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Medicare Program; Fiscal Year 2023 Skilled Nursing Facilities
Proposed Rule [CMS-1765-P] Summary

On April 15, 2022, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (87 FR 22720) a proposed rule updating for fiscal year (FY) 2023 the Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). The proposed rule would update the federal per diem rates under the SNF Prospective Payment System (PPS); the ICD-10 code mappings for patient classification; and the SNF QRP and SNF VBP Programs. CMS proposes a recalibration of the Patient Driven Payment Model (PDPM) budget neutrality adjustment (referred to as a parity adjustment). It also includes a proposal to establish a permanent cap policy to smooth year-to-year changes in the SNF wage index by applying a cap on negative wage index changes greater than a 5 percent decrease from the prior year. CMS seeks input on establishing minimum staffing requirements for LTC facilities.

For the SNF QRP, CMS proposes adopting one new measure and issues three Requests for Information (RFI), including a detailed request related to measuring health equity. Multiple changes are proposed for the SNF Value-Based Purchasing (VBP) Program that progressively expand the program's measure set and make policy revisions to implement the larger measure set. CMS also proposes a special scoring policy for the FY 2023 VBP program year that suppresses the SNF 30-Day All-Cause Readmission Measure (SNFRM) and equalizes the program's incentive payment multiplier percentage across SNFs. **Comments on the proposed rule are due by June 10, 2022.**

CMS estimates that the overall impact of the proposed rule will be a decrease of $320 million (-0.9 percent) in Medicare payments to SNFs during FY 2023.

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

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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 these 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 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 2022 SNF PPS proposed rule indicating that Medicare is paying more than it would have paid under the PDPM than if the RUG-IV classification model had continued. It refers to this as the PDPM parity adjustment and proposes a recalibration of this adjustment and solicits comments on whether CMS' calculated adjustment of -4.6 percent should be applied fully in 2023 or phased-in over two years (see section V.C for a full discussion)

CMS also provides within this rule, updates on ongoing HHS initiatives to advance health information exchange within the post-acute care (PAC) settings and within the larger health care environment including the Post-Acute Care Interoperability Workgroup (PACIO), CMS Data Element Library (DEL), and the Trusted Exchange Framework and Common Agreement (TEFCA).[1]

II. SNF PPS Rate Setting Methodology and FY 2023 Update

A summary of key data under the proposals for the SNF PPS for FY 2023 is presented below with additional details in the subsequent sections.

Summary of Key Data under Proposed SNF PPS for FY 2023	
Market basket update factor	
Market basket increase	+2.8%
Forecast error adjustment for FY 2021	+1.5%
Required productivity adjustment	-0.4%
Net MFP-adjusted update	**+3.9%**
Wage index budget neutrality adjustment	1.0011
Labor-related share	70.7%

A. Federal Base Rates

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

B. SNF Market Basket Update

CMS proposes a market basket increase for FY 2023 of 2.8 percent based on the fourth quarter 2021 forecast from IHS Global Insight, Inc. (IGI), with historical data through the third quarter of 2021. The forecast addresses the percentage increase in the FY 2018-based SNF market basket index for routine, ancillary, and capital-related expenses.

[1] CMS strongly encourages SNFs to participate in PACIO. It notes that the latest DEL standards are now available (https://www.healthit.gov/isa) and that the TEFCA Version 1 was released January 18, 2022 and is available for download at https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf

For FY 2021—the most recent year for which actual data are available—CMS applied a market basket of 2.2 percent, but the actual increase was 3.7 percent. As the difference (1.5 percentage points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposes to apply a 1.5 percentages point adjustment to the proposed FY 2023 SNF market basket. The market basket of 2.8 percent would be increased by 1.5 percentage points to 4.3 percentage points with this proposal.

The productivity adjustment required under the Affordable Care Act (ACA) is estimated to be -0.4 percentage points. CMS uses the total factor productivity (TFP) adjustment as calculated by the Bureau of Labor Statistics (BLS)[2] The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2023, based on IGI's fourth quarter 2021 forecast.

The resulting proposed SNF market basket update equals 3.9 percent (2.8 percent plus the 1.5 percentage points for forecast error and 0.4 percentage points for productivity reduction). The update may change in the final rule as more recent data and forecasts for the market basket MFP adjustment become available. The overall impact on SNFs of the market basket update, however, will be essentially eliminated by the proposed reduction to the SNF payment rates to account for the recalibrated parity adjustment (discussed in section IV.C.)

CMS also applies a 2.0 percentage point reduction to the update for SNFs that do not satisfy the reporting requirements for the FY 2023 SNF QRP. The rate update for SNFs that do not meet the SNF QRP reporting requirements would be 1.9 percent. (The rate update is applied to the unreduced FY 2023 SNF federal per diem rates). This is before application of the recalibrated parity adjustment.

Based on the proposed productivity-adjusted update, CMS proposes FY 2023 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables below. Under the PDPM case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five of these are case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). The remaining component is a non-case-mix component, as existed under the previous RUG-IV classification system.

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

Final FY 2022 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$62.82	$71.61
Occupational Therapy	$58.48	$65.77
Speech-Language Pathology	$23.45	$29.55
Nursing	$109.51	$104.63
Non-Therapy Ancillaries	$82.62	$78.93
Non-case mix adjusted	$98.07	$99.88

Proposed FY 2023 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$65.34	$74.48
Occupational Therapy	$60.83	$68.41
Speech-Language Pathology	$24.39	$30.74
Nursing	$113.91	$108.83
Non-Therapy Ancillaries	$85.94	$82.10
Non-case mix adjusted	$102.01	$103.89

C. Case-Mix Adjustment

As noted earlier, CMS replaced its previous case-mix classification methodology, the RUG-IV model, with the PDPM effective October 1, 2019. The PDPM model was designed to classify patients into payment groups based on patient characteristics, rather than the volume of therapy services provided to patients, as was done in the RUG-IV model. The proposed FY 2023 payment rates reflect the use of the PDPM classification system from October 1, 2022 through September 30, 2023. Tables 5 and 6 of the proposed rule (reproduced in the appendices of this summary) show the proposed PDPM case-mix adjusted federal rates and associated indexes. These include the proposed parity adjustment recalibration.

D. Wage Index Adjustment

CMS proposes to continue to apply the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2023, CMS proposes to use updated wage data for hospital cost reporting periods in FY 2019. It notes that to use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources from CMS and the Medicare Administrative Contractors that is not feasible at this time.

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

index. These policies are only applicable in one urban area—CBSA 25980, Hinesville-Fort Stewart, Georgia.

The Office of Management and Budget (OMB) provides the Core-Based Statistical Area (CBSA) delineations that are the basis of the labor market areas that CMS uses for the wage index adjustment. In the FY 2021 SNF PPS final rule, CMS indicated that it intended to adopt the latest revision to the OMB area delineations for purposes of the FY 2022 SNF wage index. CMS indicates that OMB published Bulletin 20-01 on March 6, 2020. This bulletin adds one micropolitan area to the CBSA delineations. It will have no effect on the SNF wage index.

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

CMS uses a four-step process to trend forward the base year (2018) weights to FY 2023 price levels. This process includes computing the FY 2023 price index level for the total market basket and each cost category of the market basket. Based on this update, the proposed SNF labor-related share is 70.7 percent, compared to a FY 2022 final labor-related share of 70.4 percent. Table 7 in the proposed rule summarizes the proposed labor-related share for FY 2023 (based on the IGI fourth quarter 2021 forecast) compared with FY 2022 for each of the cost categories.

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

The change to the labor share and wage index is required by law to be budget neutral. CMS meets this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor, equal to the ratio of the weighted average wage adjustment factor for FY 2022 to the weighted average wage adjustment factor for FY 2023. For this calculation, CMS uses the same FY 2021 claims utilization data for both the numerator and denominator of this ratio. The proposed budget neutrality factor for FY 2023 is 1.0011.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

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

meeting the level of care definition, but instead receives an individual determination using the existing administrative criteria.

In the 2019 SNF PPS final rule, CMS finalized the designation of the following classifiers for purposes of applying the administrative presumption under the PDPM. This information is posted on the SNF PPS website in the paragraph entitled "Case Mix Adjustment".[3]

CMS stresses that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely. For example, the presumption would not apply in a situation where the sole classifier that triggers the presumption is itself assigned through the receipt of services that are subsequently determined to be not reasonable and necessary. Further, CMS will do careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the assessment reference date of the initial Medicare assessment.

B. Consolidated Billing

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

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

The addition of blood clotting factor and related items to the above list is effective October 1, 2021 and was added as a result of section 134 in Division CC of the Consolidated Appropriations Act, 2021.
The rule indicates that the codes targeted for exclusion from consolidated billing represent events that could have significant financial impacts because their costs far exceed SNF PPS payments. **CMS invites comments to identify specific HCPCS codes in any of these five service categories** (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices and blood clotting factor) representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. It may consider excluding a particular service if it meets the criteria for exclusion: they must be included in the five categories and also must meet criteria as high cost and low probability in the SNF setting.[4]

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

If for the final rule CMS identifies any new services that actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, it will identify these additional excluded services by means of the HCPCS codes that are in effect as of October 1, 2021.

C. Payment for SNF-level Swing-bed Services

CMS discusses the statutory requirement that critical access hospitals (CAHs) continue to be paid on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement and that all non-CAH swing-bed rural hospitals continue to be paid under the SNF PPS. As discussed in the FY 2019 SNF PPS final rule, revisions were made to the swing-bed assessment in order to support implementation of PDPM. The latest changes in the MDS for swing-bed rural hospitals can be found at the SNF PPS website.

D. Revisions to the Regulation Text

CMS proposes to revise §413.337(b)(4) and add new paragraphs (b)(4)(i) through (iii) to reflect that the application of the wage index would be made on the basis of the location of the facility in an urban or rural area as defined in §413.333, This revision also incorporates that starting on October 1, 2022, CMS would apply a cap on decreases to the wage index such that the wage index applied to a SNF is not less than 95 percent of the wage index applied to that SNF in the prior FY (discussed below in section IV.A.)

IV. Other SNF PPS Issues

A. Proposed Permanent Cap on Wage Index Decreases

In the past, CMS notes that it had established transition policies of limited duration to phase in significant changes to labor market areas. It notes, however, that year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as COVID-19 PHE, which are unrelated to changes in labor market areas. It states that predictability in Medicare payments is important to enable providers to budget and plan their operations.

CMS proposes to apply a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. Specifically, CMS proposes that a geographic area's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY 2022 and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. It believes that the impact to the wage index budget neutrality factor in future years would continue to be minimal as typical year-to-year variation has historically been within 5 percent. CMS also proposes for a new SNF that it would be paid the wage index for the area in which it is geographically located for the first full or partial FY with no cap applied, because a new SNF would not have a wage index in the prior year.

B. Technical Updates to Patient Driven Payment Model (PDPM) ICD-10 Mappings

ICD-10 codes are used in various components of the PDPM, including assigning patients to clinical categories. The ICD-10 code mappings and lists used under PDPM are available on the PDPM website.[5]

The ICD-10 codes are updated each year in June and become effective October 1 of the same year. In the FY 2020 SNF PPS[6], CMS outlined the process it uses to maintain and update ICD-10 code mappings and lists associated with the PDPM and the SNF Grouper software. Beginning with the FY 2020 updates, nonsubstantive changes to the ICD-10 codes would be applied through the subregulatory process and substantive revisions would be proposed and finalized through notice and comment rulemaking.

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

In response to stakeholder feedback and to improve consistency between the ICD-10 code mappings and current ICD-10 coding guidelines, CMS proposes several changes to the PDPM ICD-10 code mappings.

- CMS proposes to move five ICD-10 code to "Return to Provider" category. CMS believes there are more specific codes for the diagnosis and these codes should not be the primary diagnosis for a Part-A covered SNF change.

ICD-10 Code	Diagnosis
D75.839	Thrombocytosis, unspecified
D89.44	Hereditary alpha tryptasemia
F32.A	Depression, unspecified
G92.9	Unspecified toxic encephalopathy
M54.50	Low back pain, unspecified

- CMS responds to comments received in the FY 2022 proposed rule, which includes several proposals.

ICD-10 Code	Diagnosis	CMS Proposal
K22.11	Ulcer of esophagus with bleeding	Remap to "Medical Management"
K25.0	Acute gastric ulcer with hemorrhage	Remap to "Medical Management
K25.1	Acute gastric ulcer with perforation	Remap to "Medical Management
K25.2	Acute gastric ulcer with both hemorrhage and perforation	Remap to "Medical Management

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

ICD-10 Code	Diagnosis	CMS Proposal
K26.0	Acute duodenal ulcer with hemorrhage	Remap to "Medical Management
K26.1	Acute duodenal ulcer with perforation	Remap to "Medical Management
K26.2	Acute duodenal ulcer with both hemorrhage and perforation	Remap to "Medical Management
K27.0	Acute peptic ulcer, site unspecified with hemorrhage	Remap to "Medical Management
K27.1	Acute peptic ulcer, site unspecified with perforation	Remap to "Medical Management
K27.2	Acute peptic ulcer, site unspecified with both hemorrhage and perforation	Remap to "Medical Management
K28.0	Acute peptic ulcer, site unspecified with hemorrhage	Remap to "Medical Management
K28.1	Acute peptic ulcer, site unspecified with perforation	Remap to "Medical Management
K28.2	Acute peptic ulcer, site unspecified with both hemorrhage and perforation	Remap to "Medical Management
K29.01	Acute gastritis with bleeding	Remap to "Medical Management
M62.81	Muscle weakness, generalized	Maintain "Return to Provider"
R62.7	Adult failure to thrive	Maintain "Return to Provider"

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." In the FY 2020 SNF PPS final rule, CMS finalized its policy for achieving parity.[7] Specifically, 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. As discussed in the FY 2022 SNF PPS final rule, CMS believed the PDPM may have inadvertently triggered a significant increase in overall payments under the SNF PPS of approximately 5% and that recalibration of the parity adjustment may be warranted.[8]

[7] 84 FR 38734 – 38735
[8] 86 FR 42466 - 42469

However, CMS also acknowledged that the PHE for COVID-19, which began during the first year of PDPM implementation and continued into at least part of FY 2021, likely impacted SNF PPS utilization data. Further, CMS was 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, in the FY 2022 SNF PPS final rule, CMS proposed an updated recalibration methodology. In the sections summarized below, CMS discusses comments received on the FY 2022 proposal and proposes a revised methodology for recalibrating the PDPM parity adjustment.

2. Methodology for Recalibrating the PDPM Parity Adjustment

a. Effect of COVID-19 PHE

Beginning March 1, 2020 CMS issued two temporary modifications that affected Medicare Part A SNF coverage. 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. Thus, patients not otherwise qualified for SNF coverage could obtain coverage during the PHE.

CMS acknowledges that the COVID PHE had significant impacts on SNF operations. As summarized in the FY 2022 SNF PPS final rule, many commenters were concerned about additional costs due to the COVID PHE could become permanent changes in SNF operations, including patent care and infection control.

CMS notes, however, that the relevant issue for a recalibration of the PDPM parity adjustment is whether or not the COVID PHE caused changes in the SNF case-mix distribution. Specifically, CMS needs to determine whether the impact of the PHE on patient classification in each PDPM group differs.

b. Effect of PDPM implementation

As discussed in the FY 2022 SNF PPS final rule, before the COVID PHE, the data indicated that the transition to the PDPM impacted certain aspects of SNF patient classification and the provision of care. For example, SNF patients received an average of approximately 93 therapy minutes per utilization day in FY 2019. Between October 2019 and December 2019, the average number of therapy minutes SNF patients received dropped to approximately 68 minutes per utilization day (a decrease of approximately 27 percent). Given this reduction in therapy provision, CMS found that using patient assessment data collected under PDPM resulted in a significant underestimation of what RUG-IV case-mix and payments would have been and could produce an overcorrection in the parity adjustment. CMS also noted that without having an interim assessment between the 5-day assessment and the patient's discharge from the facility, it is not able to determine if the RUG-IV group changed during the stay or if the patient continued to receive therapy services consistent with the initial RUG-IV classification. Given the

immediacy of this change in the SNF data without any concurrent change in the SNF population, CMS believed that the overall decrease in the amount of therapy services provided to SNF patients is a result of PDPM implementation, not other factors.

These changes highlight why CMS believed 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.

In the FY 2022 SNF PPS proposed rule[9], CMS described an alternative recalibration that used FY 2019 RUG-IV case-mix distribution as a proxy for what total RUG-IV payments would have been absent PDPM implementation. CMS believed this provided a more accurate representation of what RUG-IV payments would have been than using data reported under PDPM to reclassify these patients under RUG-IV.

c. FY 2022 SNF PPS Proposed Rule Potential Parity Adjustment Methodology and Comments

In the FY 2022 SNF PPS proposed rule, CMS discussed a potential methodology to account for the effects of the COVID PHE by removing those stays with a COVID-19 diagnosis and those stays using a PHE-related modification from its data set.[10] In this year's proposed rule, CMS updates this data. As compared to prior years, when approximately 98 percent of SNF beneficiaries had a qualifying prior hospital stay, approximately 86 and 81 percent of SNF beneficiaries had a qualifying prior hospitalization in FY 2020 and FY 2021, respectively. Approximately 10 percent of SNF stays in FY 2020 and 17 percent of SNF stays in FY 2021 included a COVID-19 ICD-10 diagnosis code (either as a primary or secondary diagnosis) while 17 percent of SNF stays in FY 2020 and 27 percent of SNF stays in FY 2021 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 FYs 2020 and 2021 with a prior hospitalization, and without a COVID-19 diagnosis.

As discussed in the FY 2022 SNF PPS proposed rule, 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 was approximately the same. To calculate expected total payments under RUG-IV, 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

[9] 86 FR 19988
[10] 86 FR 19986 - 19887

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 accounts 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 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. The elimination of cases using a COVID waiver or diagnosed with COVID resulted in a 5.0 percent increase. CMS concluded that a large portion of the changes in SNF utilization were due to PDPM and not the COVID PHE. CMS believed it would be more appropriate to pursue a potential recalibration using the subset population exclusive of COVID waiver patients and patients diagnosed with COVID.

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.

d. FY 2023 SNF Proposed Parity Adjustment Methodology

In response to prior comments, CMS proposes a revised methodology for calculating the parity adjustment. Instead of using a COVID-19 definition derived from the CDC coding guidelines, CMS modified its definition of COVID-19 to align with the definition used by publicly available datasets from CMS's Office of Enterprise Data and Analytics (OEDA). Using the modified definition, CMS found no significant impacts on its calculations as the COVID-19 population definition change only increased the count of the subset population by less than 1 percent.

For the proposed recalibration methodology, CMS proposes to use the same type of subset methodology that excludes stays with either a COVID waiver or that included a COVID diagnosis, with a 1-year "control period" derived from both FY 2020 and FY 2021 data. Specifically, for the control period CMS uses 6 months of FY 2020 data from October 2019 through March 2020 and 6 months of FY 2021 data from April 2021 through September 2021 to create a full 1-year period with no repeated months to account for seasonality effects. CMS notes the data suggests these periods had low COVID-19 prevalence.

CMS compares the adjustment factors based on the full and subset population for FY 2020, FY 2021, and the control period. As shown in Table 11 (reproduced below), the control period closes the gap between the full and subset population adjustment factors to 0.02 percent. CMS concludes that the control period captures additional COVID-19 related acuity that the subset population method alone does not. In addition, using the control period results in the lowest parity adjustment; the parity adjustment is approximately the same between the full SNF population (4.58%) and the subset population (4.60%) for the control period. The control period-based adjustment factor for the subset population also has the lowest budget impact (Figure 12, reproduced below).

Table 11: Adjustment Factors Based on Population and Data Period			
Data Period	**Full SNF Population**	**Subset SNF Population**	**Difference**
FY 2020-based Adjustment Factor	5.21%	4.90%	-0.31%
FY 2021-based Adjustment Factor	5.65%	5.25%	-0.40%
Control Period-based Adjustment Factor	4.58%	4.60%	0.02%

Table 12: Budget Impact Based on Subset Population and Data Period		
Data Period	**Adjustment Factor**	**Budget Impact (Reduction)**
FY 2020-based Adjustment Factor	4.90%	$1.8 billion
FY 2021-based Adjustment Factor	5.25%	$1.9 billion
Control Period-based Adjustment Factor	4.60%	$1.7 billion

CMS discusses its data analysis and monitoring efforts that support the accuracy of a 4.6 percent parity adjustment factor using the control period. For example, CMS agrees with commenters that there would have been more joint replacements admitted to SNF in the absence of the PHE. The rate of major joint replacement or spinal surgery decreased from 7.6 percent of stays in FY 2019, to 5.5 percent of stays in FY 2021, and to 5.2 percent of stays in FY 2022. Using the control period, which excludes the periods of highest COVID-19 prevalence and lowest rate of elective surgeries, major joint replacement or spinal surgery has a rate of 6.4 percent. CMS believes the control period is a closer representation of SNF patient case-mix outside of the PHE than using either FY 2021 or 2022 data alone.

CMS proposes adopting the methodology using the subset population during the control period and lower the PDPM parity adjustment factor from 46 percent to 38 percent for each of the PDPM case-mix adjusted components. CMS estimates a reduction in aggregate SNF spending of 4.6 percent or approximately $1.7 billion. The parity adjustment is calculated and applied at a systemic level to all facilities paid under the SNF PPS.

CMS invites comments on the proposed methodology. To assist comments, CMS has posted the FY 2019 RUG IV case-mix distribution and calculation of total payments under RUG-IV, and PDPM case-mix utilization data at the case mix group and component level to demonstrate the calculation of total payments under PDPM at https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps.

3. Methodology for Applying the Recalibrated PDPM Parity Adjustment

CMS believes it would be appropriate to apply the recalibrated parity adjustment across all PDPM CMIs in equal measure. This would be consistent to the methodology used for the initial increase to the PDPM CMIs to achieve budget neutrality and would maintain the integrity of the original PDPM classification methodology. (See discussion above in Section II.C).

In response to this proposal in the FY 2022 SNF PPS proposed rule, several commenters objected to this approach and recommended a targeted approach that focused the parity adjustment on the SLP, Nursing, and NTA components in proportion to their increases observed under PDPM. To explore this alternative approach, CMS updated its analysis of the average CMI

by PDPM component from the FY 2022 SNF proposed rule. CMS found significant increases in average case-mix of 18.8 percent for the SLP component and 10.8 percent for the nursing component, and a moderate increase of 3.0 percent for the NTA component (Table 13, reproduced below). CMS believes the low increase in the PT and OT classification are consistent with the original design of the PDPM which allowed only limited additional increases in PT and OT classification after PDPM implementation. CMS concludes that the increases in average case mix for these components are the result of PDPM and not the COVID-19 PHE. Table 14 in the proposed rule shows the potential impact of applying the recalibrated PDPM parity adjustment to the PDPM CMIs in a targeted manner.

Table 13: Average Case-Mix Index, Expected and Actual by PDPM Component			
Component	**Expected Average CMI (FY 2019 Estimate, Subset Population)**	**Actual CMI per Stay (Control Period, Subset Population)**	**Percentage Difference**
PT	1.51	1.52	0.4%
OT	1.51	1.52	0.4%
SLP	1.40	1.66	18.6%
Nursing	1.45	1.60	10.8%
NTA	1.16	1.20	3.0%

4. Delayed and Phased Implementation

In the FY 2022 SNF PPS proposed rule, CMS solicited comments on potential mitigation strategies to ease the transition to prospective budget neutrality: delayed implementation and phased implementation. For any option, CMS would apply the adjustment prospectively and would not affect any past year payments.

Delayed Implementation Strategies: Delay the reduction for some period of time (e.g., one or more years) but implement the full 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 with a 4.6 percent reduction would reduce the PDPM CMIs by 2.3 percent in the first year of implementation and the remaining 2.3 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.

For FY 2023, CMS proposes to recalibrate the parity adjustment with no delayed implementation or phase-in period. This proposal would lead to a prospective reduction in SNF payments of approximately 4.6 percent (-$1.7 billion) in FY 2023. CMS notes this reduction would be substantially mitigated by the proposed FY 2023 net SNF market basket update factor of 3.9 percent and the preliminary net budget impact in FY 2023 would be an estimated decrease of $320 million.

Although the majority of commenters in response to the FY 2022 proposal supported a combination strategy with no more than a 1 percent adjustment per year, CMS states that it has already granted a 1-year delayed implementation by not finalizing the parity adjustment in the FY 2022 and to take a year to consider modifications to the payment adjustment methodology. In addition, given the SNF PPS has been paying approximately $1.7 billion per year in excess of budget neutrality since PDPM was implemented in FY 2020, CMS believes that delaying the implementation or phasing the recalibration over some amount of time would only serve to prolong excess payments. Furthermore, MedPAC's March 2022 Report to Congress shows the aggregate Medicare margin in 2020 was 16.5 percent, an increase from 11.9 percent in 2019. The aggregate Medicare margin in 2020 increased to approximately 19 percent when Federal COVID-19 PHE relief funds were included.[11] Based on these findings, CMS does not believe a delayed implementation or a phase-in approach is needed.

D. Request for Information: Infection Isolation

Various patient characteristics are used to classify patients in Medicare-covered SNF stays into payment groups. Being coded for infection isolation can have a significant impact on the Medicare payment rate due to the increase in relative costliness of treating a patient who must be isolated due to an infection.

In order for a patient to qualify to be coded as being isolated for an active infectious disease, the patient must meet all of the following:

- Criterion 1: The patient has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- Criterion 2: Precautions are over and above standard precautions. Transmission-based precautions must be in effect.
- Criterion 3: The patient is in a room alone because of active infection and cannot have a roommate. This means that the resident is not cohorted with a roommate regardless of whether the roommate has a similar infection that requires isolation.
- Criterion 4: The patient must remain in their room. This requires that all services must be brought to the resident.

During the COVID PHE, stakeholders have raised concerns with the definition of "infection isolation" as it relates to the treatment of SNF patients being cohorted due to either the diagnosis or suspected diagnosis of COVID 19. Stakeholders raised concerns about criterion 1, which requires the patient have an active infection, rather than suspicion of an active infection, and criterion 3, which requires that the patient be alone in the room.

CMS is concerned that the relative increase in resource intensity for each patient being treated within a cohorted environment is the same relative increase as it would be for treating a single patient due to an active infection. **CMS invites comments on if the criteria for coding infection isolation should be expanded to allow the inclusion of cohorted patients and**

[11] The MedPAC report is available at https://www.nedpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReprtToCongress_Ch7_SEC.pdf.

whether or not the relative increase in resource utilization for each of the patients within a cohorted room, all with an active infection, is the same or comparable to that of the relative increase in resource utilization associated with a patient that is isolated due to an active infection.

V. SNF QRP

The SNF QRP was established pursuant to the IMPACT Act and is a pay-for-reporting program. SNFs submit specified data elements and quality measure data for each resident using the SNF resident assessment instrument known as the Minimum Data Set (MDS). Completed assessments are sent to CMS through the Internet Quality Improvement & Evaluation System (iQIES). Freestanding SNFs, SNFs affiliated with acute care hospitals and all non-CAH swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the SNF PPS annual update factor. FY 2018 was the first year in which the QRP affected payments. If all of the proposed adjustments to the SNF PPS rates were to be finalized, the FY 2023 rate update for SNFs that do not meet the SNF QRP reporting requirements would be -2.7 percent.

A table at the end of this summary section (located at V.G.) displays the SNF QRP measures previously adopted for the FY 2023 program year, and this list is not changed by the proposed 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.

A. New and Updated Measures

CMS proposes the addition of one new measure for the SNF QRP for FY 2025: Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #04310). Also proposed is a revision to the compliance date for the collection of the Transfer of Health Information to the Provider-Post-Acute Care (TOH-Provider-PAC) and the Transfer of Health Information to the Patient-Post-Acute Care (TOH-Patient-PAC) measures. A revised collection compliance date is also proposed for multiple standardized patient assessment data elements (SPADEs) that are part of the SNF MDS resident assessment instrument. Data collection for these measures and SPADEs has been delayed by the COVID-19 PHE. Finally, CMS proposes regulation text revisions to describe the data completion thresholds to be reached by SNFs in order to be eligible for the full SNF PPS annual update. **CMS invites comment on all proposals concerning the SNF QRP.**

1. Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)

CMS proposes to adopt a new process measure into the SNF QRP beginning with the FY 2025 program year to track the percentage of healthcare personnel (HCP) who receive the influenza vaccine. CMS believes the measure will encourage SNF HCP, whose vaccination rates are lower than for HCP working in acute care settings and who routinely care for vulnerable beneficiaries,

to receive the vaccine. CMS notes that variation in HCP vaccination rates across SNFs further supports that a quality improvement opportunity would be created by requiring this measure.

The measure would be calculated as follows:

Numerator. All HCP included in the denominator who 1) received an influenza vaccine at any time from when it first became available (typically before October 1) through March 31 of the following year;[12] and 2) received a vaccination administered at the SNF; provided documentation of being vaccinated elsewhere; were determined to have a vaccine contraindication; were offered but declined the vaccine; or had unknown vaccination status.

Denominator. The cumulative number of HCP physically present in the facility for at least one working day between October 1 and March 31 of the following year, regardless of their clinical responsibilities or extent of patient contact. The denominator is calculated separately for 1) employees (i.e., on the SNF's payroll); 2) licensed independent practitioners who are affiliated but not employed (e.g., physicians); and 3) adult students, trainees, and volunteers.[13]

Risk adjustment. The measure is a process rather than outcome measure and as such does not require risk adjustment.

Full measure specifications are available for download as part of the *Influenza Vaccination Summary* on the CDC website: https://www.cdc.gov/nhsn/vaccination/index.html. Proposed data submission requirements for the new measure are discussed in V.E. below.

In discussing the proposed measure, CMS notes the considerable morbidity and mortality experienced nationally and each year due to influenza and that are reduced by vaccination. CMS also notes the disproportionate adverse impacts of the disease on older patients as well as racial disparities in vaccination rates. CMS reviews in detail the development and specification of this measure that included pilot testing, reliability and validity analyses employing multiple methods, input from a Delphi panel, and oversight by a Steering Committee convened by the Centers for Disease Control and Prevention (CDC).

In keeping with the standard pre-rulemaking process for Medicare's quality measures, CMS included the measure on the publicly-posted December, 2021 Measures Under Consideration (MUC) List, and the measure was reviewed by the NQF-convened Measures Application Partnership (MAP). The MAP supported the measure for rulemaking, noting that this measure is actionable for facilities and is already part of the CMS QRPs for long-term acute care hospitals and inpatient rehabilitation facilities. The measure has been NQF-endorsed since 2008; it

[12] The CDC has determined that the influenza vaccination season begins October 1 or whenever the vaccine becomes available and ends on the following March 31.

[13] This measure also has an optional denominator category--"other contract personnel"—persons contracted to provide care, treatment, or services at a SNF but not belonging to any of the three required denominator categories.

currently undergoing routine measure maintenance review without changes from its previously-endorsed specifications.

CMS estimates the regulatory burden of data submission to CDC for this new measure would average 15 minutes per year at a cost of $9.38 per SNF. [14] This is based on an BLS hourly wage of an administrative assistant of $37.50, including overhead and fringe benefits.

2. Revised Compliance Dates for TOH Measures and SPADEs

CMS proposes to set a time certain date of October 1, 2023 (i.e., beginning with FY 2024) for the start of compliance (data collection) for two Transfer of Health Information (TOH) measures and five categories of SPADEs, including those falling into the Other—Social Determinants of Health (SDOH) category.[15] These measures and SPADEs were originally finalized in the FY 2020 SNF PPS final rule with data collection to begin with FY 2021 (October 1, 2020). The compliance date was delayed due to the COVID-19 PHE, as provided for in the May 8th COVID-19 Interim Final Rule with Comment period, until October 1 of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE.

Specifically, the proposed October 1, 2023 compliance date would apply to the TOH-Provider-PAC and TOH-Patient-PAC measures, the Impairment category SPADEs (hearing, vision), and the Other—SDoH SPADEs (race and ethnicity, preferred language, need for interpreter services, health literacy, transportation, and social isolation). CMS reviews information suggesting that SNFs are now successfully accommodating to the current distribution of SARS-CoV-2 infections, and they are able to collect and submit MDS assessments that include items necessary for the TOH measures as well as the Impairment and SDoH category SPADEs. CMS indicates that the MDS version with support for the TOH measures and SPADE elements will be released early in calendar year 2023 and will be accompanied by CMS-sponsored education and training events. CMS notes that collection of SDoH data from SNFs is consistent with the agency's strategy for identifying and addressing healthcare disparities through its quality programs.

3. Regulation Text Updates

CMS proposes regulation text revisions to accompany the HCP COVID-19 Vaccine measure previously finalized for adoption into the SNF QRP in the FY 2022 SNF PPS final rule for program year FY 2024. The revised text would also be applicable to the addition of the Influenza Vaccination HCP measure as proposed in this rule for FY 2025, if finalized. The revised text would consolidate and clarify the data completeness thresholds that SNFs would be required to reach in order to be eligible for the full SNF PPS annual update.

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[14] CMS also states within the text that it would take each SNF an average of 15 minutes per month (instead of a year) to collect data for the Influenza Vaccination Coverage among HCP (NQF #0431) measure and enter it into NHSN. This is not consistent, however, with the overall total calculations CMS presented and we believe that "per month" is a typographical mistake.

[15] The TOH measures assess provision of a current, reconciled, medication list during changes in care settings (e.g., discharge to home). The SPADE categories are cognitive function, special services/treatments/interventions, medical conditions and comorbidities, impairments, and other as deemed necessary and appropriate by the Secretary. The "other" category includes the SDoH SPADEs.

Data submission for the previously finalized HCP COVID-19 Vaccine measure, and the Influenza Vaccination HCP measure if finalized, is done through the CDC's National Health Safety Network (NHSN). CDC processes the data, calculates measure results, and transmits results to CMS. Because of the significance of infection and other patient safety measures to the outcomes of beneficiaries, Medicare's quality programs require 100 percent data completeness for NHSN-reported measures.

The revised regulation text would codify that the data completeness threshold for all QRP measures reported through the NHSN is 100 percent while the threshold for measure data and SPADEs submitted through the MDS is 80 percent. Further, the revised text would clearly state that both completeness thresholds apply to all QRP measures and SPADEs and that both must be met by a SNF in order to be eligible for a full annual PPS payment update. The changes would be made to §413.360 and include adding a new paragraph (f) titled *Data completion thresholds*.

B. Request for Information (RFI): SNF QRP Quality Measures under Consideration for Future Years

CMS seeks input on three concept areas in which one or more measures would be developed for future use in the SNF QRP.

1. Cross-Setting Function – CMS is considering a functional measure for use across all PAC settings that would incorporate both of the domains of self-care and mobility.
2. Health Equity Measures – CMS expresses interest in structural measures that assess an organization's leadership in advancing health equity goals or assess progress towards achieving equity priorities.
3. COVID-19 Vaccination Coverage among PAC Patients – CMS invites comment on the value of a measure assessing whether SNF patients are current on their vaccinations.

CMS indicates that it will not respond specifically to comments received about this RFI through the FY 2023 SNF PPS final rule, but that all input from commenters will be considered in future policy making.

C. Request for Information (RFI): Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs

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

The agency is committed to addressing persistent inequities through improving data collection to better measure and analyze disparities across its quality programs, policies, and measures. Already underway are confidential reporting to acute care hospitals about readmissions stratified by dual eligibility status and reporting of stratified Health Effectiveness Data Information Set

(HEDIS) measure performance results to Medicare Advantage (MA) plans using several demographic and social risk factor variables.

In this RFI, CMS describes key principles and approaches the agency will consider when addressing disparities through quality measure development and stratification. Topics for comment and supporting information provided are grouped by CMS around 5 key considerations and 2 potential measures. Highlights from the topics for comment and extensive supporting information provided by CMS are reviewed below; topics for comment appear in bold font. (See section VI.E. of the rule for the full set of topics and complete background material.)

- **Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs**
    - **Within- and between-provider disparity methods to present stratified SNF quality measure results.**
    - **Decomposition approaches to explain possible causes of measure performance disparities.**
    - **Alternative methods to identify disparities and the drivers of disparities.**

In discussing methodological approaches to reporting disparities, CMS notes that the "within-provider" method compares a measure's results between subgroups of patients treated by a single provider with or without a given demographic or social risk factor. The "between-provider" method compares performance across providers on measures for subgroups who all have the factor of interest (e.g., compare a single provider with a national benchmark). CMS views the two methods as complementary when reporting data stratified by the presence or absence of a demographic or social risk factor.[16]

Another approach, regression decomposition, can facilitate analysis when an identified performance disparity may have multiple contributing factors, allowing estimation of the relative contributions of the factors.[17] CMS walks through a decomposition analysis of hypothetical SNF data for the Medicare Spending Per Beneficiary Measure stratified by dual-eligible status, for the factors of health literacy level and Emergency Department service utilization (see section VI.B.2.a. of the rule).

- **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting**

    Measures to be prioritized could include:
    - **Existing, validated, reliable, clinical quality measures for which application of disparities methods and stratified reporting are feasible.**
    - **Measures related to treatment or outcomes for which some evidence of disparities has been shown.**

[16] 2020 Disparity Methods Updates and Specifications Report, prepared for CMS by the Yale Center for Outcomes Research and Evaluation. Available at https://qualitynet.cms.gov/inpatient/measures/disparity-methods/resources#tab3.
[17] Rahimi E, Hashemi Nazari S. A detailed explanation and graphical representation of the Blinder-Oaxaca decomposition method with its application in health inequalities. Emerg Themes Epidemiol. (2021)18:12. https://doi.org/10.1186/s12982-021-00100-9.

- **Measures for which predetermined standards for statistical reliability and representativeness (e.g., sample size) have been met prior to results reporting.**
- **Measures that offer meaningful, actionable, and valid feedback to providers.**

- **Principles for Social Risk Factor and Demographic Data Selection and Use**
  - **Patient-reported data are the gold standard;**
  - **Criteria for appropriate use of administrative data, area-based indicators (e.g., Area Deprivation Index) and imputed variables when patient-reported data are unavailable; and**
  - **Data collection and submission burden (time and costs) imposed on providers.**

CMS notes the numerous and diverse demographic and social risk factor variables to be considered during disparities analysis (e.g., gender identity, social isolation). CMS reports early positive experience using Medicare Bayesian Improved Surname Geocoding (MBISG) to impute missing values for race and ethnicity from administrative data, surname, and residence.[18]

- **Identification of Meaningful Performance Differences**

  Methods for detecting meaningful differences could include:
  - **Statistical approaches for reliably grouping results (e.g., confidence intervals, clustering algorithm, cut points based on standard deviations);**
  - **Application of ranked ordering and percentiles to providers based on their disparity measure performances, for beneficiary use in decision making;**
  - **Categorizing different levels of provider performance by applying defined thresholds and fixed intervals to disparity measure results;**
  - **National or state-level benchmarking (e.g., mean, median); and**
  - **Criteria for when ranking performances is inappropriate (i.e., when only measure results can or should be reported without making comparisons)**

CMS states an intention to standardize its analytic approaches wherever possible. However, the agency also states that approaches must be tailored to contextual variations at the program level. Input on the benefits and limitations of the above list of methods is sought.

- **Guiding Principles for Reporting Disparity Measures**
  - **Guiding principles for the use and application of the results of disparity measurement.**

CMS believes that varying approaches to results reporting may be useful for driving quality improvement in different contexts and settings. CMS emphasizes that overall improvement without resolution of disparities would be undesirable.

[18] Haas A., Elliott M.N., Dembosky J.W., et al. Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity. *Health Serv Res*, 54(1):13-23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338295/pdf/HESR-54-13.pdf

- **Measures Related to Health Equity**
    - **Usefulness of a HESS score for SNFs in terms of actionability for providers to improve health equity;**
    - **Usefulness of a HESS score for SNFs in assisting beneficiary decision making;**
    - **Potential for a structural measure assessing a SNF's commitment to health equity, specific domains to be captured, and options for reporting these data that would minimize provider burden; and**
    - **Options to collect facility-level information for use in calculating a structural measure of health equity.**

Health Equity Summary Score[19]
CMS seeks input about adapting the Health Equity Summary Score (HESS) for use in the SNF QRP. The HESS was developed by the CMS Office of Minority Health to assess care provided by MA plans to beneficiaries with social risk factors or high-risk demographics. It is a composite measure that includes multiple measures – clinical and experience-of-care survey items – and multiple at-risk groups[20].

Hospital Commitment to Health Equity
CMS seeks input about adopting a structural measure for the SNF QRP to assess engagement of hospital leadership in collecting health equity performance data. The measure – *Hospital Commitment to Health Equity* – combines attestations from 5 distinct domains of commitment: strategic plan for disparities reduction; demographic and social risk factor data collection; disparities analysis; quality improvement activities; and leadership involvement in reducing disparities. CMS began the pre-rulemaking process by including this measure on the 2021 MUC List. As such, it was reviewed by the MAP and received conditional support for rulemaking.[21] CMS also solicits comments on other potential SNF QRP equity measures.

D. Request for Information (RFI): Inclusion of the CoreQ: Short Stay Discharge Measure in a Future SNF QRP Program Year

CMS believes that incorporating patient preferences is essential to keeping the Medicare program patient-centered. Patient satisfaction data, including results of patient-reported outcome (PRO) measures, are necessary for understanding patient preferences and can enable identification of deficiencies not easily detected through other data sources. Through prior RFIs, CMS has explored the incorporation of patient satisfaction data into the SNF QRP. In this RFI,

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[19] Agniel D., Martino S.C., Burkhart Q, et al. Incentivizing excellent care to at-risk groups with a health equity summary score. J Gen Intern Med, 2021; 36(7):1847-1857. https://link.springer.com/content/pdf/10.1007/s11606-019-05473-x.pdf.

[20] Clinical measures are from HEDIS (maintained by the National Committee for Quality Assurance); survey items are from the Consumer Assessment of Healthcare Providers and Systems (CAHPS, maintained by the Agency for Healthcare Research and Quality).

[21] The MAP conditionally supported this measure, but prior to adoption in rulemaking recommended that: the measure be submitted for NQF endorsement; verification of the attestations should be required; and additional data be presented to evaluate its impact on quality of care (i.e., linking elements of the measure to clinical outcomes or process improvements). https://www.qualityforum.org/Publications/2022/03/MAP_2021-2022_Considerations_for_Implementing_Measures_Final_Report_-_Clinicians,_Hospitals,_and_PAC-LTC.aspx

CMS seeks feedback on the CoreQ: Short Stay Discharge Measure for adoption into the SNF QRP, asking the questions listed below.

- **Would you support utilizing the CoreQ to collect PROs?**
- **Do SNFs believe the questions asked in the CoreQ would add value to their patient engagement and quality of care goals?**
- **Should CMS establish a minimum number of surveys to be collected per reporting period or a waiver for small providers?**
- **How long would facilities and customer satisfaction vendors need to accommodate data collection and reporting for all participating SNFs?**
- **What specific challenges do SNFs anticipate for collecting the CoreQ: Short Stay Discharge measure? What are potential solutions for those challenges?**

The CoreQ measure calculates the percentage of individuals discharged from a SNF during a 6-month period whose satisfaction with their stays is assessed using the Discharge questionnaire. The survey tool consists of four survey questions, each scored on a 5-point Likert scale, and is administered by a customer satisfaction survey vendor. The measure was supported for rulemaking by the MAP during the fall 2017 pre-rulemaking cycle, though with concern expressed about the imposed provider burden. The measure was re-endorsed by the NQF (#2614) in its 2020 routine measure maintenance review cycle.

The measure is calculated as follows:

Numerator: Individuals in the facility having a satisfaction score of 3 or above for the four questions.

Denominator: All patients, regardless of payer, admitted to the SNF and discharged within 100 days, who respond within 2 months of survey receipt.

Exclusions: Patients who die during the stay, are transferred to another inpatient facility, have court-appointed legal guardians or suffer from dementia, are discharged on hospice, or leave the SNF against medical advice.

E. Form, Manner, and Timing of Data Submission

Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)

CMS proposes an initial data submission period for the Influenza Vaccination HCP measure of October 1, 2022 through March 31, 2023 for the FY 2025 program year. The start date would be adjusted to match the earliest date of vaccine availability. The submission period is consistent with the CDC determination that the influenza vaccination season begins annually on October 1, or whenever the vaccine first becomes available, and ends on the following March 31. The same period would be advanced by one year for each subsequent SNF QRP program year.

Each SNF would submit at least one report using the CDC's NHSN by May 15th immediately following the end of the influenza season. Any data revisions made by SNFs after that date will not be included in the measure results transmitted by CDC to CMS. If data are submitted more frequently, they will be aggregated to calculate a single summary score for reporting on Care

Compare. Reporting to the CDC requires the online completion of two forms, one to specify the data type being submitted and one with actual measure 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.[22] CMS proposes to publicly report the Influenza Vaccination HCP measure as soon as technically feasible after confidential reporting to facilities and a review and corrections period. Publicly-reported data each year will reflect the October through March data collection period.

G. Summary Table of Measures Currently Adopted for the FY 2023 SNF QRP

Short Name	Measure Name & Data Source
Data Source: Resident Assessment Instrument Minimum Data Set (MDS)	
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	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).
TOH-Provider*	Transfer of Health Information to the Provider – PAC Measure
TOH-Patient*	Transfer of Health Information to the Patient – PAC Measure
Data Source: Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
* Data 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). In this rule, a proposal if finalized will change the start date for these two measures to October 1, 2023 (FY 2024).	
Source: HPA modification of Table 15 of the proposed rule	

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

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

In this rule, CMS proposes substantial changes to the SNF VBP Program. Most stem from provisions of the Consolidated Appropriations Act of 2021 (CAA, 2021) that permit the Secretary to expand the Program beyond the current, single measure. Several other changes are proposed to modify the SNF VBP Program for FY 2023 to adjust for continued impacts of the COVID-19 PHE. Also proposed are regulation text revisions to update the *Definitions* used in § 413.338. All proposals in this section of the rule are open to comment.

The SNF VBP Program was implemented for discharges beginning in FY 2019 and applies to all SNFs paid under the SNF PPS: freestanding, affiliated with acute care facilities, and non-CAH swing-bed rural facilities. Measures for the program and a performance scoring methodology were adopted in the FY 2016 and 2017 SNF PPS final rules. An Extraordinary Circumstances Exception (ECE) policy was finalized for FY 2019; the FY 2019 and FY 2020 final rules added scoring adjustments and data suppression policies for low-volume facilities. In response to the COVID-19 PHE, in the FY 2022 final rule CMS adopted a cross-program measure suppression policy for the duration of the PHE,[23] accompanied by a special scoring policy for the SNF VBP Program for the FY 2022 program year.

Currently, the SNF VBP Program withholds 2.0 percent of the payments that would be made to SNFs and redistributes approximately 60 percent of the money withheld for redistribution based on performance on a readmission measure. Specifically, amounts redistributed are delivered by applying a value-based incentive adjustment at the individual claim-level to each SNF's adjusted FY federal per diem rate. The remaining 40 percent is returned as savings to the Medicare program, minus funds used for adjustments made according to low-volume facility policies. CMS estimates that if all of the changes proposed for the Program are finalized, approximately $463.87 million will be withheld from SNFs and $278.32 million will be redistributed among SNFs as value-based incentive payments in FY 2023. Approximately $188.55 million will be returned through the SNF VBP Program to the Medicare Program as savings in FY 2023.

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

A. SNF VBP Program Measures

Measures adopted thus far into the SNF VBP Program are the SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510) and the Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure (SNFPPR). Currently, only the SNFRM is in use; as required by statute, CMS plans to replace the SNFRM with the SNFPPR, once the latter is NQF-endorsed.

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

Section 111 of CAA, 2021 amended Section 1888(h) of the Act and allows the Secretary to add up to 9 additional measures to the Program, as determined to be appropriate by the Secretary. The new measures could be applied to payments beginning on or after October 1, 2023.

A summary table of current and proposed SNF VBP Measures is provided below in section VII.I.

1. SNFRM Suppression for the FY 2023 Program Year

CMS expresses concern that ongoing effects of the COVID-19 PHE during 2021 will impair the agency's ability to assess performance on the SNFRM for program year FY 2023. CMS characterizes the major PHE effects as fewer SNF admissions; regional and temporal variations in COVID-19 prevalence; and altered hospitalization patterns producing downstream effects on SNFs. Based on extensive data analyses, CMS believes that these effects when combined will preclude accurate assessments across SNFs based on 2021 performance data. For example, using FY 2021 data is projected to cause a 15 percent decrease in SNFRM reliability. To guide its decision making about measure suppression, CMS considered the four previously finalized Measure Suppression Factors (86 FR 42504) and found Factor 4 to be applicable--significant national shortages or rapid or unprecedented changes in healthcare personnel; medical supplies, equipment, or diagnostic tools or materials; or patient case volumes or facility-level case mix.

CMS, therefore, proposes to invoke the cross-program measure suppression policy for the FY 2023 SNF VBP program year. The policy permits CMS to suppress use of the SNFRM for purposes of program scoring and payment adjustments when the agency determines that significant impacts on the measure and the resulting performance scores have occurred due to the COVID-19 PHE. In conjunction with measure suppression, CMS proposes to apply a special SNF VBP program scoring policy for program year FY 2023, as discussed in section VII.E.2. of the rule and section VII.D.1. of this summary. However, CMS perceives that SNFs are adapting as the COVID-19 PHE evolves and are benefiting from vaccine availability to return towards pre-PHE operations. As a result, CMS states an intent to resume use of the SNFRM for scoring and payment adjustment purposes beginning with the FY 2024 program year.

2. Technical Updates to the SNFRM to Risk Adjust for COVID-19 Patients

CMS indicates that it will update the technical specifications of the SNFRM for the FY 2023 SNF VBP program year and subsequent years to adjust for observed differences between SNF patients with and without COVID-19 diagnoses made up to 12 months prior to or during the hospitalizations that preceded their SNF admissions (prior proximal hospitalization, PPH). CMS considers the update technical rather than substantive in nature and thereby not subject to rulemaking.

CMS reports being prompted by the high prevalence of COVID-19 in patients admitted to SNFs to consider developing an adjustment to the SNFRM to account for potential effects on the measure caused by including COVID-19 patients. CMS explored the prevalence of COVID-19 among SNF patients and differences in readmissions between those patients with and without COVID-19. Also examined were differences in clinical and demographic characteristics

between the two groups. Readmissions were higher for patients with COVID-19 diagnosed during their PPHs; a history of COVID-19 outside of the PPH did not increase readmissions after accounting for comorbidities.

CMS evaluated four options to adjust the SNFRM for COVID-19 patients:

1) whether to add a binary risk-adjustment variable for patients who had a primary or secondary diagnosis of COVID-19 during the PPH;
2) whether to add a binary risk-adjustment variable for patients who had a history of COVID-19 in the 12 months prior to the PPH;
3) adding a categorical risk-adjustment variable that combines options 1 and 2;[24] or
4) removing patients with a COVID-19 diagnosis during the PPH from the measure cohort.

CMS chose option 3, addition of a categorical risk-adjustment variable. Therefore, COVID-19 patients admitted to SNFs who were diagnosed at any time within the 12 months preceding the PPH or during the PPH will remain in the SNFRM cohort. However, beginning with program year FY 2023, a variable will be added to separately identify patients diagnosed during or outside of their PPHs in recognition of clinical outcome differences found between these two groups. CMS believes that retention of all patients diagnosed with COVID-19 in the measure cohort could facilitate future analyses of long COVID effects on the SNFRM. Retention also helps maintain the measure's reliability by preserving the measure cohort's size. CMS adds that the updated specifications would not be sufficient to compensate entirely for the COVID effects on the SNFRM on which CMS is basing its decision to suppress the SNFRM for FY 2023. (See section VII.B.2. of the rule for the detailed discussion of the data examined and the analyses performed.)

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

CMS proposes to add 2 new measures to the SNF VBP measure set beginning with the FY 2026 program year and 1 new measure for the FY 2027 program year. The SNF VBP Program has contained only a single active measure since the program's inception, the SNFRM. If the measure set is expanded by one or more of the proposed additions, CMS proposes at § 413.338 that the measures applicable to a given program year will be specified by CMS from the program's expanded measure set; this stipulation was unnecessary when the measure set contained only 1 active measure. CMS believes that delaying new measure adoption until program year FY 2026 will facilitate SNFs gaining familiarity with the new measures and with other programmatic changes needed to support the larger measure set.

SNF VBP program measure expansion has been enabled by Section 111 of CAA, 2021, which amended section 1888(h) of the Act, and allows the Secretary to add up to 9 additional measures to the Program, such as measures of patient safety, care coordination, or patient experience, as

[24] The reference category is patients without a history of COVID-19 and no COVID-19 diagnosis during the PPH. The first comparison category is patients who had a history of COVID-19 in the 12 months prior to the PPH and no COVID-19 diagnosis during the PPH. The second comparison category is patients who had a primary or secondary diagnosis of COVID-19 during the PPH. If a patient had both a history of COVID-19 and a COVID-19 diagnosis during the PPH, they would be included in the second comparison category.

determined to be appropriate by the Secretary. Further, the Secretary must consider for addition quality measures specified under section 1899B(c)(1) of the Act (i.e., measures of functional status, skin integrity, medication reconciliation, and major falls). CAA, 2021 also provided that the new measures could be applied to payments for services furnished beginning on or after October 1, 2023.

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

CMS proposes to add this claims-based, patient safety, outcome measure to the SNF VBP program's measure set beginning with program year FY 2026.

> Description. The measure uses Medicare Fee-for-Service (FFS) claims to estimate the risk-standardized rate of HAIs acquired during SNF care that result in hospitalizations.[25]
> Numerator. The risk-adjusted estimate of the number of SNF stays predicted to have an HAI that results in hospitalization.[26] HAIs reported during ED visits and hospital observation stays are excluded.
> Denominator. The risk-adjusted "expected" number of SNF stays with HAI that results in hospitalization (i.e., that would occur in an "average" SNF).
> Inclusions. All Part A FFS Medicare SNF residents 18 years or older admitted to a SNF during the measurement period. Residents who die during the SNF stay are included.
> Exclusions. There are several exclusions (e.g., SNF stay less than 4 days), that are fully described in the measure's specifications.
> Risk adjustment. The hierarchical logistic regression risk model estimates both the average predictive effect of resident characteristics across all SNFs, and the degree to which each SNF has an effect on the outcome that differs from that of the average SNF. Multiple variables are included, such as gender, end-stage renal disease, and prior ICU stay.

For the facility-level HAI rate, a lower measure score indicates better performance. To enhance clarity for public reporting, CMS proposes to invert the HAI measure rate so that higher is better (SNF HAI Inverted Rate = 1 - Facility SNF HAI Rate).

In a detailed discussion of the proposed 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. CMS notes that many SNF HAIs are preventable and that interventions are available for adoption by SNFs to reduce their HAI rates (e.g., antibiotic stewardship).

Following the usual pre-rulemaking process for stakeholder input including a Technical Expert Panel (TEP), the proposed measure was placed on the December, 2021 Measures Under

[25] Full measure specifications are found in the SNF HAI Technical Report, available for download 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.

[26] HAIs are defined as infections acquired while receiving care at a health care facility that were not present or incubating at the time of admission.

Consideration List. The Measure Applications Partnership (MAP) conditionally supported the measure 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.

Under current policies, SNFs are provided quarterly confidential feedback reports on their SNFRM performances and SNF VBP performance information is publicly posted on the Provider Data Catalog website hosted by HHS. CMS proposes to update and redesignate the confidential and public reporting policies to include the SNF HAI measure if finalized.

Because this measure is claims-based, CMS assigns no burden for providers from adopting this measure.

b. Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing)

CMS proposes to add this structural measure to the SNF VBP program's measure set beginning with program year FY 2026.

Description. The measure uses SNF MDS data and data from the CMS Payroll Based Journal (PBJ) system to derive case-mix adjusted nurse staffing hours per SNF resident day.
Numerator. Total nursing hours in a facility per quarter, reported to PBJ by staff type.[27]
Denominator. Daily count of residents extracted from MDS assessments (aggregated for measure calculations quarterly).
Exclusions. Facilities whose staffing data meet preset criteria for "highly improbable" (e.g., total nurse staffing < 1.5 hours per resident day).
Risk adjustment. The data are adjusted for facility case-mix.

In a detailed discussion of the proposed measure, CMS shares data about the many reported correlations between nurse staffing (most often RN type) to a variety of clinical outcomes, most recently COVID-19 infections and deaths. CMS notes that considerable variation in nurse staffing patterns has been identified through the PBJ system and supports the utility of a staffing measure for assessing SNF quality performance. CMS describes developing the PBJ system for electronic, auditable collection of staffing data that are required under the Conditions of Participation for long-term care facilities; the first mandatory PBJ reporting period began July 1, 2016. Payroll data are considered the gold standard for use in nurse staffing measures, and PBJ data are auditable back to verifiable payroll sources. CMS states that the Total Nurse Staff measure has been part of the Nursing Home Five-Star Quality Reporting System since 2008 and as such is publicly reported; staffing levels increased after public reporting began in April, 2018. CMS also describes the many opportunities for stakeholder input during development of this measure.

[27] Staff types as used in this measure are RN (Registered Nurse), LPN/LVN (License Practical or Vocational Nurse), and NA (Certified Nursing Assistant, aides in training, medication aides and techs). Staff are categorized as facility employees or working under contract. "Private duty" staff employed by residents/families are not included.

Following the standard pre-rulemaking process, the Total Nurse Staffing measure was placed on the December, 2021 MUC List. The MAP conditionally supported the measure contingent upon NQF endorsement. CMS plans to seek NQF endorsement of the measure.

Under current policies, SNFs are provided quarterly confidential feedback reports on their SNF VBP performances and performance information is publicly posted on the Provider Data Catalog website hosted by HHS. CMS proposes to update and redesignate the current confidential and public reporting policies to include the Total Nurse Staffing measure if finalized.

CMS assigns no provider burden to this measure, since PBJ and MDS reporting are already required of SNFs for other purposes.

c. Discharge to Community – Post-Acute Care Measure for SNFs (DTC-PAC-SNF) (NQF #3481)

CMS proposes to add this claims-based outcome measure to the SNF VBP program's measure set beginning with program year FY 2027. It is currently part of the SNF QRP measure set.

Description. The measure uses 2 years of Medicare FFS claims data to assess the rate of successful discharge to the community from the SNF setting.
Numerator. Risk-adjusted estimated number of SNF residents discharged to the community who remain alive for 31 days after SNF discharge and who do not have an unplanned acute care or long-term care hospital admission during that same time. Home health services provided post-SNF discharge do not impact this measure's score.
Denominator. The risk-adjusted expected number of discharges to the community.
Exclusions. There is a lengthy list of exclusions, including discharge to a psychiatric hospital or to court/law enforcement.
Risk adjustment. Performed for multiple variables including renal disease, age, and sex.

In its discussion of the proposed measure, CMS notes that SNF DTC rates ranged from 39 to 54 percent in 2019 (pre-COVID PHE), suggesting room for improvement and supporting the utility of this measure for assessing SNF quality performance. Besides being an outcome generally desired by SNF residents, beneficiary discharge to the community often results in lower costs to Medicare. CMS also believes the DTC-PAC-SNF measure to be actionable for SNFs, as interventions targeted toward increasing DTC rates have shown some success (e.g., improved discharge planning).

CMS also describes the many opportunities for stakeholder input during development of this measure.
Following the standard pre-rulemaking process, the DTC-PAC-SNF measure was placed on the December, 2021 MUC List. The MAP supported the measure for rulemaking.

Under current policies, SNFs are provided quarterly confidential feedback reports on their SNF VBP performances and performance information is publicly posted on the Provider Data Catalog website hosted by HHS. CMS proposes to update and redesignate the current confidential and public reporting policies to include the DTC-PAC-SNF measure if finalized.

Because this measure is claims-based, CMS estimates zero added burden for providers from adopting this measure.

B. SNF VBP Performance and Baseline Periods

1. Baseline and Performance Periods for the FY 2025 Program Year

For the FY 2025 SNF VBP program year, CMS proposes to use FY 2019 as the baseline period. Previously established policy would call for the use of FY 2021 for this purpose. However, CMS expresses significant concerns that COVID-19 PHE impacts on SNFs during FY 2021 would seriously degrade SNFRM validity and reliability if FY 2021 data were to be used for the measure's baseline. (The same impacts -- fewer SNF admissions; regional and temporal variations in COVID-19 prevalence; and altered hospitalization patterns producing downstream effects on SNFs – have also led CMS to propose suppression of the SNFRM measure and a special scoring policy for program year FY 2023 as discussed earlier in the rule and this summary.)

CMS considered the alternatives of using either FY 2020 or FY 2022 as the FY 2025 baseline period. CMS believes FY 2020 is unsuitable as the SNFRM baseline period because only 6 months of claims data are available for measure calculation. Data from Q1 and Q2 were excepted from use under the program's Extraordinary Circumstances Exception (ECE) policy as part of the CMS response to the COVID-19 PHE. CMS states that using FY 2022 as the baseline period for the FY 2025 program year is not operationally feasible for the agency since standards for the associated performance year (FY 2023) could not be determined and published sufficiently in advance to meet the statutory deadline for their publication.

2. SNF HAI Measure Baseline and Performance Periods

a. Performance Period

CMS has proposed adding this measure to the SNF VBP measure set beginning with program year 2026. To operationalize SNF HAI measure addition, CMS proposes a 1-year performance period for the measure. CMS also proposes a measure performance period that is 2 fiscal years prior to the associated program year.
CMS further proposes to adopt FY 2024 as the performance period for the SNF HAI measure for the FY 2026 SNF VBP program year. Finally, CMS proposes to automatically adopt future performance periods by advancing the beginning of the period by 1 year from that used for the previous program year.

In setting the SNF HAI measure's timeline, CMS states taking into consideration numerous factors: the statutory requirement to announce program payment adjustments no later than 60 days prior to their associated program year; measure reliability as determined during measure testing; emphasizing the link between quality performance and value-based payment adjustments by minimizing the lag between the performance and program payment years; and providing predictability for facilities.

b. Baseline Period

CMS proposes adoption of a SNF HAI baseline period that occurs 4 fiscal years prior to the associated SNF VBP program year and 2 fiscal years prior to the measure's performance period. CMS also proposes to adopt a 1-year baseline period for the measure and further proposes to set FY 2022 as the baseline period for the FY 2026 program year. Finally, CMS proposes to automatically set future baseline periods by advancing the beginning of the period by 1 year from the baseline used for the previous program year. CMS notes that these proposals align with the timeline previously established for the SNFRM measure.

When setting measure baseline periods, CMS considers the time needed to calculate performance standards and announce them no later than 60 days prior to their associated program year, as required by statute. CMS balances this requirement with its intentions 1) to set baseline periods whose durations are close as possible to the durations of their associated baseline period; 2) to seasonally align the measure's baseline and performance periods to enhance the accuracy of measure result comparisons; and 3) to create predictability for facilities.

3. Total Nurse Staffing Measure Baseline and Performance Periods

a. Performance Period

CMS has proposed adding this measure to the SNF VBP measure set beginning with program year 2026. To operationalize the measure's addition, CMS proposes a 1-year performance period for the measure. For implementation, the agency further proposes that Total Nurse Staffing measure data that currently are reported on a quarterly basis for the Nursing Home Five-Star Quality Rating System would be aggregated into a single performance period using a simple mean of the quarterly case-mix adjusted scores. (Measure testing has shown stability of the data across quarters.) CMS also proposes a measure performance period that is 2 fiscal years prior to the associated program year. CMS further proposes to adopt FY 2024 as the performance period for the Total Nurse Staffing measure for the FY 2026 SNF VBP program year. Finally, CMS proposes to automatically adopt future performance periods by advancing the beginning of the period by 1 year from that used for the previous program year.

In setting the Total Nurse Staffing measure's timeline, CMS states taking into consideration numerous factors: the statutory requirement to announce program payment adjustments no later than 60 days prior to their associated program year; measure reliability as determined during measure testing; emphasizing the link between quality performance and value-based payment adjustments by minimizing the lag between the performance and program payment years; and providing predictability for facilities.

b. Baseline Period

CMS proposes adoption of a Total Nurse Staffing baseline period that occurs 4 fiscal years prior to the associated SNF VBP program year and 2 fiscal years prior to the measure's performance period. CMS also proposes to adopt a 1-year baseline period for the measure and further

proposes to set FY 2022 as the baseline period for the FY 2026 program year. Finally, CMS proposes to automatically set future baseline periods by advancing the beginning of the period by 1 year from the baseline used for the previous program year. CMS notes that these proposals align with the timeline previously established for the SNFRM measure.

When setting measure baseline periods, CMS considers numerous factors: the time needed to calculate performance standards and announce them no later than 60 days prior to their associated program year, as required by statute. CMS balances this requirement with its intentions 1) to set baseline periods whose durations are close as possible to the durations of their associated baseline period; 2) to seasonally align the measure's baseline and performance periods to enhance the accuracy of measure result comparisons; and 3) to create predictability for facilities.

4. Discharge to Community-Post-Acute Care-SNF Measure Baseline and Performance Periods

a. Performance Period

CMS has proposed adding the DTC-PAC-SNF measure to the SNF VBP measure set beginning with program year 2027. To operationalize the measure's addition, CMS proposes a 2-year performance period for the measure to align with the measure's 2-year data reporting period. CMS further proposes to adopt FY 2024 through FY 2025 as the performance period for the DTC-PAC-SNF measure for the FY 2027 SNF VBP program year. Finally, CMS proposes to automatically adopt future performance periods by advancing the beginning of the period by 1 year from that used for the previous program year.

In setting the DTC-PAC-SNF measure's timeline, CMS states taking into consideration numerous factors: the statutory requirement to announce program payment adjustments no later than 60 days prior to their associated program year; measure reliability as determined during measure testing; emphasizing the link between quality performance and value-based payment adjustments by minimizing the lag between the performance and program payment years; and providing predictability for facilities.

b. Baseline Period

CMS proposes adoption of a DTC-PAC-SNF measure baseline period that occurs 6 fiscal years prior to the associated SNF VBP program year and 3 fiscal years prior to the measure's performance period. CMS also proposes to adopt a 2-year baseline period for the measure and further proposes to set FY 2021 through FY 2023 as the baseline period for the FY 2027 program year. Finally, CMS proposes to automatically set future baseline periods by advancing the beginning of the period by 1 year from the baseline used for the previous program year. CMS notes that these proposals align with the timeline previously established for the SNFRM measure.

When setting measure baseline periods, CMS considers the time needed to calculate performance standards and announce them no later than 60 days prior to their associated program year, as required by statute. CMS balances this requirement with its intentions 1) to set baseline periods

whose durations are close as possible to the durations of their associated baseline period; 2) to seasonally align the measure's baseline and performance periods to enhance the accuracy of measure result comparisons; and 3) to create predictability for facilities.

C. Performance Standards

CMS proposes to clarify regulation text for the SNF VBP by shortening the definition of *Performance standards* to read as "the levels of performance that SNFs must meet or exceed to earn points on a measure under the SNF VBP Program for a fiscal year". The revised language better accommodates the proposed expansion of the Program's measure set and removes information about the Program's review and correction period. CMS proposes to move the review and correction period information to § 413.338(d)(6). No changes are proposed to the performance standards correction policy itself.

CMS proposes SNF VBP estimated performance standards for program year FY 2025, shown below in Table 18 reproduced from the rule. These standards assume that the proposal earlier in the rule to use FY 2019 as the baseline period is finalized.

Proposed Estimated FY 2025 SNF VBP Program Performance Standards			
Measure ID	**Measure Description**	**Achievement Threshold**	**Benchmark**
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79270	0.83028

D. SNF VBP Performance Scoring

1. Proposed Special Scoring Policy for FY 2023 Due to COVID-19 PHE Impacts

Earlier in the rule (Section VII.B.1.) and in this summary (section VII.A.1), CMS proposes to suppress the SNFRM for program year FY 2023 and apply a SNF VBP special scoring policy for that year. To operationalize the special scoring, CMS would:

- Calculate SNFRM rates for all SNFs per the Program's established methodology and using data from the previously finalized FY 2023 performance (FY 2021) and baseline periods (FY 2019);
- Suppress use of the SNFRM for purposes of scoring and payment adjustments;
- Assign all SNFs a performance score of zero (except those who fail to meet the proposed SNFRM measure minimum of 25 cases—see below);
- Calculate the value-based incentive payment multiplier using a score of zero for each facility;
  - Use the established methodology (but modified to reflect the proposed termination of the low-volume adjustment policy and adoption of the proposed case minimum policy);
  - Since all eligible SNFs will receive identical measure scores of zero, they will also receive identical incentive payment multipliers; and
- Not assign relative rankings to eligible SNFs.

The steps above assume that the SNFRM case minimum requirement is finalized as proposed. Facilities that fail to meet the minimum for a program year would not be included (eligible) as participants in the SNF VBP for that year and would not receive value-based payment adjustments.

Under the proposed special scoring policy, CMS first would reduce each eligible facility's adjusted federal per diem rate by 2 percentage points per statute as usual (the withhold). CMS would then award back to each eligible facility 60 percent of their 2 percent withhold, resulting in a 1.2 percent payback for the FY 2023 program year. CMS believes that the withhold from eligible SNFs is required annually by statute (section 1888(h)(5)(C)(ii)(III) of the Act) and views a uniform payback to all eligible SNFs as the most equitable approach to mitigate the impact of the withhold, in conjunction with the special scoring policy, for the FY 2023 program year.

2. Proposed Case Minimum and Measure Minimum Policies

a. In General

Section 111(a)(1) of Division CC of CAA, 2021 established criteria for excluding SNFs from the SNF VBP Program. For payments for services furnished on or after October 1, 2022, the Program may not be applied to a SNF for which there are not a minimum number of cases or a minimum number of measures for the measures that have been determined by the Secretary to apply to the performance period for the applicable fiscal year.

To comply with statute, CMS makes proposals to set and implement case and minimum measures for the FY 2023 program year and subsequent years. The case and measure minimum requirements would serve as eligibility criteria for determining the inclusion or exclusion of a SNF from the VBP Program for a given program year. Included SNFs would receive a performance score and be eligible to receive a value-based incentive payment. Excluded SNFs would not be subject to the requirements of the VBP Program (§ 413.338) and would not be subject to payment reductions under § 413.337 for the applicable fiscal year. The proposed establishment of case and measure minimums as program eligibility criteria would be codified at § 413.338(b).

CMS intends to set the case and measure minimums to ensure statistical accuracy and reliability when applied and believes thereby that the Program would include only facilities for which reliable measure rates and performance scores could be calculated. As a result of applying the eligibility criteria, CMS believes that a low-volume adjustment (LVA) would no longer be needed for the SNF VBP Program and proposes removal of the LVA policy later in the rule.

b. Case Minimums by Measure and Program Year

- For Program Year FY 2023 and subsequent years, CMS proposes a case minimum for the SNFRM of 25 eligible stays during the applicable 1-year performance period.
- For Program Year FY 2026 and subsequent years, CMS proposes a case minimum for the SNF HAI measure of 25 eligible stays during the applicable 1-year performance period.

- For Program Year FY 2026 and subsequent years, CMS proposes a case minimum for the Total Nurse Staffing measure of 25 eligible stays during the applicable 1-year performance period.
- For Program Year FY 2027 and subsequent years, CMS proposes a case minimum for the DTC-PAC-SNF measure of 25 eligible stays during the applicable 2-year performance period.

CMS believes the alignment of case minimums among the SNF VBP measures will offer simplicity and clarity. CMS reviewed pertinent measure testing data and reliability results and found them to support the proposed case minimums (see section VII.E.3.b. and 3.c. of the rule for details of CMS analyses).

c. Measure Minimums by Program Year

To comply with statute, CMS proposes to set measure minimums for the FY 2026 and FY 2027 program years, in which the SNF VBP measure set would contain 3 measures (SNFRM, SNF HAI, and Total Nurse Staffing) and 4 measures (SNFRM, SNF HAI, Total Nurse Staffing and DTC-PAC-SNF), respectively. Only SNFs that meet the measure minimums for the applicable program year would be eligible for inclusion in the SNF VBP Program. In setting measure minimums CMS considered SNF performance score reliability and maximizing the number of SNFs eligible to receive performance scores and value-based incentive payments.

For program year FY 2026, CMS proposes that an eligible SNF must meet the case minimums for 2 of the 3 measures applicable for that year. For program year FY 2027, CMS proposes that an eligible SNF must meet the case minimums for 3 of the 4 measures applicable for that year. CMS provides some analytic results in support of the proposed measure minimums (see section VII.E.3.d. of the rule for details). If the proposed case and measure minimums are finalized, CMS projects that 14 percent of SNFs would be excluded from the Program for FY 2026. The excluded subgroup in aggregate would provide care for about 2 percent of potentially eligible SNF stays. For program year FY 2027, CMS projects that 16 percent of SNFs would be excluded from the Program. The excluded subgroup in aggregate again would provide care for about 2 percent of potentially eligible SNF stays.

3. Scoring for SNFs Without Sufficient Baseline Period Data

CMS proposes a policy update for measure scoring beginning with program year FY 2026. Currently, SNFs with fewer than 25 eligible stays during a baseline period are scored only on SNFRM achievement and not improvement for the associated program year. CMS proposes that for each SNF VBP measure, SNFs who fail to meet the measure-specific minimum during that measure's associated baseline period would be scored only on achievement for the applicable program year. Eligibility for achievement and performance point scoring will be assessed independently by CMS for each measure for each SNF. CMS believes that this update is necessary once the SNF VBP measure set is expanded to maintain SNF performance scoring reliability.

4. Low-volume Adjustment (LVA) Policy Removal

CMS proposes to remove the LVA policy from the SNF VBP Program beginning with the FY 2023 program year. The policy was developed to maintain reliability of SNFRM measure rates and resultant performance scores by assigning a net-neutral value-based incentive payment performance adjustment to SNFs with fewer than 25 eligible stays for SNFRM measure scoring during a given program year. As noted above, statute now requires setting case and measure minimums for the Program beginning with the FY 2023 program year and provides that facilities who fail to meet the applicable minimums are to be excluded from the Program for the associated program year. Excluded facilities would not be eligible for performance scoring and incentive payment adjustments. CMS believes that the LVA policy would no longer be required and proposes its removal when the case and measure minimums, if finalized, are first implemented (i.e., for the FY 2023 program year).

5. Updating the SNF VBP Program's Scoring Methodology

CMS proposes revised measure scoring policies and proposes a new score normalization policy beginning with program year FY 2026. These proposals are part of transitioning the SNF VBP Program's measure set from containing a single-measure to having multiple measures.

a. Measure-Level Scoring

Currently SNFs are able to earn between 1 and 100 points through their SNFRM performances. Points awarded are either for achievement or improvement, whichever result is higher. The performance score is then translated into the value-based incentive payment multiplier through application of a logistic exchange function. To implement the SNF VBP Program's expanded measure set for program year 2026 and subsequent years, CMS proposes to switch to a 10-point scale for each measure with implementation parameters as follows.

In General

- The benchmark for each measure is defined as the mean of the top decile of SNF performances on the measure during its applicable baseline period.
- The improvement threshold is defined as the 25th percentile of national SNF performances on each measure during its applicable baseline period.
- A maximum score of 10 achievement points is available for each measure.
- A maximum score of 9 improvement points is available for each measure.
- The higher of the achievement or improvement scores is awarded;
    - When the case minimum for a measure is not met, only an achievement score is awarded.

For Achievement Scoring

- Performance $\geq$ benchmark: 10 points are awarded
- Performance $<$ benchmark: 0 points are awarded
- Performance $\geq$ achievement threshold: 0-10 points are awarded according to the Achievement Score formula

$$\left(\left[9 \times \left(\frac{Performance\ Period\ Rate - Achievement\ Threshold}{Benchmark - Achievement\ Threshold}\right)\right] + 0.5\right)$$

For Improvement Scoring

- Performance $\leq$ facility's baseline performance: 0 points are awarded.
- Performance $\geq$ facility's benchmark: 9 points are awarded.
- Performance $>$ facility's baseline and $<$ benchmark: 0-9 points are awarded according to the Improvement Score formula

$$\left(\left[10 \times \left(\frac{Performance\ Period\ Rate - Baseline\ Period\ Rate}{Benchmark - Baseline\ Period\ Rate}\right)\right] - 0.5\right)$$

b. Normalizing Performance Scores

CMS proposes to normalize facility performance scores. The measure raw measure scores resulting from application of the parameters described above to all measures are summed and the total possible measure points available also are summed. The resulting ratio (summed raw scores/total available points) is converted to a 100-point scale. For example, a raw score sum of 27 points out of 30 for 3 measures (27/30) results in a normalized SNF performance score of 90. CMS states that this policy would remain applicable if the SNF VBP measure set were to be further expanded and that the performance scores should be readily understood by the public. CMS notes that SNF VBP scoring would now largely parallel that of the Hospital VBP Program and states that the latter program is well-understood by the public.

E. SNF VBP Program Validation Process

Section 111(a)(4) of the CAA, 2021, requires the Secretary to apply a validation process to SNF VBP Program measures and data, beginning with the FY 2023 program year. For SNFRM validation, CMS proposes to continue the current work done by the Medicare Administrative Contractors (MACs) to ensure SNF VBP incentive payment accuracy (e.g., reviews of medical necessity, pre- and post-payment audits) and to codify that work at under § 413.337. Further validation processes will be considered by CMS for future application to the proposed new Program measures, if finalized (see the RFI about SNF Validation in section VII.I.C.3 of the rule and later in this summary).

F. SNF Value-Based Incentive Payments for the FY 2023 Program Year

CMS reprises its proposals to suppress the SNFRM measures for program year FY 2023 and apply a special scoring policy due to the COVID-19 PHE's effects on measure reliability (see section VII.G. of the rule and section VII.F. of this summary). In brief, CMS proposes to:

- Suppress use of the SNFRM for purposes of scoring and payment adjustments;
- Not assign relative rankings to SNFs eligible to participate in the Program;
- Reduce each eligible facility's adjusted federal per diem rate by 2 percentage points per statute as usual (the withhold); and

- Award back to each eligible facility 60 percent of their 2 percent withhold, resulting in a 1.2 percent payback.

CMS further proposes that SNFs failing to meet SNFRM minimums for program year FY 2023 will be excluded from the Program for that year. CMS reiterates its goal to resume use of the pre-pandemic scoring methodology for the FY 2024 program year.

G. Public Reporting

Statute requires the Secretary to enable public reporting of SNF VBP program measures, and CMS first reported SNF performance scores and rankings during FY 2017. Results are first confidentially reported to facilities and made public only after a review and corrections period for facilities.

1. Provider Data Catalog

Since December, 2020, CMS has posted SNF VBP performance data publicly on the Provider Data Catalog website (https://data.cms.gov/provider-data/). As part of the proposed measure suppression process and special scoring policy for program year FY 2023, CMS would calculate SNFRM rates as usual using available data and publish those rates publicly after review by SNFs. CMS states that appropriate explanatory information will be provided along with the scores to describe the effects of the suppression policy on the information posted.

2. Data Suppression for Low-Volume SNFs

In keeping with its proposals to expand the SNF VBP Program's measure set for program years FY 2026 and 2027 and to remove the LVA policy beginning with program year FY 2023, CMS proposes the following policies for facilities who fail to meet case and/or measure minimums, beginning with the FY 2023 program year:

- If a SNF does not have the minimum number of cases during the baseline period that applies to a measure for a program year, CMS would publicly report the SNF's measure rate and achievement score if the SNF had the minimum number of cases for the measure during the applicable performance period.
- If a SNF does not have the minimum number of cases during a measure's applicable performance period for a program year, CMS would not publicly report any information on the SNF's performance on that measure for the program year.
- If a SNF does not have the minimum number of measures during the performance period for a program year, CMS would not publicly report any data for that SNF for the program year.

H. Request for Comment Related to Future SNF VBP Program Expansion Policies

1. Request for Comment on Additional SNF VBP Program Measure Considerations for Future Years

a. Staffing Turnover Measure

CMS requests comments on the following:

- **Inclusion of the staff turnover measure as currently specified for use in the Nursing Home Five-Star Quality Rating System as part of the FY 2024 SNF PPS proposed rule, or whether the measure needs respecified (percent of total nurse staff that have left the facility over the last year; see the Five-Star System User Guide for more details, available for download at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf).**
- **Whether CMS should explore development of a composite measure that would capture multiple aspects of staffing, including both total nurse hours and the staff turnover measure rather than having separate but related measures related to nursing home staffing.**
- **Actions SNFs may take or have taken to reduce staff turnover in their facilities, and for SNFs that did reduce staff turnover, the reduction's observed impact on quality of care; information about best practices is particularly sought.**
- **Any considerations CMS should take into account related to the impact that including a Nursing Home Staff Turnover measure may have on health equity.**

CMS cites some of the available literature linking high turnover rates to adverse health outcomes. CMS also calls attention to a more detailed RFI later in the rule targeting establishment of potential minimum staffing requirements for long-term care facilities.

b. CDC-National Health Safety Network (NHSN) COVID-19 Vaccination among Health care Personnel Measure (HCP COVID-19 Vaccination Measure)

CMS requests comments as to whether this measure – recently added to the SNF QRP measure set – **should be added to the SNF VBP measure set** to determine the percentage of facility HCP who have received a complete COVID-19 vaccination course.

c. Updating the SNF VBP Program's Exchange Function

The SNF VBP Program's scoring methodology currently includes use of a logistic exchange function to translate performance scores to value-based incentive payment adjustments. It was chosen from among linear, cube root, cube, and logistic exchange function possibilities in order to maximize the number of SNFs receiving positive adjustments while complying with the Program's statutory requirement that facilities having the lowest 40 percent Program rankings receive a negative adjustment (be penalized).

In light of the many proposed changes to the SNF VBP in this rule, **CMS is considering whether a new form of exchange function should be implemented or the current logistic**

function revised. CMS in particular notes the linear exchange function currently used in the Hospital VBP Program that served as a model for the SNF VBP. CMS refers to its technical paper that guided its choice of a logistic function type (available for download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/Scoring-Methodology-and-Payment-Adjustment-).

2. Request for Comment on Validation of SNF VBP Program Measures and Assessment Data

Section 111(a)(4) of the CAA, 2021, requires the Secretary to apply a validation process to SNF VBP Program measures and data, beginning with the FY 2023 program year. For SNFRM validation, CMS has proposed to continue processes already being used by their Medicare Administrative Contractors (MACs) to ensure SNF VBP incentive payment accuracy (e.g., reviews of medical necessity, pre- and post-payment audits). CMS requests feedback on approaches to validation of Program measures, quality measure data, and MDS assessment data, with a focus on the following:

- **The feasibility and need to select SNFs for validation via a chart review to determine the accuracy of elements entered into MDS 3.0 and PBJ as well as data validation methods and procedures that could be utilized to ensure data element validity and accuracy.**
- **The volume of facilities to select from the over 15,000 SNFs for validation under the SNF VBP Program.**
    - **CMS notes that under the Hospital Outpatient Quality Reporting Program, 450 hospitals of approximately 3,300 are randomly selected for validation as well as 50 hospitals identified for targeted review based on predefined criteria (e.g., interval since last validation).**
- **Whether both random and targeted facility selection for validation should be employed.**
- **Potential implementation timeline for a validation process; CMS suggests the earliest feasible option would be the FY 2026 program year.**

3. Request for Comment on a SNF VBP Program Approach to Measuring and Improving Health Equity

CMS first refers readers to a more extensive RFI earlier in the rule on a guiding framework and general principles for use across the CMS quality enterprise to address disparities in healthcare quality (see section VI.E. of the rule and section VI.C. of this summary). In this section, CMS specifically focuses its request for feedback on policy changes that could be made in support of health equity in the context of the many changes and measure set expansion being proposed for the SNF VBP over the near-term future.

- **Should adjustments be incorporated into the SNF VBP Program to reflect the varied patient population that SNFs serve nationwide?**
- **Should payment adjustments to SNFs under the Program be tied to health equity outcomes?**
- **How could equity-based payment adjustments be structured in an expanded Program?**

- **At the measure, scoring, or incentive payment level?**
- **Using stratification or including measures of social determinants of health?**
- **Modified benchmarks, point adjustments, or modified incentive payment multipliers?**
- **Which adjustments might be most effective at accounting for health equity issues found in the SNF population?**

I. SNF VBP Program Measure Summary Table

Measures that would be included in the expanded SNF VBP Program's measure set, if finalized as proposed, are shown in the table below.

Summary Table HPA SNF-1: SNF VBP Program Measures by Program Year						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Claims						
SNF 30-Day All-Cause Readmission Measure (NQF #2510)	X	X	X	X	X	X
SNF Potentially Preventable Readmissions after Hospital Discharge	I	I	I	I	I	I
Discharge to Community – Post-Acute Care Measure for SNFs (NQF #3481)						P
CDC NHSN						
SNF Healthcare-Associated Infections Requiring Hospitalization					P	P
CMS Payroll Based Journal and SNF MDS Assessments						
Total Nursing Hours per Resident Day Staffing					P	P
X = In Measure Set and in active use I = In Measure Set but not in active use P = Proposed						
Source: Created by HPA based on Section VII.B. of the rule						

VII. RFI – Revising LTC Facilities to Establish Mandatory Minimum Staffing Requirements

A. Background

CMS discusses the statutory and regulatory requirements for LTC facilities (SNFs and NFs) including the requirement that LTC facilities have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practical well-being of each resident. Certain nursing staffing requirements may be waived under specific circumstances.

CMS reviews the research that evaluates the amount of nursing time that is necessary to provide adequate quality of care and the composition of residents in LTC facilities. Abt Associates reported in 2001, that facilities with staffing levels below 4.1 hours per resident day (HPRD) for long stay residents (residents that reside in the facility at least 90 days) may provide care that results in harm and jeopardy to residents.[28] A recent report by The Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that from 2002 to 2014, the proportion of

[28] Appropriateness of Minimum Nursing Staffing Ratios in Nursing Homes, Phase II Final Report, 2001, Abt Associates, https://theconsumervoice.org/uploads/files/ossies/CMS-Staffing-Study-Phase-II.pdf.

older adults residing in LTC facilities declined as the prevalence of dementia increased among these residents.[29] The study also found the proposition of LTC facility residents with limitations in three or more activities of daily living was higher among adults in LTC facilities as compared to other settings. CMS notes that this and other studies suggest these changes resulted in direct care responsibilities from nursing personnel to CNAs.

Beginning in April 2018, CMS has been using Payroll Based Journal[30] (PBJ) data to calculate staffing data. This information is posted on Nursing Home Compare and used in the Five Star Quality System. Staffing data is submitted quarterly and facilities are downgraded to a one-star staffing rating for a quarter if they either fail to report data for the reporting quarter or report four or more days in a quarter with zero registered nursing hours. In April 2019, CMS established new thresholds for staffing ratings and adjusted the staffing rating's grid to increase the weight RN staffing hours has on the staffing rating. CMS also reduced the number of days without an RN onsite that triggers an automatic downgrade to one-star from 7 days to 4 days. In January 2022, CMS began posting on Care Compare the level of total nurse and RN staffing on weekends provided by each facility over a quarter and the percent of nursing staff and number of administrators that stopped working at the nursing home over a 12-month period. Beginning July 2022, this data will be used in the Nursing Home Five Star Quality Rating System.

CMS also reviews the research examining the availability of staff, including their skills and competencies for working in LTC facilities. BLS reported in May 2020 that 143,250 RNs were employed in SNFs, a decrease from 151,300 in May 2019.[31] For the same time period, 527,480 CNAs were employed in SNFS in 2020, a decrease from 566, 240 in May. Based on CASPER data, the number of LTC facilities has decreased from 15,844 in FY 2012 to 15,691 in FY 2015. A 2022 analysis by Buerhaus et al. suggests that the labor market for RNs, LPNs, and CNAs is tightening as marked by falling employment and rising wages through 2021. The study notes that overall employment in LTC facilities has fallen more than in other nonhospital sectors.[32]

The COVID PHE has also highlighted and exacerbated long-standing concerns with inadequate staffing in LTC facilities. In addition, the care needs of, and the type of care provided to, LTC facility residents has changed. To address this issue, CMS intends to conduct a new research study to determine the level and type of staffing to ensure safe and quality care and expects to propose minimum standards for staffing adequacy within 1 year.

B. Request for Information

CMS seeks input on the effects of direct care staffing (nurses, aides, and other professionals) requirements to improve the LTC requirements for participation and promote informed staffing

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[29] https://aspe.hhs.gov/reports/trends-use-residential-settings-among-older-adults-issue-brief-0.

[30] The Affordable Care Act (Pub. L. 111-148, March 23, 2010) added new section 1128I(g) to the Act which allows submission of staffing data by LTC facilities and allows the Secretary to require facilities to electronically submit direct care staffing information. Since July 2016, nursing homes have submitted payroll data to the Payroll Based Journal (PBJ).

[31] https://www.bls.gov/oes/current/oes291141.htm.

[32] Nurse Employment During the First Fifteen Months of the COVID-19 Pandemic, PI Buerhaus, DO Staiger, DI Auerbach, et al. *Health Affairs* 2022 41:1, 79085.

plans and decisions within facilities to meet resident's needs, including maintaining or improving resident function and quality of life. Highlights of the RFI are listed below; the reader is referred to the proposed rule for additional details. CMS also welcomes input on other aspects of staffing in LTC facilities. CMS is particularly interested in data, evidence and relevant experience on these issues.

1. Additional evidence that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? What are the benefits of adequate staffing in LTC facilities?
2. What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities?
3. Evidence of the actual costs of implementing recommended thresholds, including projected savings from reduced hospitalizations and other adverse events?
4. Evidence that resources that could be spent on staffing are used on expenses that are not necessary to quality patient care?
5. What factors impact a facility's capability to successfully recruit and retain nursing staff?
6. What should CMS do if facilities are unable to obtain adequate staffing despite good faith efforts to recruit workers?
7. How should nursing staffing turnover be considered in establishing a staffing standard?
8. What fields and professions should be considered to count towards a minimum staffing requirement?
9. How should administrative nursing time be considered in establishing a staffing standard?
10. How should a minimum staffing requirement be measured?
11. How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? How State laws limiting or otherwise restricting overtime for health care workers would interact with minimum staffing requirements?
12. Have minimum staffing requirements been effective at the State level?
13. Are any existing State approaches particularly successful?
14. Should CMS require the presence of an RN 24 hours a day 7 days a week.
15. Are there unintended consequences from implementing a minimum staffing ratio?
16. Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas?
17. What constitutes "an unacceptable level of risk of harm?"

VIII. Economic Analyses

CMS estimates that under the proposed rule in FY 2023, SNFs would experience a decrease of about $320 million in payments or an average decrease of 0.9 percent across all SNFs. This impact reflects a $1.4 billion (3.9 percent) increase from the update to the payment rates and a $1.7 billion decrease (4.6 percent) from the proposed reduction to the SNF payment rates to account for the recalibrated parity adjustment. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $185.55 million.

Table 19 of the proposed rule (reproduced below) shows the estimated impact of the proposed rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the proposed parity adjustment recalibration and the proposed budget neutral updates to the wage index data. The combined effects of all of these changes vary by specific type of providers and by location. For example, CMS estimates that due to the changes in this proposed rule, payment rates for SNFs in rural areas would decrease by 1.0 percent overall.

Table 19: Impact to the SNF PPS for FY 2023

Impact Categories	Number of Facilities	Parity Adjustment Recalibration	Update Wage Data	Total Changes
Group				
Total	15,472	-4.6%	0.0%	-0.9%
Urban	11,140	-4.7%	0.1%	-0.9%
Rural	4,332	-4.5%	-0.3%	-1.0%
Hospital-based urban	374	-4.7%	0.2%	-0.8%
Freestanding urban	10,766	-4.7%	0.0%	-0.9%
Hospital-based rural	414	-4.5%	-0.4%	-1.2%
Freestanding rural	3,918	-4.5%	-0.3%	-1.0%
Urban by region				
New England	746	-4.7%	-0.7%	-1.7%
Middle Atlantic	1,485	-4.8%	0.1%	-1.0%
South Atlantic	1,938	-4.6%	-0.3%	-1.1%
East North Central	2,148	-4.6%	-0.1%	-1.0%
East South Central	546	-4.5%	-0.3%	-1.0%
West North Central	941	-4.6%	-0.6%	-1.4%
West South Central	1,401	-4.6%	0.3%	-0.6%
Mountain	540	-4.6%	-0.1%	-1.0%
Pacific	1,389	-4.8%	1.0%	-0.1%
Outlying	6	-4.0%	-1.4%	-1.7%
Rural by region				
New England	121	-4.6%	0.2%	-0.7%
Middle Atlantic	213	-4.5%	-0.4%	-1.2%
South Atlantic	499	-4.5%	0.0%	-0.7%
East North Central	927	-4.5%	-0.8%	-1.6%
East South Central	499	-4.4%	-0.5%	-1.2%
West North Central	1,042	-4.5%	0.0%	-0.8%
West South Central	721	-4.5%	0.5%	-0.2%
Mountain	217	-4.6%	-0.3%	-1.1%
Pacific	93	-4.7%	-1.3%	-2.3%
Ownership				
For profit	10,868	-4.6%	0.1%	-0.9%
Non-profit	3,613	-4.6%	-0.2%	-1.1%
Government	991	-4.6%	-0.1%	-1.0%

Note: The total column includes the FY 2023 3.9 percent market basket update factor.

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

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

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

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

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$94.74	1.41	$85.77	0.64	$15.61	ES3	3.84	$437.41	3.06	$262.98
B	1.61	$105.20	1.54	$93.68	1.72	$41.95	ES2	2.90	$330.34	2.39	$205.40
C	1.78	$116.31	1.60	$97.33	2.52	$61.46	ES1	2.77	$315.53	1.74	$149.54
D	1.82	$118.92	1.45	$88.20	1.38	$33.66	HDE2	2.27	$258.58	1.26	$108.28
E	1.34	$87.56	1.33	$80.90	2.21	$53.90	HDE1	1.88	$214.15	0.91	$78.21
F	1.52	$99.32	1.51	$91.85	2.82	$68.78	HBC2	2.12	$241.49	0.68	$58.44
G	1.58	$103.24	1.55	$94.29	1.93	$47.07	HBC1	1.76	$200.48	-	-
H	1.10	$71.87	1.09	$66.30	2.7	$65.85	LDE2	1.97	$224.40	-	-
I	1.07	$69.91	1.12	$68.13	3.34	$81.46	LDE1	1.64	$186.81	-	-
J	1.34	$87.56	1.37	$83.34	2.83	$69.02	LBC2	1.63	$185.67	-	-
K	1.44	$94.09	1.46	$88.81	3.5	$85.37	LBC1	1.35	$153.78	-	-
L	1.03	$67.30	1.05	$63.87	3.98	$97.07	CDE2	1.77	$201.62	-	-
M	1.20	$78.41	1.23	$74.82	-	-	CDE1	1.53	$174.28	-	-
N	1.40	$91.48	1.42	$86.38	-	-	CBC2	1.47	$167.45	-	-
O	1.47	$96.05	1.47	$89.42	-	-	CA2	1.03	$117.33	-	-
P	1.02	$66.65	1.03	$62.65	-	-	CBC1	1.27	$144.67	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
Q	-	-	-	-	-	-	CA1	0.89	$101.38	-	-
R	-	-	-	-	-	-	BAB2	0.98	$111.63	-	-
S	-	-	-	-	-	-	BAB1	0.94	$107.08	-	-
T	-	-	-	-	-	-	PDE2	1.48	$168.59	-	-
U	-	-	-	-	-	-	PDE1	1.39	$158.33	-	-
V	-	-	-	-	-	-	PBC2	1.15	$131.00	-	-
W	-	-	-	-	-	-	PA2	0.67	$76.32	-	-
X	-	-	-	-	-	-	PBC1	1.07	$121.88	-	-
Y	-	-	-	-	-	-	PA1	0.62	$70.62	-	-

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

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$108.00	1.41	$96.46	0.64	$19.67	ES3	3.84	$417.91	3.06	$251.23
B	1.61	$119.91	1.54	$105.35	1.72	$52.87	ES2	2.90	$315.61	2.39	$196.22
C	1.78	$132.57	1.60	$109.46	2.52	$77.46	ES1	2.77	$301.46	1.74	$142.85
D	1.82	$135.55	1.45	$99.19	1.38	$42.42	HDE2	2.27	$247.04	1.26	$103.45
E	1.34	$99.80	1.33	$90.99	2.21	$67.94	HDE1	1.88	$204.60	0.91	$74.71
F	1.52	$113.21	1.51	$103.30	2.82	$86.69	HBC2	2.12	$230.72	0.68	$55.83
G	1.58	$117.68	1.55	$106.04	1.93	$59.33	HBC1	1.76	$191.54	-	-
H	1.10	$81.93	1.09	$74.57	2.7	$83.00	LDE2	1.97	$214.40	-	-
I	1.07	$79.69	1.12	$76.62	3.34	$102.67	LDE1	1.64	$178.48	-	-
J	1.34	$99.80	1.37	$93.72	2.83	$86.99	LBC2	1.63	$177.39	-	-
K	1.44	$107.25	1.46	$99.88	3.5	$107.59	LBC1	1.35	$146.92	-	-
L	1.03	$76.71	1.05	$71.83	3.98	$122.35	CDE2	1.77	$192.63	-	-
M	1.20	$89.38	1.23	$84.14	-	-	CDE1	1.53	$166.51	-	-
N	1.40	$104.27	1.42	$97.14	-	-	CBC2	1.47	$159.98	-	-
O	1.47	$109.49	1.47	$100.56	-	-	CA2	1.03	$112.09	-	-
P	1.02	$75.97	1.03	$70.46	-	-	CBC1	1.27	$138.21	-	-
Q	-	-	-	-	-	-	CA1	0.89	$96.86	-	-
R	-	-	-	-	-	-	BAB2	0.98	$106.65	-	-
S	-	-	-	-	-	-	BAB1	0.94	$102.30	-	-
T	-	-	-	-	-	-	PDE2	1.48	$161.07	-	-
U	-	-	-	-	-	-	PDE1	1.39	$151.27	-	-
V	-	-	-	-	-	-	PBC2	1.15	$125.15	-	-
W	-	-	-	-	-	-	PA2	0.67	$72.92	-	-
X	-	-	-	-	-	-	PBC1	1.07	$116.45	-	-
Y	-	-	-	-	-	-	PA1	0.62	$67.47	-	-