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

On August 7, 2023, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (88 FR 53200) a final rule updating the fiscal year (FY) 2024 Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). The final rule updates the federal per diem rates under the SNF Prospective Payment System (PPS); the ICD-10 code mappings for patient classification; and the SNF QRP and SNF VBP Programs. CMS also finalizes revisions in the procedures for facilities facing civil monetary penalties (CMPs) to actively waive their right to a hearing in order to receive a penalty reduction.

CMS is implementing the second phase of the 2-year phase-in period for the Patient Driven Payment Model (PDPM) parity adjustment, resulting in a reduction of 2.3 percent, or approximately $789 million, in FY 2024. For the SNF QRP, CMS finalizes its proposals to adopt two new measures, remove three measures, and modify one measure. CMS also increases the SNF QRP data completion thresholds for the Minimum Data Set (MDS) data items and requires public reporting of four measures. CMS is not finalizing its proposal to adopt the CoreQ: Short Stay Discharge (CoreQ: SS DC) measure.

Substantive policies are made for the SNF Value-Based Purchasing (VBP) Program that progressively change the program's measure set and make policy revisions to implement the larger measure set. CMS adopts a Health Equity Adjustment that will reward SNFs that perform well and whose resident population during the applicable performance period includes at least 20 percent of residents with dual eligibility status; this adjustment will begin with the FY 2027 program year and FY 2025 performance year. In addition, CMS is increasing the payback percentage policy under the SNF VBP program.

CMS estimates that the overall impact of the final rule will be an increase of $1.4 billion (+4.0 percent) in Medicare payments to SNFs during FY 2024. Wage index tables are no longer published in the Federal Register. Instead, these tables are available exclusively at https://www.cms.gov/medicare/medicare-fee-service-payment/snfpps/list-snf-federal-regulations/1826905559/cms-1779-f

Table of Contents

I. Background on SNF PPS

CMS reviews relevant statutory and regulatory history, including the Protecting Access to Medicare Act (PAMA) of 2014 and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. PAMA required the Secretary to establish a Medicare SNF VBP Program. The IMPACT Act required the Secretary to implement a quality reporting program for SNFs and requires SNFs to report standardized data for specified quality and resource use domains. CMS also notes that section 1888(e)(4) of the Social Security Act (the Act) requires that the SNF PPS be updated annually and that certain elements be published in the *Federal Register* including the unadjusted federal per diem rates for covered SNF services, the applicable case-mix classification system, and the factors to be applied in making the area wage adjustment for these services.

CMS also provides an update on ongoing HHS initiatives to advance health information exchange within the post-acute care (PAC) settings and within the larger health care environment including the Post-Acute Care Interoperability Workgroup (PACIO), CMS Data Element Library (DEL), and the Trusted Exchange Framework and Common Agreement (TEFCA). The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement is a contract that advances those principles.[1] HHS recently recognized the first set of applicants accepted to the Qualified Health Information Network (QHINs), entities that will connect directly to each other as the core for nationwide interoperability.[2]

II. SNF PPS Rate Setting Methodology and FY 2024 Update

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

Summary of Key Data under SNF PPS for FY 2024	
Market basket update factor	
Market basket increase	+3.0 percent
Forecast error adjustment for FY 2022	+3.6 percent
Total Factor Productivity (TFP) adjustment	-0.2 percent
Parity adjustment for Patient Driven Payment Model (PDPM)	-2.3 percent
Net TFP-adjusted update	**+4.0 percent**
Wage index budget neutrality adjustment	0.9997
Labor-related share	71.1 percent
Note: CMS uses a multiplicative formula to derive the 4.0 percent total percentage change with the parity adjustment. This formula is (1 + the Payment Rate Update Percentage) * (1 + Parity Adjustment Percentage) * (1 + Wage Index Budget Neutrality Adjustment Percentage). The total change figure is 4.0 percent or (1 + 6.4 percent) * (1 – 2.3 percent) * (1 – 0.03 percent) - 1.	

A. Federal Base Rates

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

B. SNF Market Basket Update

CMS is adopting a market basket increase for FY 2024 of 3.0 percent based on the second quarter 2023 forecast from IHS Global Insight, Inc. (IGI), with historical data through the first quarter of 2023. The forecast addresses the percentage increase in the FY 2018-based SNF market basket index for routine, ancillary, and capital-related expenses.

For FY 2022—the most recent year for which actual data are available—CMS applied a market basket of 2.7 percent, but the actual increase was 6.3 percent. As the difference (3.6 percentage

[1] Additional information is available at https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.
[2] https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.

points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposed to apply a 3.6 percentage point adjustment to the FY 2024 SNF market basket. For the final rule, the market basket of 3.0 percent would be increased by 3.6 percentage points to 6.6 percent prior to the total factor productivity and parity adjustments.

The total factor productivity (TFP) adjustment required under the Affordable Care Act (ACA) is estimated to be -0.2 percentage points. CMS uses the TFP adjustment as calculated by the Bureau of Labor Statistics (BLS).[3] The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2024, based on IGI's second quarter 2023 forecast.

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

CMS is also applying a 2.0 percentage point reduction to the SNF market basket percentage changes for SNFs that do not satisfy the reporting requirements for the FY 2024 SNF QRP. This is before application of the PDPM parity adjustment.

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

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

Final FY 2024 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$70.27	$80.10

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

Final FY 2024 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Occupational Therapy	$65.41	$73.56
Speech-Language Pathology	$26.23	$33.05
Nursing	$122.48	$117.03
Non-Therapy Ancillaries	$92.41	$88.29
Non-case mix adjusted	$109.69	$111.72

Selected Comments and Responses

Forecast Error Correction. There were comments that the current forecast error correction methodology may not capture impacts such as the entirety of the cost changes during times of high healthcare resource utilization (for example, during COVID–19 pandemic) or that inflation can alter the time-value of money. CMS disagrees with the commenter that the CMS forecast error adjustment is inadequate or that it should reflect other factors (such as the time value of money). The final rule uses the most complete and available data for purposes of determining the market basket forecast, forecast error adjustment, and productivity adjustment as well as the most recent claims data when determining the SNF PPS payment rates.

Urban/Rural Differences. One commenter stated that the case-mix adjusted rates for PT, OT, SLP, and nursing categories are higher in urban areas than in rural areas, which exacerbate inequalities between rural and urban SNFs. CMS responds that it disagrees that the rates for urban areas are higher than for rural areas (as shown in the above table, the rural rates are higher than the urban rates for PT, OT and SLP and lower for the nursing and non-therapy ancillaries). CMS responds that federal per diem rates were established separately for urban and rural areas using allowable costs from FY 1995 cost reports, and therefore, account for and reflect the relative costs differences between urban and rural facilities.

Labor Costs in the Index. Several commenters believe the SNF market basket does not adequately account for growing labor costs. One commenter cited a report that stated the average hourly wage for nurses on the Medicare cost report increased 17 percent from 2019 to 2022 compared to a market basket increase of less than 6 percent during the same period. CMS responded that the hourly wages of nearly all other medical occupational categories in the SNF market basket have not increased by nearly as much nursing. The compensation price proxy used in the SNF market basket would reflect trends in all occupations combined, which would partly explain why the Employment Cost Index for wages and salaries for private industry workers in nursing care facilities has not increased at the pace of nursing wages alone.

Productivity Adjustment. Several commenters asked CMS to work with Congress to permanently eliminate the productivity adjustment applied to SNF payments. Further, they requested that CMS use its exceptions authority under section 1888(e)(3)(A) of the Act to remove the productivity adjustment for any fiscal year that was covered under COVID-19 PHE. CMS responded that while it recognizes the concerns of the commenters, it is required by statute to apply the productivity adjustment.

MedPAC. While MedPAC recognized CMS' statutory obligation for how it applies the update, it recommended a 3 percent reduction to the SNF base payment because the combination of federal relief policies and the implementation of the new case-mix system resulted in overall improved financial performance for SNFs. In a prior comment, MedPAC notes the forecast error adjustment is not mandated by law. CMS responds that it is providing an update as directed by section 1888(e)(4)(E)(ii)(IV) of the Act with an adjustment for forecast error correction as applicable under regulatory policies CMS previously adopted.

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 FY 2024 payment rates reflect the use of the PDPM classification system from October 1, 2023 through September 30, 2024. Tables 5 and 6 in the final rule (reproduced in the appendix of this summary) show the PDPM case-mix adjusted federal rates and associated indexes. These rates include the second phase of the PDPM parity adjustment recalibration.

Selected Comments and Responses

A few commenters requested that the PDPM parity adjustment be delayed, reduced, canceled or be phased in over an additional 2 years. CMS responds that the 2-year phase-in was sufficient to mitigate adverse payment impacts while also ensuring that payment rates for all SNFs are set accurately and appropriately. CMS will not be expanding the phase-in period beyond what was finalized in the FY 2023 SNF PPS final rule.

D. Wage Index Adjustment

CMS proposed to continue to apply the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2024, CMS proposed to use updated wage data for hospital cost reporting periods in FY 2020—the same data that CMS is using for the FY 2024 IPPS. 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 proposed to use the same policy it has used in prior years. For rural areas without hospitals, CMS would use the average wage index from all contiguous urban areas as the SNF proxy wage index. For urban areas without hospitals, CMS would use the average wage index of all urban areas within the state as the SNF proxy wage

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

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

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

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

CMS uses a four-step process to trend forward the base year (2018) weights to FY 2024 price levels. This process includes computing the FY 2024 price index level for the total market basket and each cost category of the market basket. Based on this update, the SNF labor-related share is 71.1 percent, compared to a FY 2023 final labor-related share of 70.8 percent. Table 7 in the final rule summarizes the labor-related share for FY 2024 (based on the IGI second quarter 2023 forecast) compared with FY 2023 for each of the cost categories.

To calculate the labor portion of the case-mix adjusted per diem rate, CMS multiplies the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies and the non-case-mix component rate, by the FY 2024 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 final rule provide a hypothetical rate calculation to illustrate the methodology including the wage index adjustment and case mix adjustment.

The change to the labor share and wage index is required by law to be budget neutral. CMS meets this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor, equal to the ratio of the weighted average wage adjustment factor for FY 2023 to the weighted average wage adjustment factor for FY 2024. For this calculation, CMS

[4] https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/wageindex.

uses the same FY 2022 claims utilization data for both the numerator and denominator of this ratio. The final budget neutrality factor for FY 2024 is 0.9997.

Selected Comments and Responses

Labor Share. There were comments that the labor share should not be increased because of its impact on low-wage hospitals (a comment that appears to contradict other comments suggesting the market basket should reflect a higher labor share and the more rapidly increasing costs for clinical labor). CMS responded that the slight increase in the labor-related share is due to an increase in the wages and salaries relative importance cost weight, reflecting the faster growth in wage prices compared to other nonwage prices in the SNF market basket. Consistent with its statutory obligation to make appropriate adjustments to the labor-related portion of SNF costs, CMS is finalizing the proposed change to the labor-related share.

Non-Budget Neutral Implementation of the Cap on Reductions in the Wage Index. Commenters support the permanent 5-percent cap on wage index decreases but requested that it be implemented non-budget neutral. CMS responded that section 1888(e)(4)(G)(ii) of the Act requires that adjustments for geographic variations in labor costs be made budget-neutral.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

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

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

CMS stresses that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely. For 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.

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

B. Consolidated Billing

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

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

The rule indicates that the codes targeted for exclusion from consolidated billing represent events that could have significant financial impacts because their costs far exceed SNF PPS payments. In the proposed rule, CMS invited comments to identify specific HCPCS codes in any of these five service categories representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. To exclude a particular service from consolidated billing, the service must be included in the five categories and be high cost and low probability in the SNF setting.[6]

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

Selected Comments and Responses

CMS received a number of comments for products that should be excluded from consolidated billing. However, CMS responded that none of these products met the criteria for being excluded because they had not been assigned a HCPCS code, were not within one of the 5 categories listed above, or were not high cost/low probability for being provided in a SNF.

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

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

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 proposed several revisions to the regulatory text to reflect the creation of new Medicare benefit categories for marriage and family therapist services and mental health counselor services. Section 1888(e)(2)(A)(ii) of the Act excludes these services from SNF consolidated billing. Public commenters supported these proposed changes. One commenter asked CMS to expand the exclusions list to include clinical social workers (CSW) but CMS indicated that exclusion of CSWs from consolidated billing would require a statutory change. Since the proposed rule, CMS identified other conforming changes to the consolidated billing rules that needed to be made related to telehealth that it is also finalizing in this rule.

IV. Other SNF PPS Issues

A. Technical Updates to PDPM ICD-10 Mappings

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

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

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

[8] PDPM Website is available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/pdpm
[9] 84 FR 38750

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

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

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

Some commenters objected to the proposed change of "prolonged grief disorder" and "other reactions to severe stress" as "Return to Provider" when used as a primary diagnostic to assign a patient under the PDPM. These commenters said a subset of SNFs that specialize in behavioral and mental health treatment may require use of these two new diagnosis codes. CMS responded that there are many other behavioral and mental health diagnoses available that are a more appropriate primary diagnosis for a SNF stay than these two codes. The proposal is being finalized without modification.

2. Clinical Category Changes for Unspecified Substance Use Disorder Codes

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

Table 1, Proposed Clinical Category Changes for Unspecified Substance Use Disorder Codes is available on the CMS website https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/pdpm. (Go to "FY 2024 *Draft* PDPM ICD-10 Mapping (ZIP). Download the accompanying workbook and Table 1 is within that workbook—as are Tables 2 and 3 described below).

Public commenters both supported and opposed the proposal regarding the edit that will "Return to Provider" "unspecified" SUD codes. Those opposing this policy said it would increase burden

on SNFs and believe it is the responsibility of the physician to code at the highest level of specificity. CMS is finalizing the proposal responding that more specificity in diagnoses will improve quality of care and that clinicians caring for the patient at the facility also have obligations regarding the plan of care and making diagnoses that are included on the SNF claim.

3. Clinical Category Changes for Certain Subcategory Fracture Codes

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

CMS proposed allowing 45 subcategory S42.2-codes for displaced fractures to be eligible for one of two orthopedic surgery categories. CMS noted its proposal did not extend to subcategory S42.2-codes for nondisplaced fractures, which typically do not require surgery. CMS also proposed adding the surgical option to subcategory 46 M84.5-codes for pathological fractures to certain major weight-bearing bones to be eligible for one of two orthopedic surgery categories. Table 2, Proposed Clinical Category Changes for S42.2 and M84.5 Fracture Codes, lists all 91 codes included in CMS' proposal and is available on the PDPM website (see above link and instructions for finding Table 2).

There were no public comments on CMS' proposal that it is finalizing without modification.

4. Clinical Category Changes for Unacceptable Principal Diagnosis Codes

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

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

CMS also proposed to make future updates to align the PDPM ICD-10 code mapping with the MCE Unacceptable Principal Diagnosis edit code list on a subregulatory basis. There were no public comments. CMS finalizing its proposal without modification.

V. SNF Quality Reporting Program (QRP)

CMS finalizes its proposals to:

- Beginning with the FY 2025 SNF QRP:
    - Adopt the Discharge Function Score (DC Function) measure;
    - Modify The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure; and
    - Remove three measures: (1) the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (Application of Functional Assessment/Care Plan) measure; (2) the Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure; and (3) the Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure;
- Beginning with the FY 2026 SNF QRP, adopt the COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date (Patient/Resident COVID-19) Vaccine; and
- Change the SNF QRP data completion thresholds for the Minimum Data Set (MDS) data items; and
- Begin public reporting of 4 measures.

CMS is not finalizing its proposal to adopt the CoreQ: Short Stay Discharge (CoreQ: SS DC) measure.

Additionally, CMS summarizes comments in response to its requests information on principles to be used to select and prioritize SNF quality measures in future years.

The overall SNF QRP burden changes estimated to result from this final rule are a benefit of about $258,670 for all SNFs annually, composed of an estimated annual benefit of $1,037,261 by reason of the removal of the Application of Function Assessment/Care Plan measure beginning with the FY 2025 SNF QRP and the estimated increase in aggregate cost beginning with the 2026 SNF QRP of $778,591 by reason of the adoption of the Patient/Resident COVID-19 Vaccine measure.

A. Background and Statutory Authority

The SNF QRP is authorized under section 1888(e)(6) of the Act and is a pay-for-reporting program. SNFs submit specified data elements and quality measure data for each resident using the SNF resident assessment instrument known as the Minimum Data Set (MDS). Completed assessments are sent to CMS through the Internet Quality Improvement & Evaluation System (iQIES). Freestanding SNFs, SNFs affiliated with acute care hospitals, and all non-CAH swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the SNF PPS annual update factor. FY 2018 was the first year in which the QRP affected payments.

B. General Considerations Used for Selection of Measures

The table below (Table 11 reproduced from the final rule with minor modifications) shows the current quality measures for the FY 2024 SNF QRP.[10]

Table 11: Quality Measures Currently Adopted for the FY 2024 SNF QRP	
Short Name	**Measure Name & Data Source**
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CBE #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (CBE #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (CBE #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (CBE #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (CBE #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (CBE #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider*	Transfer of Health Information to the Provider – PAC Measure
TOH-Patient*	Transfer of Health Information to the Patient – PAC Measure
Data Source: Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
Data Source: NHSN	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage amount Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

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

*In response to the public health emergency (PHE) for COVID-19, the Interim Final Rule (85 FR 27595 through 27597) delayed the compliance date for collection and reporting of the Transfer of Health (TOH) Information measures for at least 2 full fiscal years after the end of the PHE. The compliance date for the collection and reporting of the TOH Information measures was revised to October 1, 2023 in the FY 2023 SNF PPS final rule (87 FR 47547 through 47551)

C. SNF QRP Quality Measure Updates

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

a. Modification of the COVID-19 Vaccination Coverage among HCP Measure

CMS finalizes its proposal to, beginning with the FY 2025 SNF QRP measure set, update the HCP COVID-19 Vaccine measure specification to reflect the most current guidance that specifies for HCP to receive primary series and booster vaccine doses in a timely manner. The modifications:

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

Background. The HCP COVID-19 Vaccine measure is a non-risk-adjusted process measure developed by the CDC to track COVID-19 vaccination coverage among HCP in facilities such as SNFs. The current measure was adopted[11] into the SNF QRP measure set beginning with FY 2023, and requires each SNF to submit data on the percentage of HCP eligible to work in the SNF for at least one day during the reporting period who have received a complete vaccination course against SARS-CoV-2 (excluding persons with contraindications to the COVID-19 vaccine). CMS describes how vaccination remains the most effective means to prevent the severe consequences of COVID-19, and that it continues to believe that monitoring of vaccination rates among HCP is important in order to provide residents and their caregivers with information to support informed decision-making.

Measure Calculation. The modified measure is calculated as follows:

- *Denominator*. The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCP include employees of the facility, licensed independent practitioners, and adult students/trainees and volunteers.[12] There are no changes to the denominator or denominator exclusions from that of the current measure.
- *Numerator*. The number of HCP in the denominator population who are considered up to date[13] with CDC recommended COVID-19 vaccines.

[11] FY 2022 SNF PPS final rule; 86 FR 42480 through 42489.
[12] Only the three categories of HCP listed above are included in the measure, but SNFs report to NHSN those three categories plus a fourth category of HSN, which is "Other Contract Personnel".
[13] Providers are to refer to the definition of up to date as of the first day of the reporting quarter. The definition can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf.

Reporting requirements.

- SNFs will report on the modified measure for at least one self-selected week during each month of the reporting quarter and submit the data to the NHSN Long-Term Care Facility (LTCF) Component before the quarterly deadline. For SNF QRP compliance in FY 2025, SNFs will report on the modified measure beginning in quarter 4 of CY 2023. Beginning with the FY 2026 SNF QRP, SNFs will be required to submit data for the entire calendar year.
- Each quarter, the CDC will calculate a single quarterly COVID-19 HCP vaccination coverage rate for each SNF by taking the average of the data from the three weekly rates submitted by the SNF for that quarter.
- Public reporting of the modified measure will begin with the October 2024 Care Compare refresh or as soon as technically feasible.

Pre-rulemaking. The current version of the HCP COVID-19 Vaccine ("Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel") measure received endorsement by the consensus-based entity (CBE) on July 26, 2022 (CBE #3636). The CDC is pursuing CBE endorsement for the modified version of the measure.[14]

Selected Comments/Responses. Several commenters supported the proposed modification for various reasons, including that (i) although the COVID-19 emergency declaration has expired SNF residents have been disproportionately vulnerable throughout the COVID-19 pandemic and infection prevention and control measures are essential, (ii) access to transparent and complete information is essential for informed decision-making, and (iii) public display of vaccination rates provides vital information for residents and their caregivers. Other commenters raised concerns about the changing nature of the definition of up to date and related reporting inaccuracies, confusion, and burden.

CMS responds that the evolving definition is necessary to align the changing nature of the virus's transmission and community spread and the agency's responsive approach. In response to concerns about burden, CMS notes that the CDC used the up-to-date numerator during quarter 4 of the 2022 surveillance period and SNFs have been reporting the measure in accordance with the modifications since then. CMS clarifies that the CDC currently posts, and will continue to post, updated documents two weeks before a reporting quarter with any changes. If requirements change from one quarter to the next, SNFs will have the up to date definition at the beginning of the quarter (using the CDC NHSN webpage at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf) and will have at least three weeks to assess whether their HCP meet the definition before submitting the self-selected week's data for a month.

[14] Even though the modified measure is not CBE-endorsed, CMS is adopting it under the exception under section 1899B(e)(2)(B) of the Act, having found no currently available, alternative measure that is comparable, CBE-endorsed, feasible, and practical.

The most frequently mentioned reason for opposing the modifications to the measure was that the COVID-19 PHE ended on May 11, 2023, and CMS lifted staff vaccination requirements. CMS emphasizes that the PHE declaration (and related conditions of participation referenced) is distinct from reporting requirements under the SNF QRP pay-for-reporting program (which does not require HCP to receive a vaccine or booster and is independent of the COVID-19 PHE declaration). Comments also included a recommendation to coordinate public display on Care Compare of the measure with existing measure of staff and resident COVID-19 vaccination, and CMS responded it will take this suggestion into consideration.

b. Adoption of the Discharge Function Score Measure

CMS finalizes its proposal to adopt the Discharge Function (DC Function) measure beginning with the FY 2025 SNF QRP.

Background. Section 1888(e)(6)(B)(i) of the Act requires CMS to develop and implement standardized quality measures from five quality measure domains, including the domain of functional status, cognitive function, and changes in function and cognitive function, across post-acute care settings. CMS emphasizes the need for a cross-setting functional outcome measure to align measure specifications across settings, including the use of a common set of standardized functional assessment data elements, and specifically notes the importance of assessing functional status as a health outcome in SNFs for making treatment decisions.

Measure Description. The DC Function measure is an assessment-based outcome measure that evaluates functional status by calculating the percentage of Medicare part A SNF residents who meet or exceed an expected discharge function score during the reporting period. The measure will replace the topped-out Application of Functional Assessment/Care Plan measure (which is finalized for removal in section VII.C.1.c. of the rule). The DC Function measure uses a set of cross-setting assessment items that facilitate data collection, quality measurement, outcome comparison, and interoperable data exchange among PAC settings, whereas existing functional outcome measures do not use a set of cross-setting assessment items. The measure considers two dimensions of function (self-care and mobility activities) and accounts for missing data by recoding missing functional status data to the most likely value had the status been assessed (i.e., using statistical imputation) based on a resident's clinical characteristics and codes assigned on other standardized functional data elements. In contrast, the topped-out measure treats residents with missing values the same as residents who were coded to the lowest functional status.

The measure is calculated as follows:

- *Numerator*. The number of SNF stays with an observed discharge function score that is equal to or greater than the calculated expected discharge function score.
    - Observed discharge function score is the sum of individual function item values at discharge.
    - Calculated expected discharge function score is computed by risk-adjusting (for resident characteristics, such as admission function score, age, and clinical conditions) the observed discharge function score for each SNF stay.

- *Denominator*. The total number of SNF stays with an MDS record in the measure target period (four rolling quarters) that do not meet the measure exclusion criteria.[15]

Measure testing. Validity was assessed for the measure performance[16], the risk adjustment model[17], face validity[18], and statistical imputation models.[19]

Pre-Rulemaking. The measure is not CBE-endorsed.[20] CMS intends to submit the proposed measure to the CBE when feasible.

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

Selected Comments/Responses. Several commenters did not support the adoption of the measure because it is not CBE-endorsed. CMS believes that it is an important measure to adopt since the measure fills gaps in the SNF QRP measurement set, is a cross-setting measure, and assesses both domains of function. It plans to submit the measure for CBE endorsement as soon as feasible.

Several commenters raised concern that the measure uses statistical imputation, including because it is believed to override the clinical judgment of the clinicians. CMS clarifies that clinicians are still expected to use their clinical judgment and that statistical imputation is a component in measure calculation of reported data. It believes that by using each resident's available functional and clinical information to estimate the missing values, the measure improves on the imputation approach already implemented in the Change in Mobility Score, Change in Self-Care Score, Discharge Mobility Score, and Discharge Self-Care Score measures. The agency explains that under the imputation approach for the DC Function measure it estimates a different recode value for each patient based on their clinical comorbidities, on their score on all other section GG coding items, and on each setting. CMS further believes that the validity testing conducted showed that the DC Function measure reflected more accurate performance scores compared to the current simple imputation method used in the SNF QRP.

---

[15] For additional details regarding the numerator, denominator, risk adjustment, and exclusion criteria, refer to the Discharge Function Score Skilled Nursing Facilities (SNFs) Technical Report. https://www.cms.gov/files/document/snf-discharge-function-score-technical-report-february-2023.pdf.

[16] Validity testing of measure performance tested the strength and directional correlations between the proposed measure's performance for providers with 20 or more stays and the performance of other publicly reported SNF quality measures. Results indicated that the proposed DC Function measure captures the intended outcome, as detailed in Table 12 of the Final Rule.

[17] Validity testing of the risk adjustment model showed the measure model has the predictive ability to distinguish residents with low expected functional capabilities from those with high expected functional capabilities.

[18] Cross-Setting Discharge Function Technical Expert Panels and resident-family feedback showed strong support for the face validity and importance of the proposed measure as an indicator of quality of care.

[19] Validity testing of the measure's statistical imputation models indicated that the models demonstrate good discrimination and produce more precise and accurate estimates of function scores for items with missing scores when compared to the current imputation approach.

[20] CMS is adopting the measure under the exception at section 1899B(e)(2)(B) of the Act, which allows the Secretary to select non-CBE-endorsed measures when the Secretary is unable to identify a suitable CBE-endorsed measure that is available, feasible, and practical.

c. Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) Measure

CMS finalizes its proposal to remove the Application of Functional Assessment/Care Plan measure beginning with the FY 2025 SNF QRP. Public reporting of the measure will end by the October 2024 Care Compare refresh or as soon as technically feasible when public reporting of the proposed DC Function measure will begin. Beginning for the FY 2025 SNF QRP:

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

Basis for Removal. The basis for removal is that the measure satisfies the following 2 of the 8 factors considered for removal of a measure:[21]

- Removal factor one: The measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made. The average performance rates on the measure since 2019 have been near 100 percent, indicating the measure has "topped out", and the measure no longer provides for any variation that would show distinction among SNFs.[22]
- Removal factor six: There is an available measure that is more strongly associated with desired resident functional outcomes (the DC Function measure).

Burden Assessment. The removal of this measure is estimated to result in a reduction of total burden for complying with the SNF QRP requirements of 12,032 hours and $1,037,261 for all SNFs annually.

d. Removal of Two Application of IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) Measure and Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) Measure

CMS finalizes its proposal to remove two measures of IRF Functional Outcomes—the Change in Self-Care Score measure and the Change in Mobility Score measure—beginning with the FY 2025 SNF QRP. Public reporting of the measures will end by the October 2024 Care Compare refresh or as soon as technically feasible.

Background. At the time the Change in Self-Care Score and Change in Mobility Score measures were adopted[23], CMS also adopted 2 other measures addressing the functional status, cognitive

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

function, and changes in function and cognitive function domain. Those Application of IRF Functional Outcome measures are the Discharge Self-Care Score for Medical Rehabilitation Patients (Discharge Self-Care Score) measure and the Discharge Mobility Score for Medical Rehabilitation Patients (Discharge Mobility Score) measure. By monitoring the measures since 2018 CMS concludes that the 2 self-care functional outcome measures, and similarly the 2 mobility score measures, provide almost identical information about the quality domain to SNFs and are therefore duplicative.

Basis for Removal: The basis for removal is that the measures satisfy removal factor eight: the costs associated with each of the measures outweighs the benefits of the measures' uses in the SNF QRP. Specifically, the costs to SNFs associated with tracking similar or duplicative measures in the SNF QRP outweigh any benefit that might be associated with the measures, and the costs to CMS associated with program oversight of the measures outweigh the benefit of information obtained from the measures.

Burden Assessment. Since the data elements used to calculate the measures will still be collected by SNFs for other quality measures under the SNF QRP, there would be no change in burden.

Selected Comments/Responses. Several commenters support the removal of the measures since they are duplicative of other measures and their removal will reduce costs to SNFs and CMS. Several commenters did not support the removal of the measures because they believe the information on the amount of change patients experience, which is captured by these measures to be removed, is more important than capturing whether patients meet or exceed an expected amount of change (captured by the Discharge Self-Care Score and the Discharge Mobility Score measures). CMS acknowledges the trade-offs between maintaining the Change in Self-Care Score and Change in Mobility Score measures (being removed) versus the Discharge Self-Care Score and the Discharge Mobility Score measures (being retained). However, the agency points out that the majority of the technical expert panel (TEP) consulted by CMS agreed that the two measures being retained better capture a patient's relevant functional abilities, and the agency also believes the two measures being retained are more easily interpreted by many patients and their caregivers.

2. SNF QRP Quality Measures Beginning with the FY 2026 SNF QRP

a. CoreQ: Short Stay Discharge (SS DC) Measure (CBE #2614)

CMS is not finalizing its proposal to add the CoreQ: SS DC measure beginning with the FY 2026 SNF QRP. It is taking further time to conduct additional research to identify or develop a meaningful measure that addresses resident satisfaction or resident experience with the quality of care received in SNFs, and intends to propose such a measure for the SNF QRP in future rulemaking.

Background. There is currently no national standardized satisfaction questionnaire that measures a resident's satisfaction with the quality of care received by SNFs. Resident satisfaction data is collected using Consumer Assessment of Healthcare Providers and Systems (CAHPS) resident

experience surveys in other settings, such as home health, hospice, and hospital. The CAHPS Nursing Home survey: Discharged Resident Instrument (NHCAHPS-D) was developed for short-stay SNF residents but because of its length (50 questions) and potential burden was not adopted for the SNF QRP.

Proposed Measure. In the FY 2024 SNF PPS proposed rule, CMS proposed to adopt the CoreQ: SS DC measure for the SNF QRP beginning with the FY 2026 SNF QRP.[24] That measure is a resident-reported outcome measure based on the CoreQ: SS DC questionnaire that calculates the percentage of residents discharged in a 6-month period from a SNF, within 100 days of admission, who are satisfied with the SNF. The measure is not risk-adjusted by sociodemographic status. Unless exempt from collecting and reporting on the CoreQ: SS DC measure, each SNF would need to contract with an independent CMS-approved CoreQ survey vendor to administer the CoreQ: SS DC measure questionnaire and to report the results to CMS. The CoreQ suite of questionnaires was developed by nursing home providers and researchers to assess satisfaction among SNF and assisted living residents and families.

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

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

- *Numerator*. The sum of the resident respondents in the denominator that submitted an average satisfaction score of greater than or equal to 3 for the 4 Primary Questions on the CoreQ: SS DC questionnaire. If a questionnaire is missing one response out of the 4 Primary Questions, imputation would be used to represent the average value from the other three available response.
- *Denominator*. The sum of all of the questionnaire-eligible residents, regardless of payer, who (1) are admitted to the SNF and discharged within 100 days, (2) receive the CoreQ: SS DC questionnaire, and (3) respond to the CoreQ: SS DC questionnaire within two months of discharge from the SNF.

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

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

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

Pre-Rulemaking. The MAP recommended support for the rulemaking, supporting the value of resident-reported outcomes but cautioning about the potential burden of collecting the information. The measure is CBE-endorsed.

Selected Comments/Responses. Several commenters supported adoption of the measure for a number of reasons, including that it is a reliable and valid tool for assessing resident satisfaction, it is CBE-endorsed, and it is a more concise and efficient survey than other tools. However, several questioned the choice of the CoreQ survey (including some questioning the use of a tool developed by AHCA, an organization whose members would be measured by the tool) instead of using standardized measures in the CAHPS, specifically the NHCAHPS-D instrument (or portion of that instrument). CMS responds that it proposed the CoreQ because it is the only CBE-endorsed survey of SNF resident satisfaction and it underwent extensive testing, and that the NHCAHPS-D was believed to pose excess burden on residents.

Several other commenters opposed adoption of the measure on the basis that it provides limited actionable feedback for performance improvement. CMS acknowledges that the measure score would not provide a detailed set of information on specific actions, but that there are benefits to a single score such as facilities being able to easily track their performance and allowing for easy comparison of facilities. A number of commenters raised concerns that the measure was not adequately tested to determine if it produces valid and meaningful data. CMS describes the three

steps used in testing the reliability of the measure and additional testing with tens of thousands of residents.

Many commenters noted concerns about residents excluded from receiving the survey whom they believe should not be excluded, including those who left against medical advice, those transferred to other facilities, those with Alzheimer's disease or other forms of dementia, and those for whom surveys are completed by a family member or representative. CMS responds that many of the named exclusions were pursuant to the measure developer determining that the responses would not be able to be validated as reliable, accurate, or unbiased, or because such residents were believed to be incapable or unlikely to complete a questionnaire. The agency notes that all residents capable of any communication should be asked to provide information for the measure and that self-reporting is the most reliable indicator of resident satisfaction. It clarifies that the additional two proposed questions for the survey were intended to identify when residents require assistance only because of visual, hearing or motor coordination impairments and residents receiving assistance for those reasons would not be excluded. Several other commenters did not support the measure because they believe the response scale is skewed to the positive, had no middle neutral choice, and provides only one negative response option, which could create bias.

After consideration of the comments, CMS decides to not finalize the proposal to adopt the measure, specifically acknowledging concerns that the measure may not have enough questions to adequately measure resident satisfaction and that the measure would require SNFs to contract with a survey vendor and implement a workflow to send a resident information file to the vendor on a weekly basis.

b. Adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure

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

Background. CMS describes how COVID remains a major challenge to PAC facilities, including SNFs, and emphasizes that older persons are at a significantly higher risk of mortality and severe disease following infection. CMS details that studies have shown (i) COVID vaccines provide strong protection against severe disease, hospitalization, and death in adults, and (ii) protection is higher among individuals receiving booster doses (specifically the bivalent booster in the case of Omicron subvariants) than among those only receiving the primary series. It also details significant gaps and disparities in vaccination rates between those receiving the primary vaccination series and the boosters. Variations are also present when examining vaccination rates by race, gender, and geographic location.

Measure Calculation and Specifications.

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

Pre-rulemaking. The MAP Coordinating Committee recommended not adopting the measure, with 3 potential mitigation strategies presented:

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

Even though the measure is not CBE-endorsed, CMS supports the measure adoption stating (1) exclusions for medical contraindications were not included because of the belief capturing the raw vaccination rate would be most helpful in resident and family/caregiver decision-making; (2) CMS plans to conduct reliability and validity measure testing once there is enough data; and (3) CMS intends to submit the proposed measure to CBE for endorsement when feasible.

Burden Assessment. One data element would be added to the MDS at discharge, with an estimated increase of 12,032 hours and $778,591 in burden for all SNFs annually.

Selected Comments/Responses. Many commenters supported the adoption of the measure, including because it will be a source of valuable information in the decision-making process for SNF residents and their caregivers. Several commenters state the measure does not measure quality of care because it does not reflect provider action, but the agency responds that while residents have the choice whether or not to get vaccinated, it believes SNFs have the ability to encourage residents to be vaccinated and that residents and their caregivers should have the information on the measure available to them in selecting providers. Several commenters did not support adoption of the measure given the announcement of the end of the COVID-19 PHE. CMS emphasizes that regardless of the end of the COVID-19 PHE, the virus remains a public health priority, and it believes this measure promotes resident vaccination and education, which are important tools against the worst impacts of the virus.

Other commenters did not support the measure due to the measure not being fully tested and concern about burden. CMS acknowledges the validity testing has not yet been completed because the COVID-19 vaccination item does not yet exist on the MDS, but the measure is based on prior use of similar items (such as the Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine for the IRF and LTCH QRPs, and four nursing home quality initiative pneumococcal vaccination measures). CMS also responds that SNFs should be assessing whether residents are up to date with COVID-19 vaccination as part of routine care and infection control, and that burden would also be mitigated since SNFs are able to use many sources of information to obtain vaccination status, such as resident interviews, medical records, proxy response, and vaccination cards. Several commenters did not support the measure because of lack of exclusions, but the agency asserts that the measure promotes

transparency by providing residents and their caregivers with important information for informed decision-making, this is a pay-for-reporting measure (so payment will not be affected based on performance), and exclusions were not included because the focus groups with which it met provided feedback that capturing the raw vaccination rate would be most helpful in patient and family/caregiver decision-making.

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

In the proposed rule CMS solicited comments on the following:

- A set of principles for selecting measures for the SNF QRP. CMS identified: (i) actionability, (ii) comprehensiveness and conciseness, (iii) focus on provider response to payment, and (iv) compliance with statutory requirements.
- The identification of measurement gaps, specifically in (i) cognitive function, (ii) behavioral and mental health, (iii) resident experience and resident satisfaction, and (iv) chronic conditions and pain management.
- Measures that are available for immediate use, or that may be adapted or developed for use, in the SNF QRP to address the identified measurement gaps.

CMS is not responding to specific comments in the final rule, but intends to use the input to inform future efforts.

Selected Comments on Principles for Selecting and Prioritizing Measures. Many commenters supported the principles listed as well as emphasized the importance of prioritizing measures that are meaningful to residents and their caregivers, support shared decision-making, and are constructed from clearly defined, validated, and standardized data.

Selected Comments on Gaps in Measure Set. For developing measures that focus on cognitive function, some commenters raised concerns about the use of the Confusion Assessment Method (CAM) or Brief Interview of Mental Status (BIMS) cognitive assessment as a source of data. Commenters encouraged the agency to collaborate with SNFs and experts in cognition to assess and consider measures that offer information on a broad set of elements related to cognitive function that could also be used to assess change in cognitive abilities throughout a SNF episode. Other measurement gap areas not raised in the RFI were identified, such as measures on malnutrition screening and intervention, degenerative cognitive conditions, health equity, psychosocial issues, and caregiver status.

E. Health Equity Update

1. Background

CMS notes that health inequity, manifested by significant disparities in healthcare outcomes, persists in the United States, particularly for individuals belonging to underserved communities. The agency describes goals outlined in the CMS *Framework for Health Equity 2022-2023* as

consistent with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."

CMS seeks to advance health equity and whole-person care as one of eight goals comprising the CMS National Quality Strategy (NQS). The agency references its solicitation of public comment in the FY 2023 SNF PPS proposed rule (87 FR 22754 through 22760) regarding principles for measuring equity and healthcare quality disparities across CMS quality programs, and notes that it will take comments into account as it continues work in this area.

2. Anticipated Future State

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

3. Selected Comments/Responses

Some commenters supported the idea of measure stratification and the incorporation of screening measures. Some of the other comments included the suggestion to incorporate workforce equity measures, to incorporate more in-depth evaluations of underlying social and economic drivers of health, and to collect and analyze data on disability status, veteran status, preferred language, health literacy, food security, transportation access, housing stability, social support, and access to care. CMS responds that it will take comments into consideration in its future work.

F. Form, Manner, and Timing of Data Submission

1. Reporting Schedule for the Minimum Data Set (MDS) Assessment Data for the Discharge Function Score Measure

CMS finalizes its proposal that SNFs be required to report MDS assessment data for the DC Function Score measure beginning with residents discharged on October 1, 2023, for the FY 2025 SNF QRP. Starting with the FY 2026 SNF QRP, SNFs would be required to (starting in CY 2024) submit data for the entire calendar year.

2. Data Submission and Reporting Schedule for the CoreQ: Short Stay Discharge Measure

Since CMS is not finalizing its proposal to add the CoreQ:SS DC measure, it is not finalizing its related proposals to (i) require Medicare-certified SNFs to contract with a third-party vendor to administer the measure questionnaire; (ii) for low volume and new provider exemptions from

data collection and reporting;[25] or (iii) its proposed schedule for data submission and participation.

The proposed data submission and participation schedules were the following:

- SNFs would send a resident information file to the CMS-approved CoreQ survey vendor on a weekly basis.[26]
- To avoid the 2 percentage point reduction to the annual payment update, a SNF would need to submit resident information files, on a weekly basis, that includes at least 90 percent of the required data fields to their CMS approved CoreQ survey vendors for at least 75 percent of the weeks in a reporting year.
- Proposed Participation Requirements for FY 2026 and FY 2027 SNF QRP were shown in Tables 16 and 17 in the FY 2024 SNF PPS proposed rule (88 FR 21359).

3. Reporting Schedule for the Data Submission of Minimum Data Set (MDS) Assessment Data for the COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date Measure

CMS finalizes its proposal that:

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

Selected Comment. Several commenters voiced concerns about the data collected using the assessment item on the MDS being duplicative of what is reported to NHSN.

4. SNF QRP Data Completion Threshold for the MDS Data Items

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

[25] The low volume exemption proposed had been to exempt SNFs with fewer than 60 residents, regardless of payer, discharged within 100 days of SNF admission in the prior calendar year. The new provider exemption had been to exempt SNFs certified for Medicare participation on or after January 1 of the reporting year.
[26] See Table 14 in the Proposed Rule for data elements to be included in the CoreQ: SS DC Measure Resident Information File.

Selected Comments/Responses. Several commenters opposed the increased data completion thresholds, stating that SNFs need more time to adjust to the collection of the new standardized patient assessment data elements that begins October 1, 2023, and raising concerns about burden on staffing workforce. CMS responds that its data shows that the majority of SNFs are already meeting the increased threshold and that many of the new SPADES data elements are already collected using current SNF staffing levels.

G. Public Display of Measure Data for the SNF QRP

1. Background

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

2. Public Reporting of the Transfer of Health (TOH) Information to the Provider – Post-Acute Care (PAC) Measure and Transfer of Health Information to the Patient – PAC Measure

CMS finalizes its proposal to begin public display of data for the TOH-Provider PAC measure and TOH-Patient PAC measure beginning with the October 2025 Care Compare refresh or as soon as technically feasible. These 2 assessment-based measures were adopted in the FY 2020 SNF final PPS rule. After delayed compliance dates for collecting and reporting due to the COVID-19 PHE, data collection for the measures will begin with residents discharged on or after October 1, 2023.

As finalized, CMS will publicly display four rolling quarters of the data received, initially using data on discharges from January 1, 2024, through December 31, 2024. It will not publicly report a SNF's performance on a measure if the SNF had fewer than 20 eligible cases in any four consecutive rolling quarters for that measure.

3. Public Reporting of the DC Score Measure

CMS finalizes its proposal to begin public display of data for the DC Function measure beginning with the October 2024 refresh of Care Compare or as soon as technically feasible, and will use data collected from January 1, 2023, through December 31, 2023. Provider preview reports will be provided to SNFs in July 2024, or as soon as feasible; thereafter, a SNF's measure scores will be publicly displayed based on 4 quarters of data and updated quarterly. CMS will not publicly report a SNF's performance on a measure if the SNF had fewer than 20 eligible cases in any quarter for that measure.

4. Public Reporting of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure

CMS is finalizing its proposal to begin public display of data for the measure with the October 2025 refresh of Care Compare or as soon as technically feasible, and will use data collected from

the fourth quarter of 2024. Provider preview reports will be distributed to SNFs in July 2025 for data collected in Q4 of 2024 and thereafter the data will be publicly displayed based on one quarter of data updated quarterly. A SNF's performance on the measure will not be publicly reported if the SNF had fewer than 20 eligible cases in the quarter.

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

In this rule, CMS finalizes a number of changes to the SNF VBP Program, including:

- Adopting four new quality measures to the SNF VBP Program as follows:
  - Effective beginning with the FY 2026 program year, the Total Nursing Staff Turnover Measure, and
  - Effective beginning with the FY 2027 program year, the Falls with Major Injury (Long-Stay) measure, the DC Function measure, and the Long-Stay Hospitalization measure;
- Refining the Skilled Nursing Facility 30-Day Potentially Preventable Readmission (SNFPPR) measure specifications and updating the name to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure effective with the FY 2028 program year;
- Adopting new processes to validate SNF VBP program data beginning with the FY 2027 program year; and
- Adopting a Health Equity Adjustment that rewards top tier performing SNFs that serve higher proportions of dual eligible SNF residents, effective with the FY 2027 program year, and adopting a variable payback percentage to maintain an estimated payback percentage for all SNFs of no less than 60 percent.

The SNF VBP Program was implemented for discharges beginning in FY 2019 and applies to all SNFs paid under the SNF PPS: freestanding, affiliated with acute care facilities, and non-CAH swing-bed rural facilities. Measures for the program and a performance scoring methodology were adopted in the FY 2016 and 2017 SNF PPS final rules. An Extraordinary Circumstances Exception (ECE) policy was finalized for FY 2019; the FY 2019 and FY 2020 final rules added scoring adjustments and data suppression policies for low-volume facilities. In response to the COVID-19 PHE, in the FY 2022 and 2023 final rules, CMS implemented a cross-program measure suppression policy for the duration of the PHE,[27] accompanied by a special scoring policy for the SNF VBP Program for the FY 2022 and 2023 program years. In the FY 2023 final rule, CMS modified the SNF 30-Day All-Cause Readmission Measure beginning with the FY 2023 program year by adding a risk-adjustment variable for both patients with COVID-19 during the prior proximal hospitalization (PPH) and patients with a history of COVID-19.

Currently, the SNF VBP Program withholds 2.0 percent of the payments that would be made to SNFs and redistributes approximately 60 percent of the money withheld for redistribution based on performance on a readmission measure. Specifically, amounts redistributed are delivered by applying a value-based incentive adjustment at the individual claim-level to each SNF's adjusted

[27] 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).

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 the changes finalized for the Program will result in approximately $462.12 million being withheld from SNFs and $277.27 million being redistributed among SNFs as value-based incentive payments in FY 2024. Approximately $184.85 million will be returned through the SNF VBP Program to the Medicare Program as savings in FY 2024. These estimates are unchanged from the estimates presented in the proposed rule. The detailed analysis of the impacts of the FY 2024 SNF VBP Program final policies is shown in Table 32 of the final rule.

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

A. SNF VBP Program Measures

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

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

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

1. SNFPPR Measure Specifications Refinement and Measure Name Update

CMS finalizes its proposal to refine the SNFPPR measure specifications as follows:

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

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

Selected Comments/Responses. One commenter urged the agency to delay adopting the measure as refined until it is endorsed by the CBE; CMS responds by noting that SNF VBP measures need not be CBE-endorsed to be included in the program. Another commenter raised concerns about the accuracy of predicted and expected outcomes for residents. CMS notes that the current SNFRM is calculated in this manner, and it believes claims data are sufficiently validated and thus accurate for use in calculating claims-based measures. Some commenters raised concerns with attributing preventable hospital readmissions to the SNF; another worried that increasing the number of days between hospital discharge and SNF admission could increase factors outside the control of the hospital or SNF to influence a resident's condition before the SNF admission. While acknowledging that there is a risk of attributing a PPR to a SNF when the readmission occurs due to factors outside the SNF's control, CMS nonetheless believes the measure specifications minimize that risk. It also believes the measure's exclusion criteria in combination with the variables included in the risk adjustment model will sufficiently control for medically complex patients.

a. Overview of the Updated Measure

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

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

CMS tested the updated measure for reliability and validity. It was found to have good reliability, and validity tests showed it can accurately predict PPRs while controlling for differences in resident case-mix. For the updated measure's technical specifications, see https://www.cms.gov/files/document/snfvbp-snfwsppr-draft-technical-measure-specification.pdf. The Measure Applications Partnership (MAP) conditionally supported the measure contingent on NQF endorsement.[28]

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

b. Measure Specifications

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

Inclusions. Medicare FFS beneficiaries who are admitted to a SNF during a 2-year measurement period who are not excluded. Each stay of a SNF resident with multiple stays during the 2-year readmissions window is separately eligible for inclusion. The index SNF admission must have occurred within 30 days of discharge from a prior proximal hospital (PPH) stay (an inpatient stay in an IPPS hospital, a CAH, or an inpatient psychiatric facility). *Exclusions*. There are 11 exclusions (e.g., age, enrollment, more than 30-day gap between PPH discharge and SNF admission, certain cancer treatment, pregnancy, care furnished by provider outside the U.S.) that are fully described in the measure's specifications.[29]

Numerator. The measure numerator is the risk-adjusted "predicted" estimate of the number of residents with an unplanned PPR that occurred during a SNF stay. The unadjusted, observed count of the measure outcome (i.e., the number of residents with an unplanned PPR during a SNF stay) is risk-adjusted for resident characteristics and a statistical estimate of the SNF's facility effect. An unplanned PPR is a readmission from a SNF to an acute care hospital or a LTCH, with a diagnosis considered to be unplanned and potentially preventable.

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

c. Risk Adjustment

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

[29] https://www.cms.gov/files/document/snfvbpsnfwsppr-draft-technical-measure-specification.pdf

d. Measure Calculation

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

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

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

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

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

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

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

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

3. Adoption of Quality Measures for the SNF VBP Expansion Beginning with the FY 2026 Program Year

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

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

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

Table 15 in the final rule (reproduced below) lists the SNF VBP measures—current and newly proposed—and the first program year and performance period. Data on five measures would be collected starting with the FY 2024 performance period and data on another four measures, for a total of 9, would be collected starting with the FY 2025 performance period.

Measure Name	Measure Short Name	Measure Status	First Program Year	First Performance Period*
SNF 30-Day All-Cause Readmission Measure	SNFRM	Adopted, implemented	FY 2017**	FY 2015
SNF Healthcare-Associated Infections Requiring Hospitalization Measure	SNF HAI Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nurse Staffing Hours per Resident Day Measure	Total Nurse Staffing Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nursing Staff Turnover Measure	Nursing Staff Turnover Measure	Proposed	FY 2026+	FY 2024
Discharge to Community – Post-Acute Care Measure for SNFs	DTC PAC SNF Measure	Adopted, not implemented	FY 2027	FY 2024 and FY 2025
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure	Falls with Major Injury (Long-Stay) Measure	Proposed	FY 2027+	FY 2025
Discharge Function Score for SNFs Measure	DC Function Measure	Proposed	FY 2027+	FY 2025
Number of Hospitalizations per 1,000 Long Stay Resident Days Measure	Long Stay Hospitalization Measure	Proposed	FY 2027+	FY 2025
SNF Within-Stay Potentially Preventable Readmissions Measure	SNF WS PPR Measure	Proposed	FY 2028+	FY 2025 and FY 2026

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

a. Total Nursing Staff Turnover Measure

Citing several studies, CMS expresses concern that higher turnover rates of nursing staff is associated with poorer quality of care for SNF residents. The agency believes adding a nursing staff turnover measure to the SNF VBP Program will provide a comprehensive assessment of the quality of care provided to residents and drive improvements in nursing staff turnover, which CMS views will likely translate into positive resident outcomes. It also believes this measure will complement the Total Nurse Staffing measure. The Nursing Staff Turnover measure is measured and publicly reported for nursing facilities on the Care Compare website and is used in the Five-Star Quality Rating System.[30] The MAP offered conditional support of the measure for rulemaking, contingent upon endorsement by the consensus-based entity.[31] CMS will adopt it beginning with the FY 2026 program year.

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

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

Exclusions. SNFs would be excluded in the following circumstances:

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

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

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

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

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

The measure will be calculated using six consecutive quarters of PBJ data. Data from a baseline quarter[32] (Q0) and the first two quarters of the performance period are used to identify employees in the denominator. Data from the four quarters of the performance period (Q1 through Q4) are used to identify the number of employment spells that ended in turnover for the numerator. An employment spell is a continuous period of work. Data from the sixth quarter (Q5), which occurs after the four-quarter numerator (performance) period, are used to identify gaps in days worked that started in the last 60 days of the fifth quarter (Q4) used for the measure. To calculate the measure score, CMS first determines the measure denominator by identifying the total number of employment spells, and then calculates the numerator as the total number of employees who had a 60-day gap during the performance period.

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

$$\textit{Nursing Staff Turnover Inverted Rate} = 1 - \textit{Nursing Staff Turnover Rate}$$

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

Selected Comments/Responses. CMS received feedback asking that it consider the impact of staffing changes, such as staff who move "or float" within a health system, who are on family or medical leave for extended periods, or who are students or seasonal workers. Another comment suggested including all direct care workers and rehabilitation professionals. CMS believes that its final measure specifications, which were developed based on extensive data analyses, will result in reliable and valid measurement of nursing staff turnover.

A request was made to have the measure distinguish between voluntary and involuntary turnover; another commenter suggested excluded nursing staff who work solely in an

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

administrative capacity. The agency responds that the TEP concluded that continuity of care is impacted when a caregiver does not work for 60 or more days, regardless of whether they are still employed by the facility or the reason they are no longer employed. It also found that retention of directors of nursing and nursing administrators is associated with better resident outcomes and fewer facility health and safety deficiencies.

Other commenters asserted that the measure reflects circumstances outside of SNFs' control such as market conditions; CMS counters that it believes turnover is related to management practices. Some commenters objected to the measure, believing that they were being penalized for widespread healthcare personnel shortages. The agency reiterates that turnover is a high agency priority because of its central role in the quality of care for SNF residents.

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

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

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

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

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

CMS notes that the MDS includes a series of assessments and tracking documents, such as Omnibus Budget Reconciliation Act (OBRA) Comprehensive Assessments, OBRA Quarterly Assessments, OBRA Discharge Assessments, or PPS assessments. A target assessment, which presents the resident's status at the end of the episode of care or their latest status if their episode of care is ongoing, is selected for each long-stay resident. Target assessments may be (i) an Omnibus Budget Reconciliation Act (OBRA) admission, quarterly, annual, or significant change/correction assessment; (ii) PPS 5-day assessments; or (iii) discharge assessment with or without anticipated return.

Exclusions.

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

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

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

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

Measure calculation. The Falls with Major Injury (Long-Stay) measure is calculated and reported at the facility level.[33] CMS will determine the measure denominator by identifying the total number of long-stay residents who have a qualifying target assessment, who have one or more look-back scan assessments, and who do not meet the exclusion criteria. To calculate the numerator, CMS would identify the total number of those residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury. The numerator would then be divided by the denominator and multiplied by 100 for the percentage of long-stay residents who experience one or more falls with major injury. A lower measure rate indicates better performance on the measure.

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

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

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

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

Selected Comments/Responses. Concerns were expressed about MDS data not being sufficiently valid without an auditing program and that the measure is not risk adjusted. Others objected to the use of a long-stay measure for SNFs. CMS responds that it is adopting a validation process for SNF VBP measures calculated using MDS data. It acknowledges that it was unable to find a risk-adjustment model with sufficient predictability, but it believes the measure is appropriate to adopt to ensure resident's safety because it will be a strong incentive for SNFs to protect residents from falls.

One commenter suggested a measure for all falls, and another encouraged CMS to require MA plans to report falls data. CMS is unaware of a measure of all falls but may consider one if it is developed. On the issue of MA plan reporting, CMS will consider whether to incorporate such a measure in the MA Star Ratings system.

c. Discharge Function Score

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

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

Selected Comments/Responses. One commenter recommended scoring the measure on the resident's change in the DC Function score so that the Program rewards facilities based on the degree of a resident's improvement in function rather than if they met or exceeded an expected discharge score. CMS declines to adopt the recommendation noting the measure's strong reliability and validity, positive feedback from a TEP and other interested parties, and its high reportability and usability. CMS will consider a recommendation to include the expected discharge function score, which is already calculated during the measure evaluation, along with

the observed function score on the provider reports, so that providers have transparency into their performance.

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

CMS cites studies that have found that many unplanned hospitalizations could have been safely avoided by early intervention by the facility, and notes that data on Care Compare show considerable variation in performance across nursing homes regarding unplanned hospitalizations. It adopts the Number of Hospitalizations per 1,000 Long Stay Resident Days Measure ("Long Stay Hospitalization measure") beginning with the FY 2027 SNF VBP Program. CMS believes the Long Stay Hospitalization measure is a better way to capture the quality of care provided to the entirety of the population that resides in facilities that are dually certified as SNFs and NFs. The MAP offered conditional support of the measure for rulemaking, contingent upon endorsement by the consensus-based entity.[34]

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

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

Denominator. A Medicare beneficiary enrolled in both Parts A and B with a single stay, or sequence of stays, during which the individual resides in the nursing home for a total of 101 days or more without a gap of 30 contiguous days living in the community or another institution. The denominator is the total number of days (in thousands) during the target period that all long-stay residents were in the nursing home facility after they obtained long-term resident status.

Exclusions.

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

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

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

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

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

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

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

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

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

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

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

$$\textit{Long Stay Hospitalization Inverted Rate} = 1 - (\textit{Long Stay Hospitalization Risk Standardized Rate} / 1000)$$

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

Selected Comments/Responses. Concerns were again expressed about the addition of another long-stay measure to the SNF VBP program, about what additional information this measure provides beyond the SNF WS PPR measure, and about the exclusion of residents who are MA enrollees. CMS believes long-stay measures do a better job of capturing the quality of care provided to the entire population residing in facilities that are dually certified as SNFs and nursing facilities. CMS also notes that this measure focuses on risks experienced by long-stay residents whereas the SNF WS PPR assesses readmission rates for SNF residents who are admitted to a short-stay acute care hospital or long-term care hospital with a principal diagnosis considered to be unplanned and potentially preventable while within SNF care. With respect to the exclusion of MA enrollees, CMS notes that Medicare Advantage claims are not generally available for its use on the same timing or in the same way that FFS claims are used to calculate this measure.

B. SNF VBP Performance and Baseline Periods

1. Background

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

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

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

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

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

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

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

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

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

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

CMS will automatically adopt the performance period for a SNF VBP program year by advancing the beginning of the performance periods and baseline periods by 1 year from the previous program year for this measure.

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

C. SNF VBP Performance Standards

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

CMS finalizes SNF VBP numerical performance standards for program year FY 2026, shown below in Table 17 reproduced from the rule.

Final FY 2026 SNF VBP Program Performance Standards		
Measure Short Name	**Achievement Threshold**	**Benchmark**
SNFRM	0.78800	0.82971
SNF HAI Measure	0.92315	0.95004
Total Nurse Staffing Measure	3.18523	5.70680
Nursing Staff Turnover Measure	0.35912	0.72343

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

Final FY 2027 SNF VBP Program DTC PAC Performance Standards		
Measure Short Name	**Achievement Threshold**	**Benchmark**
DTC PAC SNF Measure	0.42946	0.66370

D. SNF VBP Performance Scoring

1. Case Minimum and Measure Minimum Policies

As noted above, CMS adopts the Nursing Staff Turnover measure beginning with the FY 2026 program year; the Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures beginning with the FY 2027 program year; and the SNF WS PPR measure beginning with the FY 2028 program year. Thus, it proposed to adopt case minimums for the new measures and to update the previously finalized measure minimum for the FY 2027 program year, which it finalizes without modification.

a. Case Minimums by Measure and Program Year

CMS finalizes the following case minimums:

Measure Short Name	Program Year	Case Minimum
Nursing Staff Turnover	FY 2026	(i) at least 1 eligible stay during the 1-year performance period, and (ii) at least 5 eligible nursing staff (RNs, LPNs, and nurse aides) during the 3 quarters of PBJ data included in the measure denominator
Falls with Major Injury (Long-Stay)	FY 2027	At least 20 residents in the measure denominator during the 1-year performance period
DC Function	FY 2027	At least 20 eligible stays during the 1-year performance period
Long Stay Hospitalization	FY 2027	At least 20 eligible stays during the 1-year performance period
SNF WS PPR	FY 2028	At least 25 eligible stays during the 2-year performance period

Comments/Responses. A commenter recommended case minimum requirements that meet a reliability standard of 0.7. They noted that CMS could expand the number of SNFs meeting the higher reliability standard by including multiple years in a performance period with greater weight given to more recent years. CMS believes its case minimums are sufficiently reliable, noting that its testing indicated increasing the case minimum requirements to achieve a 0.7 reliability standard would result in minimal improvements to a measure's reliability while increasing the number of SNFs that would not meet the higher case minimum requirement. The agency believes the case minimums appropriately balance a quality measure's reliability with its goal to score as many SNFs as possible on the measures.

b. Measure Minimums by Program Year

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

FY 2027. For program year FY 2027, CMS previously finalized that an eligible SNF must meet the case minimums for 3 of the 4 measures applicable for that year. Because CMS adopts 3 additional measures for the FY 2027 program year, resulting in a measure set of eight, it finalizes its proposal to require an eligible SNF to meet the case minimums for 4 of the 8 measures applicable for that year. Under these final case minimums, CMS estimates that roughly 8 percent of SNFs would be excluded from the SNF VBP for the FY 2027 program year.

2. Application of the SNF VBP Scoring Methodology to Measures

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

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

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

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

a. Overview

Extensive background is provided on the need to address health disparities and the actions the agency has undertaken to do so. CMS believes the SNF VBP program can incentivize SNFs who serve a high proportion of underserved individuals to deliver high quality care. CMS says that dual eligible residents are an underserved population that is clinically complex, have significant social needs and are more frequently admitted to SNFs that have larger populations of Medicaid residents and fewer resources than SNFs that do not care for dual eligible individuals.

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

exceed a certain threshold, and its resident population during the applicable performance period must include at least 20 percent of residents with DES.

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

b. HEA Beginning with the FY 2027 Program Year

CMS finalizes its policies for the HEA as proposed.

The term "underserved population" means Medicare beneficiaries who are SNF residents in a Medicare Part A stay with DES; CMS will only use DES data to identify SNF residents who are underserved. The agency considered other indicators (e.g., LIS, ADI) to identify those who are underserved for this HEA policy, but it determined that the DES data are readily available, are evidenced based in the SNF setting, and are already used in the Hospital Readmissions Reduction Program.

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

Each measure is assessed independently, and HEA bonus points for one measure is not conditioned on receiving HEA bonus points for another one. CMS will assign a measure performance scaler for each SNF that equals the total number of assigned points the SNF earns on each measure. Thus, if a SNF were a top tier performer for each of the 8 measures, it will receive the maximum measure performance scaler of 16.

The term "underserved multiplier" for a SNF means the number representing the SNF's proportion of residents with DES out of its total resident population in the applicable program year, translated using a logistic exchange function. Underserved multipliers are calculated for those SNFs with at least 20 percent of residents with DES during the applicable performance period. In the final rule, CMS clarifies that the underserved multiplier is for a SNF, the mathematical result of applying a logistic function to the number of SNF residents who are members of the underserved population out of the SNF's total Medicare population, as identified from the SNF's Part A claims, during the performance period that applies to the 1-year measures for the applicable program year. A single underserved multiplier will be calculated using the performance period of the 1-year measures and will be applied to all measures in the Program. However, the periods for calculating measure performance and calculating the proportion of residents with DES will overlap. Thus, a SNF's proportion of residents with DES may change

for each SNF VBP program year, and the SNF's underserved multiplier may change for each program year, in the same way that the set of residents used to calculate measure scores for each measure changes.

The term "total resident population at each SNF" means Medicare beneficiaries identified from the SNF's Part A claims during the performance period of the 1-year measures. The term "residents with DES" (or DES residents) means the percentage of Medicare SNF residents who are also eligible for Medicaid. Dual eligibility status will be assigned for any Medicare beneficiary who was deemed by Medicaid agencies to be eligible to receive Medicaid benefits for any month during the performance period of the 1-year measures.[35]

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

Selected Comments/Responses. Concerns were raised that high performing facilities with high proportions of residents with DES will get payment adjustments and lower performing facilities with high proportions of residents with DES will not get payment adjustments. CMS agrees that this could be the case but reminds stakeholders that the goal of the SNF VBP is to encourage and reward quality. It also clarifies that the term resident, as used in the context of the HEA, refers to both short- and long-term residents.

Other reactions to the proposal were negative, alleging that it was premature, discriminatory and would not provide meaningful data to address health equity. CMS disagrees with these comments, arguing that the HEA is designed to incentivize high quality care for this population, that the HEA is not included in the program until the FY 2027 payment year, and that the data derived from measures also includes long-stay measures which will capture some Part B claims information. However, CMS indicates that it will explore other ways to incorporate health equity into the SNF VBP.

One commenter observed that if there is low variability in a measure score between the top and bottom third, there may not be a clinically meaningful difference. CMS acknowledges that some measures may have low variability in performance, but it says it wants to incentivize lower performance SNFs to improve even if the improvements are small. Another commenter objected to setting any floor for the underserved multiplier; CMS believes the 20 percent floor carries out the policy goal of appropriately measuring performance by rewarding SNFs that are serving higher proportions of SNF residents with DES while also achieving high performance.

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

c. Calculation Steps

HEA bonus points for a SNF will be calculated as follows:

HEA bonus points = measure performance scaler × underserved multiplier

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

1. Calculate a Measure Performance Scaler Based on a SNF's Score on each of the SNF VBP Program Measures

Top tier performing SNFs on that measure (i.e., those in the top third across all SNFs for that measure) will be assigned 2 points. Top tier performance on each measure is calculated by determining the percentile that the SNF falls in based on their score on the measure as compared to the score earned by other SNFs who are eligible to receive a score on the measure. If the SNF performs in the bottom two-thirds of performance on all measures, that SNF is assigned a point value of 0 for each measure, resulting in a measure performance scaler of 0.

2. Calculate the Underserved Multiplier

As noted above, a logistic exchange function is used to calculate the underserved multiplier for scoring SNFs such that there will be a lower rate of increase at the beginning and the end of the curve. The formula for the underserved multiplier using a logistic exchange function is as follows:

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

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

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

3. Calculate the HEA Bonus Points

To calculate the HEA bonus points that may be awarded for a measure, the measure performance scaler is multiplied by the underserved multiplier. Table 20 shows examples of how the measure performance scaler and underserved multiplier would be used to calculate the bonus points.

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

CMS would add a SNF's HEA bonus points (calculated in Step Three) to the normalized sum of all points awarded to a SNF for each measure, which would be the SNF Performance Score

earned by the SNF for the program year. However, CMS will cap the SNF's Performance Score at 100 points.

Selected Comments/Responses. The agency disagrees with commenters who thought the scoring methodology was too complex; it believes the methodology addresses the challenges of adding a HEA to high performing SNFs that also care for high proportions of residents with DES in a straightforward way.

d. Increasing the Payback Percentage to Support the HEA

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

CMS finalizes its proposal to vary the payback percentage by program year to account for the application of the HEA so that SNFs that do receive the HEA will not experience a decrease in their value-based incentive payment amount, to the greatest extent possible, relative to no HEA in the Program and maintaining a payback percentage of 60 percent.

For a program year, CMS will first calculate SNF value-based incentive payment amounts with a payback percentage of 60 percent without the application of the HEA. Next, it will identify which SNFs receive the HEA based on the proportion of DES residents and individual measure performance. Third, while maintaining the value-based incentive payment amounts calculated in the first step for those SNFs that do not receive the HEA, it will calculate the payback percentage needed to apply the HEA. Table 23 in the final rule shows that assigning 2 points per measure would require an estimated increase in the 60 percent payback percentage of 6.02 percentage points for the FY 2027 program year and 5.40 percentage points for the FY 2028 program year. CMS does not anticipate that any factors will result in an increase in payback beyond the 70 percent maximum, but it will closely monitor the data and may make adjustments in future rulemaking.

Selected Comments/Responses. Commenters supported the variable payback percentage but also encouraged CMS to pay out the full 70 percent as authorized under the statute. CMS responds that the payback percentage is designed to appropriately balance the number of SNFs that receive a positive payment adjustment, the marginal incentives for all SNFs to reduce hospital readmissions and make broad-based care quality improvements, and the Medicare Program's long-term sustainability through the additional estimated Medicare trust fund savings.

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

CMS sought feedback on additional ways to incentivize the achievement of health equity in the SNF VBP Program. It requested information in four main topic areas:

a) Resident-level demographic and social risk indicators, as well as geographic-level indices that could be used to assess health equity gaps.
b) Health equity advancement approaches that could be added to the Program and questions that should be considered for each.
c) Other approaches that could be considered for inclusion in the SNF VBP Program in conjunction with the approaches described in the second section.
d) Adopting domains that could incorporate health equity.

Some commenters supported additional polices for the SNF VBP to address health equity. They suggested that the agency make facility level data on race and ethnicity available to help SNFs address inequities, align SDOH data across all care settings for future health equity measures to ease reporting burden, and prioritize measures that address recurring resident and caregiver complaints. Some concerns were raised about using these types of indices to assess disparities as current measure designs may mask regional and individual disparities. A number of comments recommended domain weights to address health equity as they believe that some measures and data are more impacted by inequity than others.

E. Update to the Extraordinary Circumstances Exception Policy Regulation Text

The Extraordinary Circumstances Exception (ECE) policy for the SNF VBP Program under §413.338(d)(4) applies to the SNF Readmission Measure. To apply the ECE policy to additional quality measures, CMS finalizes its proposal to modify the regulation text at §413.338(d)(4)(v) by removing specific references to the SNF Readmission Measure and substituting a more general statement that CMS will calculate a SNF performance score for a program year that does not include the SNF's "performance during the calendar months affected by the extraordinary circumstance." No comments were received on this proposal.

F. Update to SNF VBP Program Validation Process

Section 1888(h)(12) of the Act requires the Secretary to apply a validation process to the SNF VBP Program measures and relevant data. In light of the number of previously finalized adopted measures and the additional measures adopted in this rule, CMS finalizes the following proposals:

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

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

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

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

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

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

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

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

Currently, there is no process to verify that the MDS data submitted by providers to CMS for quality measure calculations is accurate for use in SNF quality reporting and value-based purchasing programs. CMS finalizes its proposal to adopt a new validation method for the SNF VBP measures that are calculated using MDS data; the method is similar to the one used to validate measures reported by hospitals under the Hospital IQR Program.

Under the validation process:

(a) Each year, CMS will randomly select up to 1,500 active and current SNFs, including non-critical access hospital swing bed facilities providing SNF-level services, that submit at least one MDS record in the calendar year 3 years prior to the fiscal year of the relevant program year or were included in the SNF VBP Program in the year prior to the relevant program year.
(b) The validation contractor will request up to 10 randomly selected medical charts (either digital or paper copies) from each of the selected SNFs for each quarter that applies to validation.

(c) The SNF will have 45 days from the date of the request to submit the records to the validation contractor. If the SNF has not complied within 30 days, the validation contractor will send the SNF a reminder.

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

Selected Comments/Responses. Some commenters recommended validation of MDS data before using MDS-based measures in the SNF VBP, but CMS does not think this is feasible before the FY 2027 SNF VBP program year. A number of commenters recommended that CMS not include a penalty for SNFs that fail validation of MDS-based measures because facilities are already penalized through the withholding of funds; CMS does not agree.

Other commenters recommended against validating MDS-based measures, arguing that CMS should instead phase out self-reported measures or that state audits and surveys already extensively validate the measures CMS notes that SNFs already submit MDS data under the SNF QRP. The agency also believes that state audits and surveys are insufficient for purposes of the SNF VBP Program's current and future quality measures. Some commenters objected to the requirement to pull up to 10 charts per SNF as burdensome. CMS responds that this policy is consistent with similar requirements applicable under the Hospital IQR Program and the HAC Reduction Program.

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

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

H. Public Reporting on the Provider Data Catalog Website

CMS did not make any proposals related to public reporting. It notes that performance information on the SNF WS PPR measure will be published when that measure is implemented beginning in the FY 2028 program year.

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

Section 488.436 permits a facility to waive its right to a hearing and receive a 35 percent reduction in the amount of civil money penalties (CMPs) owed in lieu of contesting the enforcement action. The facility must submit a written waiver request to avail itself of this

opportunity. CMS notes very high rates of waiver requests and extremely low rates of facilities that use the full hearing process over the years (roughly 4 percent).

CMS finalizes its proposal to remove the requirement that a facility must submit a written request and substitute a constructive waiver process that would operate by default when a timely request for hearing is not received; the current 35 percent penalty reduction continues to apply. Specifically, section 488.436(a) is revised to state that a facility is deemed to have waived its rights to a hearing if the 60-day time period for requesting a hearing has expired and timely request for a hearing has not been received. The regulation text specifies that the 35 percent reduction will be applied after the 60-day timeframe.

The agency still has the opportunity (under §488.444) to settle CMP cases at any time before a final administrative decision for Medicare-only SNFs, state-operated facilities, or other facilities for which an agency enforcement action prevails, in accordance with §488.30. CMS does not believe the elimination of the requirement for a written waiver will negatively impact facilities.

Some commenters objected to the proposal, believing that an automatic reduction of 35 percent would be seen by SNFs as a cost of doing business and thereby discouraging compliance with applicable rules and regulations. They argue the CMP would lose any value as a deterrent. CMS disagrees, noting that the majority of SNFs currently submit the waivers and receive the reduction and that the constructive waiver process does not affect the frequency of CMPs, the agency's ability to penalize facilities for infractions, or the publication of facility infractions through Care Compare. However, CMS indicates that it will review the appropriateness of the 35 percent penalty reduction in future rulemaking.

VIII. Economic Analyses

CMS estimates that SNFs would experience an increase of $1.4 billion in payments or an average increase of 4.0 percent as result of this final rule. This impact reflects a $2.2 billion (6.4 percent) increase from the update to the payment rates and a $789 million decrease (2.3 percent) as a result of the second phase of the parity adjustment recalibration. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $184.85 million.

Table 30 of the final rule (reproduced below) shows the estimated impact of the final rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the parity adjustment recalibration and the budget neutral updates to the wage index data. The combined effects of all of these changes vary by specific type of providers and by location. For example, CMS estimates that due to the changes in this final rule, payment rates for SNFs in rural areas would increase by 3.0 percent overall compared with 3.8 percent for SNFs in urban areas.

Table 30: Impact to the SNF PPS for FY 2024

Impact Categories	Number of Facilities	Parity Adjustment Recalibration	Update Wage Data	Total Change
Group				
Total	15,503	-2.3	0.0	4.0
Urban	11,254	-2.3	0.1	4.1
Rural	4,249	-2.2	-0.7	3.3
Hospital-based urban	366	-2.3	0.0	4.0
Freestanding urban	10,888	-2.3	0.1	4.1
Hospital-based rural	378	-2.2	-0.3	3.7
Freestanding rural	3,871	-2.2	-0.7	3.3
Urban by region				
New England	734	-2.3	-0.7	3.2
Middle Atlantic	1,471	-2.4	1.4	5.3
South Atlantic	1,945	-2.3	0.1	4.1
East North Central	2,181	-2.3	-0.7	3.2
East South Central	555	-2.2	0.0	4.0
West North Central	958	-2.3	-0.4	3.6
West South Central	1,454	-2.3	0.0	4.0
Mountain	546	-2.3	-0.9	3.0
Pacific	1,404	-2.4	0.1	4.0
Outlying	6	-2.0	-2.6	1.6
Rural by region				
New England	117	-2.3	-1.1	2.8
Middle Atlantic	205	-2.2	-0.3	3.7
South Atlantic	489	-2.2	0.1	4.1
East North Central	907	-2.2	-0.9	3.1
East South Central	491	-2.2	-0.8	3.2
West North Central	1,011	-2.2	-0.9	3.1
West South Central	738	-2.2	-0.5	3.5
Mountain	199	-2.3	-0.6	3.3
Pacific	91	-2.3	-2.0	1.9
Outlying	1	-2.3	0.0	3.9
Ownership				
For profit	10,912	-2.3	0.0	4.0
Non-profit	3,573	-2.3	0.0	3.9
Government	1,018	-2.3	-0.4	3.6

Note: The Total column includes the FY 2024 6.1 percent market basket update factor. The values presented in Table 30 may not sum due to rounding. CMS uses a multiplicative formula to derive total percentage change.

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

CMS notes that under PDPM providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim in order to bill for covered SNF services. The first character of the HIPPS code represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group "TA", then the first character in the patient's HIPPS code would be an A. 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 final rule (recreated below) show the case-mix adjusted federal rates and associated indexes for PDPM groups for urban and rural SNFs, respectively. In each table, Column 1 represents the character in the HIPPS code associated with a given PDPM component. Columns 2 and 3 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant PT group. Columns 4 and 5 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant OT group. Columns 6 and 7 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant SLP group. Column 8 provides the nursing case-mix group (CMG) that is connected with a given PDPM HIPPS character. For example, if the patient qualified for the nursing group CBC1, then the third character in the patient's HIPPS code would be a "P." Columns 9 and 10 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant nursing group. Finally, columns 11 and 12 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant NTA group.

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

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$101.89	1.41	$92.23	0.64	$16.79	ES3	3.84	$470.32	3.06	$282.77
B	1.61	113.13	1.54	100.73	1.72	45.12	ES2	2.90	355.19	2.39	220.86
C	1.78	125.08	1.60	104.66	2.52	66.10	ES1	2.77	339.27	1.74	160.79
D	1.81	127.19	1.45	94.84	1.38	36.20	HDE2	2.27	278.03	1.26	116.44
E	1.34	94.16	1.33	87.00	2.21	57.97	HDE1	1.88	230.26	0.91	84.09
F	1.52	106.81	1.51	98.77	2.82	73.97	HBC2	2.12	259.66	0.68	62.84
G	1.58	111.03	1.55	101.39	1.93	50.62	HBC1	1.76	215.56	.....	.....
H	1.10	77.30	1.09	71.30	2.7	70.82	LDE2	1.97	241.29	.....	.....
I	1.07	75.19	1.12	73.26	3.34	87.61	LDE1	1.64	200.87	.....	.....
J	1.34	94.16	1.37	89.61	2.83	74.23	LBC2	1.63	199.64	.....	.....
K	1.44	101.19	1.46	95.50	3.5	91.81	LBC1	1.35	165.35	.....	.....
L	1.03	72.38	1.05	68.68	3.98	104.40	CDE2	1.77	216.79	.....	.....
M	1.20	84.32	1.23	80.45	.....	.....	CDE1	1.53	187.39	.....	.....
N	1.40	98.38	1.42	92.88	.....	.....	CBC2	1.47	180.05	.....	.....
O	1.47	103.30	1.47	96.15	.....	.....	CA2	1.03	126.15	.....	.....
P	1.02	71.68	1.03	67.37	.....	.....	CBC1	1.27	155.55	.....	.....
Q	.....	.....	.....	.....	.....	.....	CA1	0.89	109.01	.....	.....

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
R							BAB2	0.98	120.03		
S							BAB1	0.94	115.13		
T							PDE2	1.48	181.27		
U							PDE1	1.39	170.25		
V							PBC2	1.15	140.85		
W							PA2	0.67	82.06		
X							PBC1	1.07	131.05		
Y							PA1	0.62	75.94		

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

PDPM group	PT CMI	PT rate	OT CMI	OT rate	SLP CMI	SLP rate	Nursing CMG	Nursing CMI	Nursing rate	NTA CMI	NTA rate
A	1.45	$116.15	1.41	$103.72	0.64	$21.15	ES3	3.84	$449.40	3.06	$270.17
B	1.61	128.96	1.54	113.28	1.72	56.85	ES2	2.90	339.39	2.39	211.01
C	1.78	142.58	1.60	117.70	2.52	83.29	ES1	2.77	324.17	1.74	153.62
D	1.81	144.98	1.45	106.66	1.38	45.61	HDE2	2.27	265.66	1.26	111.25
E	1.34	107.33	1.33	97.83	2.21	73.04	HDE1	1.88	220.02	0.91	80.34
F	1.52	121.75	1.51	111.08	2.82	93.20	HBC2	2.12	248.10	0.68	60.04
G	1.58	126.56	1.55	114.02	1.93	63.79	HBC1	1.76	205.97		
H	1.10	88.11	1.09	80.18	2.7	89.24	LDE2	1.97	230.55		
I	1.07	85.71	1.12	82.39	3.34	110.39	LDE1	1.64	191.93		
J	1.34	107.33	1.37	100.78	2.83	93.53	LBC2	1.63	190.76		
K	1.44	115.34	1.46	107.40	3.5	115.68	LBC1	1.35	157.99		
L	1.03	82.50	1.05	77.24	3.98	131.54	CDE2	1.77	207.14		
M	1.20	96.12	1.23	90.48			CDE1	1.53	179.06		
N	1.40	112.14	1.42	104.46			CBC2	1.47	172.03		
O	1.47	117.75	1.47	108.13			CA2	1.03	120.54		
P	1.02	81.70	1.03	75.77			CBC1	1.27	148.63		
Q							CA1	0.89	104.16		
R							BAB2	0.98	114.69		
S							BAB1	0.94	110.01		
T							PDE2	1.48	173.20		
U							PDE1	1.39	162.67		
V							PBC2	1.15	134.58		
W							PA2	0.67	78.41		
X							PBC1	1.07	125.22		
Y							PA1	0.62	72.56		