distribution that was expected under the new case-mix system and the actual case-mix distribution that occurs under the new case-mix system. Table 23 provides the average PDPM case-mix index expected for each of the PDPM rate components based on data from FY 2019. It also provides the actual average PDPM case-mix index for each of these components both inclusive and exclusive of patients diagnosed with COVID-19 or stays that utilized a COVID-19 related waiver.

	Expected CMI (FY 2019)	**Actual CMI (FY 2020)**	**Actual CMI w/o COVID and Waiver Stays**
Component	Average CMI	Average CMI	Average CMI
PT	1.53	1.50	1.52
OT	1.52	1.51	1.52
SLP	1.39	1.71	1.67
Nursing	1.43	1.67	1.62
NTA	1.14	1.20	1.21

These data show slight decreases for the PT and OT CMIs but large increases for the SLP, Nursing and NTA CMIs, irrespective of whether the COVID and waiver stay cases are included. CMS concludes that the increases in average case mix for these components are the result of PDPM and not the COVID-19 PHE.

CMS' basic methodology for recalibrating the parity adjustment has been to compare total payments under the new case-mix model with what total payments would have been under the prior case-mix model, were the new model not implemented. In order to calculate expected total payments under RUG-IV, in light of why CMS is not reclassifying SNF patients under RUG-IV using FY 2020 utilization data, CMS used the percentage of stays in each RUG-IV group in FY 2019 and multiplied these percentages by the total number of FY 2020 days of service. It then multiplied the number of days for each RUG-IV group by the RUG-IV per diem rate from 2019 updated to 2020. The total payments under RUG-IV also account for the difference in how the AIDS add-on is calculated under RUG-IV, as compared to PDPM, and similarly accounts for a provider's FY 2020 urban or rural status.

CMS' analysis identified a 5.3 percent increase in aggregate spending under PDPM as compared to expected total payments under RUG-IV for FY 2020 when considering the full SNF population. If those cases using a COVID waiver or diagnosed with COVID are eliminated, the increase is a 5.0 percent increase. CMS believes it would be more appropriate to pursue a recalibration using the subset population exclusive of COVID waiver patients and patients diagnosed with COVID.

Based on the above discussion and analysis, the resultant PDPM parity adjustment factor would be lowered from 46 percent to 37 percent for each of the PDPM case-mix adjusted components. If this adjustment were applied for FY 2022, CMS estimates that a reduction in SNF spending of 5.0 percent, or approximately $1.7 billion would occur.

Public commenters strongly objected to CMS' methodology for determining the parity adjustment, stating that CMS did not fully account for 1) the acuity of patients with COVID-19, and 2) the overall effect of the PHE across all patients. The majority of comments indicated that it was difficult to assess case mix from the PDPM due to the PHE. These commenters suggested a longer time period with data from outside of the PHE would be needed to evaluate the effect of the PDPM on case mix.

On the first, point, commenters indicated that there were no diagnosis codes for COVID-19 before April 2020. There was also a shortage of diagnostic testing opportunities for coronavirus. Further, there was significant confusion regarding use of the waivers. As a result, these commenters believe CMS' analysis did not exclude all of the high acuity COVID-19 patients. One commenter suggested CMS analyze the data for higher-than-expected respiratory infection cases and exclude such patients from its analysis.

On the second point, commenters indicated that SNFs faced higher acuity levels due to the PHE regardless of the patient's diagnoses. Factors explaining higher patient acuity include: suspension of elective operations resulting in more patients that could not be treated at home; limitations on SNF visitation leading to a variety of sequelae; and utilization declines leading to a higher overall case mix level. The implication of the comments is that CMS should not be subjecting these real increases in case mix to the parity adjustment.

Other commenters opposed the parity adjustment for reasons other than PHE effects. These commenters indicated that CMS did not account for the effect of an instruction to assess all patients anew in October 2019 using the PDPM assessment. This fresh assessment would likely have elevated NTA scores due to restarting the stay at the highest payment level, even though some of the newly assessed patients may temporally have been in the middle or end of their Medicare Part A coverage. There were also comments indicating that CMS' analysis was inconsistent with commenters' experiences.

There were comments opposing the parity adjustment on the grounds that SNFs were treating the same conditions pre- and post-PDPM that were not identified pre-PDPM because there were not incentives for coding some conditions. This commenter appears to be arguing against the parity adjustment but actually provides the exact justification that CMS uses for applying the adjustment—there was an increase in observed case mix without an increase in actual patient severity.

A minority of comments supported CMS' analysis, including the Medicare Payment Advisory Commission (MedPAC). With one exception, commenters in support of CMS' analysis did not recommend that the parity adjustment be applied in FY 2022. All commenters other than MedPAC suggested that the parity adjustment be adopted in the future and using a phased-in approach.

CMS acknowledged all of the above comments and indicated that the agency would consider them in adopting a future parity policy.

4. Applying the PDPM Parity Adjustment

The proposed rule acknowledged the possibility that applying a 5.0 percent reduction in payments in a single year and without time to prepare for the reduction in revenue could create a financial burden for providers. In light of this possibility, CMS considered a number of potential mitigation strategies, described below.

Delayed Implementation Strategies: Delay the reduction for some period of time (e.g., one or more years) but implement the full 5 percent reduction in a single year.

Phased Implementation Strategies: Spread the amount of the reduction over some number of years (e.g., a 2-year phased implementation approach would reduce the PDPM CMIs by 2.5 percent in the first year of implementation and the remaining 2.5 percent in the second and final year of implementation). The number of years for a phased implementation approach could be as few as 2 years but also as long as necessary to appropriately mitigate the yearly impact of the reduction.

Combination Strategies: Both delay the start and spread the reduction in the PDPM reduction over more than a single year.

CMS solicited comments on all of these approaches. It further noted that the adjustment would be applied prospectively and would not affect any past year payments. CMS does indicate that delays in applying the adjustment do allow excess payments to continue, for which reason the agency believes that it is imperative to act in a well-considered but appropriately expedient manner once excess payments are identified.

The majority of commenters supported a combination strategy with no more than a 1 percent adjustment per year. MedPAC did not support a phase-in approach because of the current high level of aggregate payment to SNFs. Some commenters supported applying the parity adjustment only to non-therapy components of the SNF PPS rates that are showing higher increases in case mix than PT and OT. Other comments suggested applying financial penalties on specific facilities driving the increase. CMS indicated that it would consider all of these comments when deciding how to apply an additional parity adjustment in the future.

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

The SNF QRP was established pursuant to the IMPACT Act and is a pay-for-reporting program. 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 annual update factor. 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 instruments are sent electronically to CMS through the Internet Quality Improvement & Evaluation System (iQIES).

A table at the end of this section (located at V.G.) displays the SNF QRP measures adopted for the FY 2022 program year. The list is not changed by the final rule. 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. This website also provides access to information about all aspects of the SNR QRP.

The Consolidated Appropriations Act, 2021 (CAA) requires the Secretary to apply a data validation process for SNF QRP and SNF VBP measures. CMS indicates that the process will most likely build on the one recently updated for use in the Hospital Inpatient Quality Reporting (IQR) Program. The agency plans to develop a SNF quality data validation policy as soon as technically feasible and to seek comment in future rulemaking.

A. New and Updated Measures for FY 2023

CMS finalizes as proposed the addition of two new measures for the SNF QRP: SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI) and COVID-19 Vaccination Coverage among Healthcare Personnel (HCP). Also proposed is a revision to the denominator of the Transfer of Health Information to the Patient-Post-Acute (TOH-Patient-PAC) measure. Finalized data submission requirements for the two new measures are discussed in VI.E below; no changes are made to the previously finalized data submission requirements for the TOH-Patient-PAC measure.

1. SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)

CMS finalizes as proposed to add this outcome measure to the SNF QRP beginning with the FY 2023 program year to address the wide variation (performance gap) reported in HAI rates among SNF providers and to specifically identify infections serious enough to result in acute care hospital admissions. The measure uses one year of Medicare Fee-for-Service claims data to estimate the risk-standardized rate of HAIs acquired during SNF stays and result in hospitalizations and is calculated as a risk-standardized ratio.

Measure specifications are fully discussed in the measure development contractor's report available at https://www.cms.gov/files/document/snf-hai-technical-report.pdf and in the CMS List of Measures Under Consideration for December 1, 2020 available at https://www.cms.gov/files/document/measures-under-consideration-list-2020-report.pdf.

In discussing the finalized measure, CMS shares data about the performance gap in HAI rates across SNFs and the factors that can contribute to the occurrence of HAIs in the SNF setting. Also reviewed are the adverse clinical and cost outcomes that may result from HAIs in this vulnerable population, and links between the rates of COVID-19 infections and HAI are explored.

Following the usual pre-rulemaking process for stakeholder input including a Technical Expert Panel (TEP), the measure was placed on the December 21, 2020 Measures Under Consideration

List. The Measure Applications Partnership (MAP) conditionally supported the measure for rulemaking contingent upon NQF endorsement and found it to be suitable for use with rural as well as urban providers. The measure showed moderate reliability and strong face validity during testing.

CMS plans to seek NQF endorsement of the measure, but finalizes adoption of the measure for FY 2023 because of the serious consequences of HAIs in this vulnerable population, and having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. Existing similar measures are disease or infection-site specific. In adopting this measure without NQF endorsement, CMS utilizes the discretion permitted to the Secretary under section 1899B(e)(2)(B) of the Act.

CMS is considering requiring use of the HAI measure in other post-acute care settings. Because the SNF HAI measure is claims-based, there is no associated new burden for providers.

Some commenters including the Medicare Payment Advisory Commission (MEDPAC) supported the adoption of the measure. MedPAC stated that the rate of infections acquired during a SNF stay that are severe enough to require hospitalization is an outcome of importance to beneficiaries and to the Medicare program. In response to commenter that disagreed that there is a performance gap regarding HAIs in SNFs, CMS reviews its analysis and cites additional evidence for such a gap. In response to concerns about the use of FY 2019 data, CMS reiterates that FY 2019 data are not being used as a benchmark for HAI performance. Rather, the measure compares facilities' HAI rates to the rates of their peers.

In response to commenters' concerns about using inpatient claims and relying on outside medical practitioners' diagnoses to capture the rates, CMS relates that the TEP discussed alternative data sources, including the use of NHSN data, but ultimately decided against using those sources because they would increase provider burden. The TEP also agreed that claims data are high quality and would strengthen the SNF QRP measure portfolio without increasing provider burden. CMS declines, in response to commenters' recommendations, to delay adopting the measure and notes that it has narrowed the interval between claim submission and public display to support more timely improvement of the HAI rate.

To those opposing the adoption of a composite score or recommending the measure incorporate emergency room and observation stays in addition to inpatient claims, CMS states that the composite score provides a summary of overall performance rather than targeting any individual type of infection and that the TEP recommended focusing on severe infections in hospitals to target quality improvement in the biggest impact areas. CMS further addresses concerns about misattribution to SNFs for infections acquired elsewhere (by excluding certain community-acquired infections), about the measure not being actionable (CMS disagrees), risk adjustment masking poor outcomes (it shares the concern but states that the lack of risk adjustment would disadvantage those SNFs that specialize in treating high-risk populations), and the absence of social risk factors (it plans to continue to evaluate this issue.) CMS also acknowledges concerns about FY 2020 data being affected by the severity of the pandemic and states that no data reflecting services provided in FY 2020 will be publicly reported.

In response to a request for best practices, CMS reviews the resources it has made available including online training modules and other resources including at https://www.cdc.gov/longtermcare/prevention/index.html; https://www.cdc.gov/longtermcare/training.html; and https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.

2. COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

CMS finalizes as proposed to add a new process measure to the SNF QRP beginning with FY 2023 to track the percentage of healthcare personnel (HCP) who receive a complete COVID-19 vaccination course. The finalized measure is designed to generate actionable quality improvement data on vaccination rates and aid patients with decision-making about post-acute care facilities.

Full specifications are available on the CDC website: https://www.cdc.gov/nhsn/nqf/index.html. In discussing the measure, CMS reviews the declaration of COVID-19 as a public health emergency, methods of viral transmission, vulnerable patient groups such as SNF residents, and guidelines for prioritizing vaccine recipients. Following the usual pre-rulemaking process for stakeholder input, the proposed measure was included on the December 21, 2020, Measures Under Consideration List. The MAP conditionally supported the measure for rulemaking contingent upon clarification of measure specifications, and CMS returned to the MAP with results from further measure testing and updated specifications.

CMS states its intention to seek NQF endorsement of the measure, but adopts the measure for FY 2023 given ongoing COVID-19 PHE impacts and having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. In adopting this measure without NQF endorsement, CMS utilizes the discretion permitted to the Secretary under section 1899B(e)(2)(B) of the Act. CMS notes that the measure most similar to the COVID-19 HCP measure is the NQF-endorsed measure of influenza vaccination among HCP (NQF #0431), already in use in the CMS quality programs for inpatient rehabilitation facilities and long-term care hospitals.

CMS estimates the regulatory burden of data submission for this new measure would be 12 hours per year for each SNF at an annual cost ranging from approximately $330 to $550 per SNF. Aggregate burden for all SNFs is estimated to total approximately 181,000 hours and $6.625 million.

A number of organizations, including provider groups and patient advocacy groups supported adoption of the COVID-19 HCP measure. Other commenters raised concerns about the collection burden including the need to collect multiple similar measures, lack of access to the vaccines, concerns related to staff intimidation if they elect not to receive the vaccine, whether a booster will be needed, and the fact that it has not yet received full FDA approval.

CMS replies to commenters who raised concerns about multiple similar or related measures including the SNF HAI measure; vaccine reporting required as a component of the LTC conditions of participation; staff and resident vaccination rates reported weekly via NHSN's

Weekly HCP and Resident COVID-19 Vaccination Module; and MIPS clinician reporting regarding Influenza Vaccination Coverage. CMS points out the differences among the different measures and reporting requirements. It further clarifies that a SNF that submits four weeks of data to meet the requirements of LTC facility reporting requirements at §483.80(g) would also meet the data submission requirement for the COVID-19 Vaccination Coverage among HCP for the SNF QRP.

CMS believes that should a booster become necessary, the numerator of the measure is sufficiently broad to include the boosters as part of a complete vaccination course. In response to those concerns and to a recommendation to delay collection of the measure, CMS states that "given the novel nature of the SARS-CoV-2 virus, and the significant and immediate health risk it poses in SNFs, we believe it is necessary to adopt this measure as soon as possible."

With respect to staff intimidation, CMS reiterates that the measure does not require HCP to complete the vaccination course in order to meet the measure's reporting requirements and that the rate of vaccination in a SNF is not tied to their Medicare payment.

CMS describes resources that it has made available for additional training and guidance including free online training modules in partnership with the CDC and Quality Improvement Organizations (QIOs). The QIO program aims to increase patient safety and care coordination, and improve clinical quality by, among other things, working with providers, other stakeholders, and Medicare beneficiaries on initiatives to improve the quality of health care for Medicare beneficiaries. Several of these resources can be found on the following webpages: https://www.cdc.gov/longtermcare/prevention/index.html and https://www.cdc.gov/longtermcare/training.html. In addition, the CMS Office of Minority Health (OMH) offers a Disparity Impact Statement as an intervention to address HAI-related disparities. This tool may be used to provide health equity technical assistance and reduce HAIs among vulnerable populations. The Disparity Impact Statement tool can be viewed at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.

3. Transfer of Health Information to the Patient-Post-Acute Care (TOH-Patient-PAC)

CMS finalizes its proposal to update the specifications for this process measure's denominator beginning with FY 2023 to exclude patients discharged home under the care of an organized home health service or hospice. Currently the denominators for the TOH-Patient-PAC measure and the companion TOH-Provider-PAC measure both include patients discharged home under the care of an organized home health service or hospice. The revised TOH-Patient-PAC denominator would be limited to discharges to a private home/apartment, board and care home, assisted living, group home, or transitional living.

Commenters were overwhelmingly supportive of the revision. In response to a few commenters who stated that it was premature to introduce the measure for FY 2023 since assessment data is not yet available to calculate performance, CMS states because it is uncertain when the PHE will end, by finalizing an effective date of FY 2023, the measure update will be in place when the PHE ends and the MDS item A2105 – Discharge Status data element collection begins.

In response to a commenter who was concerned that revising the denominator would reduce the incentive for the SNF to provide a medication list to the patient, family or caregiver when the patient is transferred, CMS reviews the requirement under §483.21(c)(2)(iii) to provide a resident at discharge with a discharge summary that includes, but is not limited to, reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

For additional technical information regarding the TOH-Patient-PAC measure, CMS refers readers to the document titled "Final Specifications for SNF QRP Quality Measures and Standardized Patient Assessment Data Elements" available at [Final Specifications for SNF QRP Quality Measures and SPADEs (cms.gov)].

B. RFI: Future Year Quality Measures

CMS sought comment on the importance, relevance, appropriateness and applicability of each of the following assessment-based quality measures and concepts under consideration for future addition to the SNF QRP:

- Frailty,
- Opioid use and frequency,
- Patient reported outcomes,
- Shared decision-making process,
- Appropriate pain assessment and pain management processes, and
- Health equity.

Most commenters were supportive of including those proposed measures for future addition to SNF QRP. Some commenters were uncertain about what is meant by the term "patient reported outcomes." Other commenters encouraged CMS to remove topped out measures and low occurrence measures to ensure the program remains relevant to quality and performance. Some additional concepts were suggested for quality measurement including nutritional status, cognitive status, and advance directives.

CMS intends to incorporate this input when considering future measure development.

C. RFI: Fast Healthcare Interoperability Resources (FHIR)

CMS sought input into the agency's planning for transformation to a fully digital quality enterprise, and specifically asked about the following:

- EHR/IT systems currently used by commenters and if they participate in a health information exchange;
- How commenters share information currently with other providers;
- Approaches by which CMS could incent or reward commenters who use health information technology (HIT) in innovative ways to reduce burden for SNFs (and other post-acute care providers);

- Resources and tools for use by SNFs (and other post-acute care providers) and HIT vendors to facilitate interoperable, fully electronic health information sharing that incorporates FHIR standards and secure application programming interfaces (APIs); and
- Willingness of HIT vendors who work with SNFs (and other post-acute care providers) to participate in pilots or models that align measure collection standards across care settings (e.g., sharing patient data via secure FHIR-based APIs for calculating and reporting digital measures).

CMS does not provide a summary of the comments that it received in response to this RFI but notes that it intends to take comments into account in developing future regulatory proposals or guidance related to digital quality measurement.

D. RFI: Closing the Health Equity Gap in Post-Acute Care QRPs

CMS requested information on potential revisions to the SNF QRP to facilitate comprehensive and actionable reporting of health disparities, specifically:

- Recommendations for measures or measurement domains addressing health equity;
- Guidance on social determinants of health to be added to those already included in the SNF QRP as standardized patient assessment data elements (SPADES);
- Recommendations that promote equity in outcomes, such as providing facility-level performance data to each SNF, stratified by social risk factors (similar to reports being given to hospitals about their readmissions for dual-eligible versus other beneficiaries);
- Data sources and methods already in use by commenters for reducing disparities and improving outcomes; and
- Changes to address current challenges in capturing and exchanging patient information on social determinants of health for use in care delivery and decision making.

CMS does not provide a summary of the comments that it received in response to this RFI but notes that it intends to take concerns, comments, and suggestions into account as it develops policies on this topic. It states that it hopes to provide additional stratified information to providers related to race and ethnicity if feasible to enable PAC providers to understand how they are performing with respect to certain patient risk groups, to support these providers in their efforts to ensure equity for all of their patients and to identify opportunities for improvements in health outcomes.

E. Form, Manner, and Timing of Data Submission

No changes were proposed to existing SNF QRP data reporting policies.

<u>SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)</u>

The newly finalized SNF HAI measure will be calculated using Medicare Fee-for-Service claims data, so that no new data submission is required of SNFs related to this measure. For the FY 2023 SNF QRP, CMS will use the full year of claims data from FY 2019, the most recent fiscal

year of data that has not been affected by data reporting exceptions related to the COVID-19 PHE. For the FY 2024 program year, CMS will use the full year of claims data from FY 2021, and advance thereafter by one FY with each annual SNF QRP data refresh. The schedule avoids using Q1 and Q2 2020 data for which a national data reporting exception was issued due to COVID-19 PHE impacts.

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

Because the COVID-19 PHE is ongoing, CMS finalizes for this measure an initial data submission period of October 1, 2021 through December 31, 2021 for use in the FY 2023 SNF QRP. For FY 2024 and subsequently, a full calendar year submission period is finalized (e.g., all 12 months of CY 2022 data would be reported for the FY 2024 program year). Data submission through the CDC's National Health Safety Network (NHSN) web-based surveillance system by each SNF will be required for at least one week each month, and the CDC will report data quarterly to CMS for use in the SNF QRP. CMS requires SNFs to utilize the NHSN's specifications and data collection tools as specified for this measure by the CDC when SNFs submit their data (NHSN materials are available at http://www.cdc.gov/nhsn/).

One commenter raised concerns about implementing a measure based on NHSN data because there is no process in place for SNF providers to receive feedback on data submissions and correct errors before the data is made public and assessed. CMS replies that SNFs will have access to provider reports on their NHSN measure performance prior to the submission deadline. In addition, CMS' contractor sends informational messages to SNFs that are not meeting Annual Payment Update (APU) thresholds on a quarterly basis ahead of each submission deadline. Information about how to sign up for these alerts can be found on the SNF QRP Help webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-QRP-Help.

CMS replies to a number of concerns raised about the burden of the measure and duplication of reporting effort. It reviews its basis for requiring the measure and reporting through the NHSN. CMS asserts that because SNFs are currently required to submit COVID-19 HCP vaccination data through the CDC's NHSN Long-term Care Facility COVID-19 Module of the NHSN it expects there will be no additional burden imposed with the adoption of the SNF QRP measure.

CMS clarifies that the new measure will be required to be reported to the CDC through the NHSN quarterly with data from at least 1 self-selected week per month. Each quarter the CDC will average 3 weeks of data collected over the 3 months and send a quarterly average vaccination rate for each provider to CMS. In response to a request for an explanation of feedback reports, CMS reviews the types of reports it provides to give providers feedback and an opportunity to review and correct data.

F. Policies Regarding Public Display of Measure Data for the SNF QRP

SNF QRP measure data are displayed via CMS' Care Compare and the Provider Data Catalog web pages in the *Nursing homes including rehab services* section.[2]

SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)

CMS finalizes as proposed to begin public reporting of the SNF HAI measure with the April 2022 Care Compare refresh, or as soon as technically feasible, and SNFs will receive provider preview reports in January 2022. SNF HAI rates will be displayed based on data from one fiscal year; the initial display will reflect FY 2019 discharge data. The October 2022 Care Compare refresh will be based on FY 2021 discharge data (avoiding use of data impacted by the COVID-19 PHE) and each subsequent annual refresh will reflect four quarters of data.

Acceptable reliability of the SNF HAI measure requires 25 or more eligible stays. The parameters of "eligible stays" are contained within the inclusion criteria for the measure. CMS will flag on Care Compare those SNFs with fewer than 25 eligible stays during a performance period as having too few stays to report, and no results will be displayed.

In response to commenters requesting CMS delay adoption of the SNF HAI measure, CMS reiterates that because the measure is claims-based, there will be no additional burden and that the measure will not compare 2019 to 2021 data. Instead the measure identifies SNFs with notably higher rates of HAIs compared to other SNFs during the same period of time. One commenter opposed excluding SNFs with fewer than 25 admissions from public reporting. CMS however, maintains that the threshold is intended to ensure sufficient reliability and to mitigate the potential of exposing protected health information.

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

CMS finalizes its proposal to add the new COVID-19 vaccination coverage measure to publicly reported SNF QRP data available on the Care Compare and the Provider Data Catalog web pages but makes one significant change. As proposed, display will begin with the October 2022 Care Compare refresh, or as soon as technically feasible, based on Q4 2021 data. In response to comment, however, CMS revises its plan for refreshing data. Instead of adding one additional quarter of data during each advancing refresh, until four full quarters is reached and then using four rolling quarters of data, CMS will instead only report the most recent quarter of data. CMS agreed with commenters who recommended this approach as it will result in publishing more up to date and more meaningful information.

Consistent with the comments above, CMS addresses concerns related to burden, duplication of effort, and requests for delaying public display of the measure. CMS declines to make additional changes in response to those concerns. In addition, a commenter recommended breaking the percentage out into first and second doses. CMS declines the recommendation, stating that it

[2] See https://www.medicare.gov/care-compare/ and https://data.cms.gov/provider-data/, respectively.

believes the value of the measure is in knowing the number of HCP who have completed their full vaccination courses.

Public Reporting of Measures with Fewer than Standard Numbers of Quarters Due to COVID-19 Effects

CMS finalizes as proposed temporary changes to the data collection quarters specified in prior rulemaking for SNF QRP measure results that are publicly displayed on Care Compare. CMS will implement the COVID-19 Affected Reporting (CAR) Scenario for public reporting of measure results for the SNF QRP Care Compare data refreshes for January 2022 through July 2023. The finalized changes are designed to account for incomplete data reporting during the COVID-19 pandemic ("exempted quarters") and to return to pre-pandemic public reporting timelines as rapidly as feasible, while preserving the usefulness and accuracy of the displayed results. Tables 27, 28, and 29 show the revised refresh schedules by measure data source. Refreshes on Care Compare for the SNF QRP measures are specific to each measure's source data: the SNF Minimum Data Set (MDS) assessment tool or Medicare claims. Normally, four contiguous quarters of data are used for MDS-derived measures while eight quarters are used for claims-based measures.

In response to the COVID-19 PHE, CMS granted a nationwide exemption to the SNF QRP reporting requirements for Q4 2019 and Q1 and Q2 2020, although facilities were able to report data voluntarily. CMS subsequently determined that the Q4 2019 data were suitable for use in Care Compare refreshes as previously scheduled but that Q1 and Q2 2020 data were not suitable. Based on its data analysis, CMS decided that freezing the publicly displayed results beginning with the October 2020 would be appropriate until such time as the data to be added were no longer affected by the Q1 and Q2 2020 nationwide data reporting exemption. The CAR scenario allows more rapid return to pre-pandemic refresh schedules by reducing the number of quarters of data collected for each refresh and was extensively tested and analyzed by CMS as described in the rule.

Most commenters expressed appreciation for the exceptions to the SNF QRP reporting requirements during the early months of the COVID-19 pandemic. However, a number of commenters raised concerns with CMS' proposal to utilize fewer than the standard number of quarters for public reporting of quality measures on Care Compare, since it includes SNF QRP reporting from Q3 2020 (July 1, 2020 through September 30, 2020) and Q4 2020 (October 1, 2020 through December 31, 2020). CMS understands those concerns but believes that the value of the information provided to users through public reporting outweighs the concerns. CMS also reminds readers that if they believe they were disproportionately affected by the PHE, they may request an extraordinary circumstances exception at the SNF QRP Reconsideration and Exception and Extension webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.

Other commenters requested the public display be delayed, raised concerns about the impact of the changes on Medicaid quality programs, and requested that CMS include a notation on Care Compare to explain temporary adjustments related to the PHE. CMS declines to delay the public

reporting and states that issues related to Medicaid quality programs are outside of the scope of this regulation. It also states that it will notify consumers of the use of fewer quarters of data on Care Compare when the website is refreshed.

G. Summary Table of SNF QRP Measures

Table HPA SNF QRP-1: Quality Measures Currently Adopted for the FY 2022 SNF QRP	
Short Name	**Measure Name & Data Source**
Data Source: Resident Assessment Instrument Minimum Data Set	
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).
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).
Beginning in FY 2022*	Transfer of Health Information to the Provider – PAC Measure
Beginning in FY 2022*	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 collection was to begin with October 2020 for FY 2022 program use but has been delayed due to the COVID-19 PHE to begin with discharges on October 1st of the year that is at least 2 full FY after the PHE ends (85 FR 27596). However, in this rule, CMS finalizes the reporting of these measures beginning with CY 2023. The associated MDS item A2015, however, has not yet become available for SNF use.
**Measure denominator revision has been proposed for the FY 2023 program year.
Source: HPA modification of Table 24 of the final rule

VI. Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing (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 FY 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. Public display of SNF VBP performance was moved to CMS' Care Compare website Nursing Homes section beginning with FY 2021: https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true.

In brief, 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. Amounts redistributed are based on each facility's performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510) and disbursed through the application of a value-based incentive adjustment 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 the SNF VBP program's low-volume facility policies.

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

A. SNF VBP Program Measures

The measures that have been adopted to date into the SNF VBP Program are the SNFRM and the Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge (SNFPPR). Currently, only the SNFRM is in use. As required by statute, CMS intends to replace the SNFRM with the SNFPPR. Toward that end, CMS plans to submit the SNFPPR to the NQF for endorsement during the fall 2021 endorsement cycle. Timing of the measure transition will be determined thereafter. Therefore, the SNF VBP measure set for FY 2022 will be unchanged from that for FY 2021.

Section 111 of the Consolidated Appropriations Act, 2021 (CAA, 2021) amended section 1888(h) of the Act, allowing the Secretary to add up to 9 additional measures to the SNF VBP Program. The new measures would not apply to payments for services until on or after October 1, 2023.

Potential Future Measures for the SNF VBP

In the proposed rule, CMS requested comments on potential new SNF VBP measures and whether the new measures should be collected for all SNF residents regardless of payer.

CMS summarizes the feedback received. There was general support for measure addition but little consensus about the best candidates for inclusion. Many agreed that the measure *Percentage of Long-Stay Residents who got an Antipsychotic Medication* should not be added so

as to avoid discouraging clinically appropriate use of this class of medications. There was considerable support for adding a patient experience of care measure but again no consensus measure identified, with support received for both the CoreQ: Short Stay Discharge measure and the Nursing Home CAHPS Resident and Family Member survey measure.

Some commenters expressed support for measures related to facility staffing, including staff turnover rates. Others expressed concern about measure confounding by the variability of state-mandated staffing requirements. Few commenters addressed the question of whether new measures should be collected for all SNF residents regardless of payer, and opinions were divided. CMS indicates an interest in a measure(s) related to facility staffing and concludes by stating that commenter suggestions will be considered in future policy development.

B. SNF VBP Policy Flexibility in Response to the COVID-19 PHE

1. Cross-program Measure Suppression Policy

CMS finalizes as proposed a "cross-program measure suppression policy" for its value-based programs, including the SNF VBP program, beginning with FY 2022 and extending for the duration of the COVID-19 PHE. Under this policy, one or more quality measures may be suppressed in the agency's value-based programs if the agency were to determine that circumstances related to the PHE have significantly compromised measure data and performance scores based on those data. Suppression may be accomplished through changes in data collection and submission, measure specifications, baseline and performance periods, and/or scoring methodology. Confidential performance reports are shared with providers that include suppressed measure data and some data are also publicly displayed.

To guide its decision making when considering measure suppression, CMS finalizes adoption of several Measure Suppression Factors, and the factors are the same across the value-based programs to which the policy may be applied, listed below.

1) Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or worse compared to historical performance during the immediately preceding program years;
2) Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the COVID-19 PHE;
3) Rapid or unprecedented changes in
   i. Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
   ii. The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin; and
4) Significant national shortages or rapid or unprecedented changes in
   i. Healthcare personnel;
   ii. Medical supplies, equipment, or diagnostic tools or materials; or
   iii. Patient case volumes or facility-level case mix.

CMS requested input on the proposed policy and suppression factors and on adoption of a measure suppression policy for future PHEs. Comments were few but supportive of the policy and the suppression factors. Some suggested that suppression policies for future PHEs take into account any geographic variations relevant to each PHE.

2. Application of Measure Suppression and SNF VBP Special Rules for FY 2022

CMS finalizes its proposal without modification to suppress the SNFRM for the SNF VBP FY 2022 program year along with the associated scoring and payment policies. The policies are being codified as "Special rules for the FY 2022 SNF VBP Program" at §413.338(g).

Steps to be taken under the special rules include:

- Calculating SNFRM rates per established methodology using data from the performance and baseline periods for FY 2022 as previously finalized;
- Changing the measure scoring methodology to assign a performance score of zero to all SNFs (except those qualifying for the low-volume adjustment under extant policies);
- Calculating the value-based incentive payment adjustment factor using a score of zero for each facility;
- Calculating the value-based incentive payment amount for each facility using the established methodology (§413.338(c)(2)(ii)); and
- For eligible facilities, applying the established low-volume scoring adjustment (§413.338(d)(3)).

The end result of applying the special rules is that all SNFs, other than low-volume facilities, will receive a net-neutral incentive payment multiplier, and 60 percent of their withheld funds will be returned to them. Low-volume facilities will receive back 100 percent of their withheld funds. The residual withheld funds, estimated to be 37.1 percent of the total of funds withheld initially, will be returned as savings to the Medicare program.

CMS reviews comments received. Many commenters offered support. One commenter objected, stating that the suppression policy as applied to the SNF VBP violates section 1888(h)(6) of the Act by not making value-based payments as required by the statute, since the suppression policy does not differentiate among facilities based on their performances. CMS responds that the SNFRM results for FY 2022 would not accurately reflect facility performance for national comparison and ranking purposes. Some commenters expressed concern about any public display of the FY 2022 data and the potential for their misunderstanding by the public. CMS notes the importance of maintaining data transparency, but adds that appropriate caveats about the use of data suppression will accompany the data.

3. SNFRM Risk Adjustment Lookback Period Revision for FY 2023 Program Year

CMS finalizes as proposed revising the lookback period to be used in the SNFRM risk adjustment model for the FY 2023 SNF VBP program year from 365 days to 90 days. This is begin done to compensate for the effect of the nationwide blanket exceptions issued for quality data reporting for Q1 and Q2 2020 that were part of the agency's early response to the PHE. No objections or substantive concerns were raised by commenters.

4. Performance and Baseline Period Updates for Fiscal Years 2022, 2023, and 2024

FY 2022. CMS reaffirms the performance period for FY 2022 as adopted in the September, 2020 COVID IFC: the combination of April 1, 2019-December 31, 2019 and July 1, 2020-September 30, 2020. CMS also summarizes the comments received in response to the September, 2020 COVID IFC. Comments were few and support was mixed.

FY 2023. CMS had proposed no changes to the previously established FY 2023 performance period – FY 2021 – and baseline period – FY 2019. However, a comment was received opposing the performance period since it includes Q4 2020 data that has not been adjusted for COVID-19 PHE effects. CMS had solicited comments on possibly adjusting the SNFRM measure specifications to address COVID-19 effects during the FY 2023 performance period (e.g., exclude residents with COVID-19 diagnoses) but received no comments on this alternative. Therefore, the performance period as established in the September, 2020 IFC will be used.

FY 2024. CMS finalizes its proposal to use FY 2019 data for the FY 2024 baseline period without modification. A commenter suggested that 2019 data may not represent a relevant comparator year for 2024. CMS notes that operational feasibility affected its baseline year choice and adds that data analysis is underway to evaluate potential changes to the SNFRM specifications. Having finalized the baseline period, CMS calculates the final SNFRM performance standards for FY 2024 as shown in Table 31 of the rule, reproduced below.

Table 31: Final FY 2024 SNF VBP Program Performance Standards

Measure ID	Measure Descriptor	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79271	0.83033

5. SNF VBP Performance Scoring for the FY 2022 Program Year

CMS finalizes applying the measure suppression policy to the SNFRM for Fiscal Year 2022 using the baseline and performance periods shown below, for use with the special scoring rules described earlier in this section and codified at §413.338(g).

Baseline Period: October 1, 2017 through September 30, 2018
Performance Period: April 1, 2019 through December 31, 2019 plus July 1, 2020 through September 30, 2020

CMS reviews comments received. A suggestion was made that CMS instead base payment adjustments for FY 2022 on performance scores from the SNF VBP FY 2021 Program Year. CMS rejected this alternative for many reasons, including that it would discourage year-to-year improvement efforts by providers. Several commenters were concerned that the proposed performance scoring for FY 2022 violated sections 1888(h)(4)(B) and 1888(h)(5)(C)(ii)(II)(cc) of the Act that deal with SNF ranking and with payment reductions to the lowest 40 percent of SNFs based on SNFRM performance. CMS states that the available data for the FY 2022 program year are sufficiently flawed due to COVID-19 PHE effects as to preclude their use for making accurate national comparisons (including rankings) across SNFs.

6. SNF Value-Based Incentive Payments

CMS finalizes the combination of SNFRM measure suppression and special scoring rules for FY 2022 to make incentive payment policy adjustments such that 1) low-volume SNFs will receive back 100 percent of the 2 percent withheld from their Federal per diem rate payments; 2) all other SNFs will receive back 60 percent of their withheld funds; and 3) the residual withheld funds, estimated to be 37.1 percent of the total withheld, will be retained as savings to the Medicare program.

CMS reviews comments received. Many supported SNFRM measure suppression but disagreed with the payment adjustments, instead recommending that 100 percent of the withheld funds be returned to SNFs on a proportional basis, that no withhold of funds be made, or that 70 percent – the maximum allowed by statute – of withheld funds be returned to SNFs. CMS declines to adopt any of these recommendations, believing the policy being finalized represents the fairest treatment of SNFs while complying with the statutory constraints of the SNF VBP. CMS also notes the limitations on policy options imposed by having a measure set with only a single performance measure to which adjustments can be made for special circumstances. CMS also declines to exclude COVID-19 cases from being counted in the SNFRM calculations for FY 2022, believing that sufficient mitigation of COVID-19 PHE effects on SNFs is being accomplished with measure suppression and special scoring rules.

C. Other SNF VBP Policy Updates

1. Phase One Review and Correction Policy

CMS finalizes as proposed a revision of its Phase One review and correction process. During the Phase One process, SNFs can review and submit corrections to their quarterly confidential SNF VBP performance reports before the performance data are publicly displayed.

Under the revised policy, after a "snapshot" date, facilities would be permitted to submit corrections of calculation errors made by CMS or its contractors but not corrections to the actual claims data used in the calculations. The snapshot's data would be extracted by CMS from claims stored in the Medicare Provider Analysis and Review (MedPAR) file at 3 months after the date of the last index SNF admission that will be included in the upcoming baseline or performance period report.

The revised policy aligns the SNF VBP program corrections policy with those of other Medicare value-based programs. CMS will begin the snapshot policy with baseline and performance period quarterly reports issued on or after October 1, 2021. The few comments received about the snapshot policy were supportive.

2. Update to Instructions for Requesting an Extraordinary Circumstances Exception

CMS finalizes several minor changes to the instructions for requesting an extraordinary circumstances exception: updating the electronic mail address to which the request is to be submitted; updating the URL of

CMS' QualityNet website; and removing a reference to "newspapers". The changes will be codified at §413.338(d)(4)(ii).

CMS states that the few comments received were supportive. CMS adds that the regulation text will specify that a SNF making an ECE request must do so in a form and manner specified by CMS on the SNF VBP website, where the electronic mail address to which the request should be made will be provided.

D. Impact Analysis of SNF VBP Program for the FY 2022 Program Year

CMS estimates that the total reduction in payments required under the statute for the FY 2022 program year (i.e., the 2.0 percent withhold) will total $516.2 million. In this final rule, using the finalized SNFRM data suppression policy and special scoring rules for the FY 2022 program year, CMS anticipates returning 100 percent of amounts withheld to low-volume SNFs and 60 percent of amounts withheld to the remaining facilities. For FY 2022, the low-volume adjustment is estimated to return $14.8 million to low-volume SNFs while $309.7 million would be returned to the remaining facilities. The total $325.4 million returned to SNFs equates to a 62.9 percent payback of withheld amounts. The remaining withheld funds, about $191.6 million, represent savings to the Medicare program.

VII. Economic Analyses

CMS estimates that the update to SNF rates will increase payments approximately $410 million in FY 2022. This increase reflects a $411 million increase from the SNF rate update of 1.2 percent less $1.2 million for the statutory exclusion of blood clotting factor and related items from SNF payment rates. These figures do not include SNF VBP reductions that CMS estimates at $191.64 million.

Table 32 of the final rule (reproduced below) shows the estimated impact of the final rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the market basket update in the total change column and the budget neutral update to the wage index data. In general, CMS estimates that because of the wage index changes, payment rates for SNFs in rural areas would grow by more than the 1.2 percent overall increase.

TABLE 32: Impact to the SNF PPS for FY 2022

Provider Characteristics	# Providers	Update Wage Data	Total Change
Group			
Total	15,560	0.0%	1.2%
Urban	10,962	-0.1%	1.1%
Rural	4,598	0.4%	1.6%
Hospital-based urban	401	-0.1%	1.1%
Freestanding urban	10,561	-0.1%	1.1%
Hospital-based rural	466	0.4%	1.6%
Freestanding rural	4,132	0.4%	1.6%
Urban by region			
New England	744	-0.7%	0.5%
Middle Atlantic	1,456	-0.5%	0.7%
South Atlantic	1,834	0.3%	1.5%

Provider Characteristics	# Providers	Update Wage Data	Total Change
East North Central	2,160	-0.2%	1.0%
East South Central	542	-0.1%	1.1%
West North Central	924	0.3%	1.5%
West South Central	1,363	-0.2%	0.9%
Mountain	539	0.2%	1.4%
Pacific	1,394	0.2%	1.4%
Outlying	6	0.4%	1.6%
Rural by region			
New England	130	-1.0%	0.2%
Middle Atlantic	246	0.6%	1.8%
South Atlantic	604	1.4%	2.6%
East North Central	921	0.5%	1.7%
East South Central	528	0.0%	1.2%
West North Central	1,064	-0.4%	0.8%
West South Central	769	0.3%	1.5%
Mountain	224	0.5%	1.7%
Pacific	112	0.2%	1.4%
Ownership			
For profit	10866	0.0%	1.2%
Non-profit	3,687	0.0%	1.2%
Government	1,007	0.1%	1.3%

Note: The Total column includes the FY 2022 1.2 percent market basket update factor. Additionally, we found no SNFs in rural outlying areas.

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 6 and 7 in the final rule (reproduced from the final rule 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 6: 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	1.53	$96.11	1.49	$87.14	0.68	$15.95	ES3	4.06	$444.61	3.24	$267.69
B	1.70	$106.79	1.63	$95.32	1.82	$42.68	ES2	3.07	$336.20	2.53	$209.03
C	1.88	$118.10	1.69	$98.83	2.67	$62.61	ES1	2.93	$320.86	1.84	$152.02
D	1.92	$120.61	1.53	$89.47	1.46	$34.24	HDE2	2.40	$262.82	1.33	$109.88
E	1.42	$89.20	1.41	$82.46	2.34	$54.87	HDE1	1.99	$217.92	0.96	$79.32
F	1.61	$101.14	1.60	$93.57	2.98	$69.88	HBC2	2.24	$245.30	0.72	$59.49
G	1.67	$104.91	1.64	$95.91	2.04	$47.84	HBC1	1.86	$203.69	-	-
H	1.16	$72.87	1.15	$67.25	2.86	$67.07	LDE2	2.08	$227.78	-	-
I	1.13	$70.99	1.18	$69.01	3.53	$82.78	LDE1	1.73	$189.45	-	-
J	1.42	$89.20	1.45	$84.80	2.99	$70.12	LBC2	1.72	$188.36	-	-
K	1.52	$95.49	1.54	$90.06	3.7	$86.77	LBC1	1.43	$156.60	-	-
L	1.09	$68.47	1.11	$64.91	4.21	$98.72	CDE2	1.87	$204.78	-	-
M	1.27	$79.78	1.30	$76.02	-	-	CDE1	1.62	$177.41	-	-
N	1.48	$92.97	1.50	$87.72	-	-	CBC2	1.55	$169.74	-	-
O	1.55	$97.37	1.55	$90.64	-	-	CA2	1.09	$119.37	-	-
P	1.08	$67.85	1.09	$63.74	-	-	CBC1	1.34	$146.74	-	-
Q	-	-	-	-	-	-	CA1	0.94	$102.94	-	-
R	-	-	-	-	-	-	BAB2	1.04	$113.89	-	-
S	-	-	-	-	-	-	BAB1	0.99	$108.41	-	-
T	-	-	-	-	-	-	PDE2	1.57	$171.93	-	-
U	-	-	-	-	-	-	PDE1	1.47	$160.98	-	-
V	-	-	-	-	-	-	PBC2	1.22	$133.60	-	-
W	-	-	-	-	-	-	PA2	0.71	$77.75	-	-
X	-	-	-	-	-	-	PBC1	1.13	$123.75	-	-
Y	-	-	-	-	-	-	PA1	0.66	$72.28	-	-

TABLE 7: 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	1.53	$109.56	1.49	$98.00	0.68	$20.09	ES3	4.06	$424.80	3.24	$255.73
B	1.70	$121.74	1.63	$107.21	1.82	$53.78	ES2	3.07	$321.21	2.53	$199.69
C	1.88	$134.63	1.69	$111.15	2.67	$78.90	ES1	2.93	$306.57	1.84	$145.23
D	1.92	$137.49	1.53	$100.63	1.46	$43.14	HDE2	2.40	$251.11	1.33	$104.98
E	1.42	$101.69	1.41	$92.74	2.34	$69.15	HDE1	1.99	$208.21	0.96	$75.77
F	1.61	$115.29	1.60	$105.23	2.98	$88.06	HBC2	2.24	$234.37	0.72	$56.83
G	1.67	$119.59	1.64	$107.86	2.04	$60.28	HBC1	1.86	$194.61	-	-
H	1.16	$83.07	1.15	$75.64	2.86	$84.51	LDE2	2.08	$217.63	-	-
I	1.13	$80.92	1.18	$77.61	3.53	$104.31	LDE1	1.73	$181.01	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
J	1.42	$101.69	1.45	$95.37	2.99	$88.35	LBC2	1.72	$179.96	-	-
K	1.52	$108.85	1.54	$101.29	3.7	$109.34	LBC1	1.43	$149.62	-	-
L	1.09	$78.05	1.11	$73.00	4.21	$124.41	CDE2	1.87	$195.66	-	-
M	1.27	$90.94	1.30	$85.50	-	-	CDE1	1.62	$169.50	-	-
N	1.48	$105.98	1.50	$98.66	-	-	CBC2	1.55	$162.18	-	-
O	1.55	$111.00	1.55	$101.94	-	-	CA2	1.09	$114.05	-	-
P	1.08	$77.34	1.09	$71.69	-	-	CBC1	1.34	$140.20	-	-
Q	-	-	-	-	-	-	CA1	0.94	$98.35	-	-
R	-	-	-	-	-	-	BAB2	1.04	$108.82	-	-
S	-	-	-	-	-	-	BAB1	0.99	$103.58	-	-
T	-	-	-	-	-	-	PDE2	1.57	$164.27	-	-
U	-	-	-	-	-	-	PDE1	1.47	$153.81	-	-
V	-	-	-	-	-	-	PBC2	1.22	$127.65	-	-
W	-	-	-	-	-	-	PA2	0.71	$74.29	-	-
X	-	-	-	-	-	-	PBC1	1.13	$118.23	-	-
Y	-	-	-	-	-	-	PA1	0.66	$69.06	-	-