"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

SNF PPS FY 2023 Final Rule

The Facts Beyond the Headlines

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after September 18, 2022

Agenda

FY 2023 SNF PPS Final Rule

- FY 2023 Updates to the SNF Payment Rates
- Wage Index Adjustments
- Methodology for Recalibrating the PDPM Parity Adjustment
- Administrative Level of Care Presumption of Coverage
- Changes in PDPM ICD-10 Code Mappings
- Skilled Nursing Facility Quality Reporting Program (SNF QRP) update
- Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program
- RFI's
- Financial Impact

FY 2023 Updates to the SNF Payment Rates

- **Market Basket Update**
  - Every year CMS updates the PPS rate based on changes in the Market Basket (the overall cost of goods and services that contribute to expenditures required to run and maintain a nursing facility). This is then adjusted by a forecast error adjustment and multi-factor productivity adjustment as applicable. For the FY 2023 market basket updates, CMS has will use second quarter 2022 forecast (with historical data through the first quarter of 2022) of the 2018-based SNF market basket
  - For FY 2023, CMS determined an update to the Market Basket of 3.9%.
  - This has been adjusted upward to 5.4% due to a 1.5% forecast error adjustment (0.5% threshold).

TABLE 2: Difference Between the Actual and Forecasted Market Basket Increases for FY 2021

Index	Forecasted FY 2021 Increase*	Actual FY 2021 Increase**	FY 2021 Difference
SNF	2.2	3.7	1.5

*Published in **Federal Register**; based on second quarter 2020 IGI forecast (2014-based index).
** Based on the second quarter 2022 IGI forecast.

  - Finally, the FY 2023 Market Basket update has been adjusted to **5.1%** due to a 0.3% Productivity Adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity).

FY 2023 Updates to the SNF Payment Rates

FY 2022 Base Rates

FY 2023 Base Rates

TABLE 4: FY 2022 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$62.82	$58.48	$23.45	$109.51	$82.62	$98.07

TABLE 5: FY 2022 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$71.61	$65.77	$29.55	$104.63	$78.93	$99.88

TABLE 3: FY 2023 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$66.06	$61.49	$24.66	$115.15	$86.88	$103.12

TABLE 4: FY 2023 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$75.30	$69.16	$31.07	$110.02	$83.00	$105.03

FY 2023 Updates to the SNF Payment Rates

- **Parity Adjustment**
  - CMS has finalized a 4.6% parity adjustment based on the difference in expected expenditures under PDPM vs. RUG IV, producing essentially a 4.6% reduction to the PDPM category CMI phased in over 2 Fiscal Years with a 2.3% reduction in both FY 2023 and 2024.
  - CMS indicates the overall economic impact will be -$780 million in aggregate payments to SNFs for FY 2023.
  - **This does not include** wage index adjustments, VBP incentive payments, QRP non-compliance APU adjustments or Sequestration.

FY 2023 Updates to the SNF Payment Rates

Urban Case Mix Adjusted Rates and Associated indexes

TABLE 5: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN (Including 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	1.49	$98.43	1.45	$89.16	0.66	$16.28	ES3	3.95	$454.84	3.15	$273.67
B	1.65	$109.00	1.59	$97.77	1.77	$43.65	ES2	2.99	$344.30	2.46	$213.72
C	1.83	$120.89	1.64	$100.84	2.60	$64.12	ES1	2.85	$328.18	1.79	$155.52
D	1.87	$123.53	1.49	$91.62	1.42	$35.02	HDE2	2.33	$268.30	1.29	$112.08
E	1.38	$91.16	1.37	$84.24	2.28	$56.22	HDE1	1.94	$223.39	0.93	$80.80
F	1.57	$103.71	1.56	$95.92	2.90	$71.51	HBC2	2.18	$251.03	0.70	$60.82
G	1.62	$107.02	1.60	$98.38	1.98	$48.83	HBC1	1.81	$208.42	-	-
H	1.13	$74.65	1.12	$68.87	2.78	$68.55	LDE2	2.02	$232.60	-	-
I	1.10	$72.67	1.15	$70.71	3.43	$84.58	LDE1	1.68	$193.45	-	-
J	1.38	$91.16	1.41	$86.70	2.91	$71.76	LBC2	1.67	$192.30	-	-
K	1.48	$97.77	1.50	$92.24	3.60	$88.78	LBC1	1.39	$160.06	-	-
L	1.06	$70.02	1.08	$66.41	4.10	$101.11	CDE2	1.82	$209.57	-	-
M	1.24	$81.91	1.26	$77.48	-	-	CDE1	1.58	$181.94	-	-
N	1.44	$95.13	1.46	$89.78	-	-	CBC2	1.51	$173.88	-	-
O	1.51	$99.75	1.51	$92.85	-	-	CA2	1.06	$122.06	-	-
P	1.05	$69.36	1.06	$65.18	-	-	CBC1	1.30	$149.70	-	-
Q	-	-	-	-	-	-	CA1	0.91	$104.79	-	-
R	-	-	-	-	-	-	BAB2	1.01	$116.30	-	-
S	-	-	-	-	-	-	BAB1	0.96	$110.54	-	-
T	-	-	-	-	-	-	PDE2	1.53	$176.18	-	-
U	-	-	-	-	-	-	PDE1	1.43	$164.66	-	-
V	-	-	-	-	-	-	PBC2	1.19	$137.03	-	-
W	-	-	-	-	-	-	PA2	0.69	$79.45	-	-
X	-	-	-	-	-	-	PBC1	1.10	$126.67	-	-
Y	-	-	-	-	-	-	PA1	0.64	$73.70	-	-

FY 2023 Updates to the SNF Payment Rates

Rural Case Mix Adjusted Rates and Associated indexes

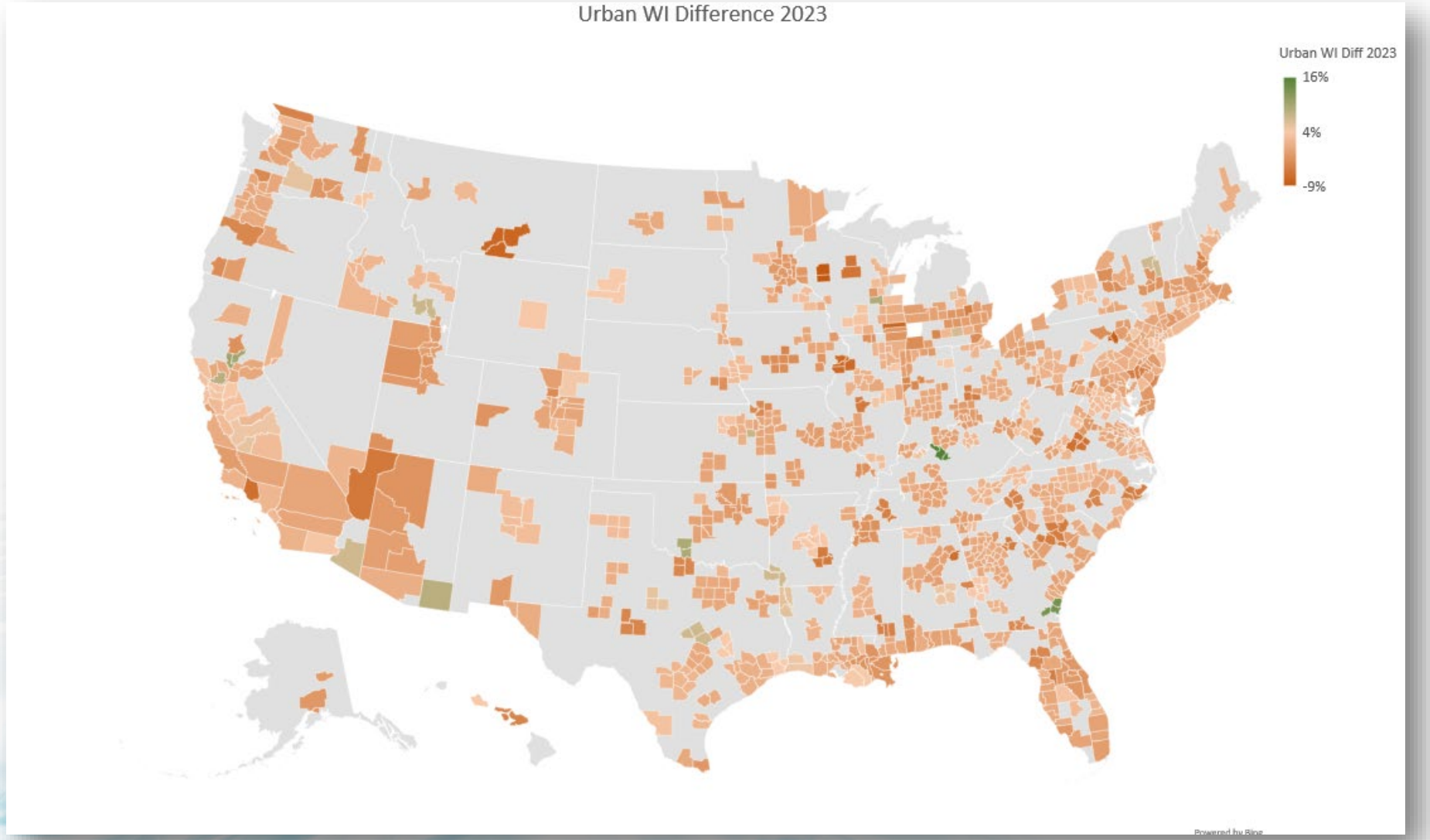
TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL (Including the Parity Adjustment Recalibration)

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	1.49	$112.20	1.45	$100.28	0.66	$20.51	ES3	3.95	$434.58	3.15	$261.45
B	1.65	$124.25	1.59	$109.96	1.77	$54.99	ES2	2.99	$328.96	2.46	$204.18
C	1.83	$137.80	1.64	$113.42	2.60	$80.78	ES1	2.85	$313.56	1.79	$148.57
D	1.87	$140.81	1.49	$103.05	1.42	$44.12	HDE2	2.33	$256.35	1.29	$107.07
E	1.38	$103.91	1.37	$94.75	2.28	$70.84	HDE1	1.94	$213.44	0.93	$77.19
F	1.57	$118.22	1.56	$107.89	2.90	$90.10	HBC2	2.18	$239.84	0.70	$58.10
G	1.62	$121.99	1.60	$110.66	1.98	$61.52	HBC1	1.81	$199.14	-	-
H	1.13	$85.09	1.12	$77.46	2.78	$86.37	LDE2	2.02	$222.24	-	-
I	1.10	$82.83	1.15	$79.53	3.43	$106.57	LDE1	1.68	$184.83	-	-
J	1.38	$103.91	1.41	$97.52	2.91	$90.41	LBC2	1.67	$183.73	-	-
K	1.48	$111.44	1.50	$103.74	3.60	$111.85	LBC1	1.39	$152.93	-	-
L	1.06	$79.82	1.08	$74.69	4.10	$127.39	CDE2	1.82	$200.24	-	-
M	1.24	$93.37	1.26	$87.14	-	-	CDE1	1.58	$173.83	-	-
N	1.44	$108.43	1.46	$100.97	-	-	CBC2	1.51	$166.13	-	-
O	1.51	$113.70	1.51	$104.43	-	-	CA2	1.06	$116.62	-	-
P	1.05	$79.07	1.06	$73.31	-	-	CBC1	1.30	$143.03	-	-
Q	-	-	-	-	-	-	CA1	0.91	$100.12	-	-
R	-	-	-	-	-	-	BAB2	1.01	$111.12	-	-
S	-	-	-	-	-	-	BAB1	0.96	$105.62	-	-
T	-	-	-	-	-	-	PDE2	1.53	$168.33	-	-
U	-	-	-	-	-	-	PDE1	1.43	$157.33	-	-
V	-	-	-	-	-	-	PBC2	1.19	$130.92	-	-
W	-	-	-	-	-	-	PA2	0.69	$75.91	-	-
X	-	-	-	-	-	-	PBC1	1.10	$121.02	-	-
Y	-	-	-	-	-	-	PA1	0.64	$70.41	-	-

Wage Index Adjustments

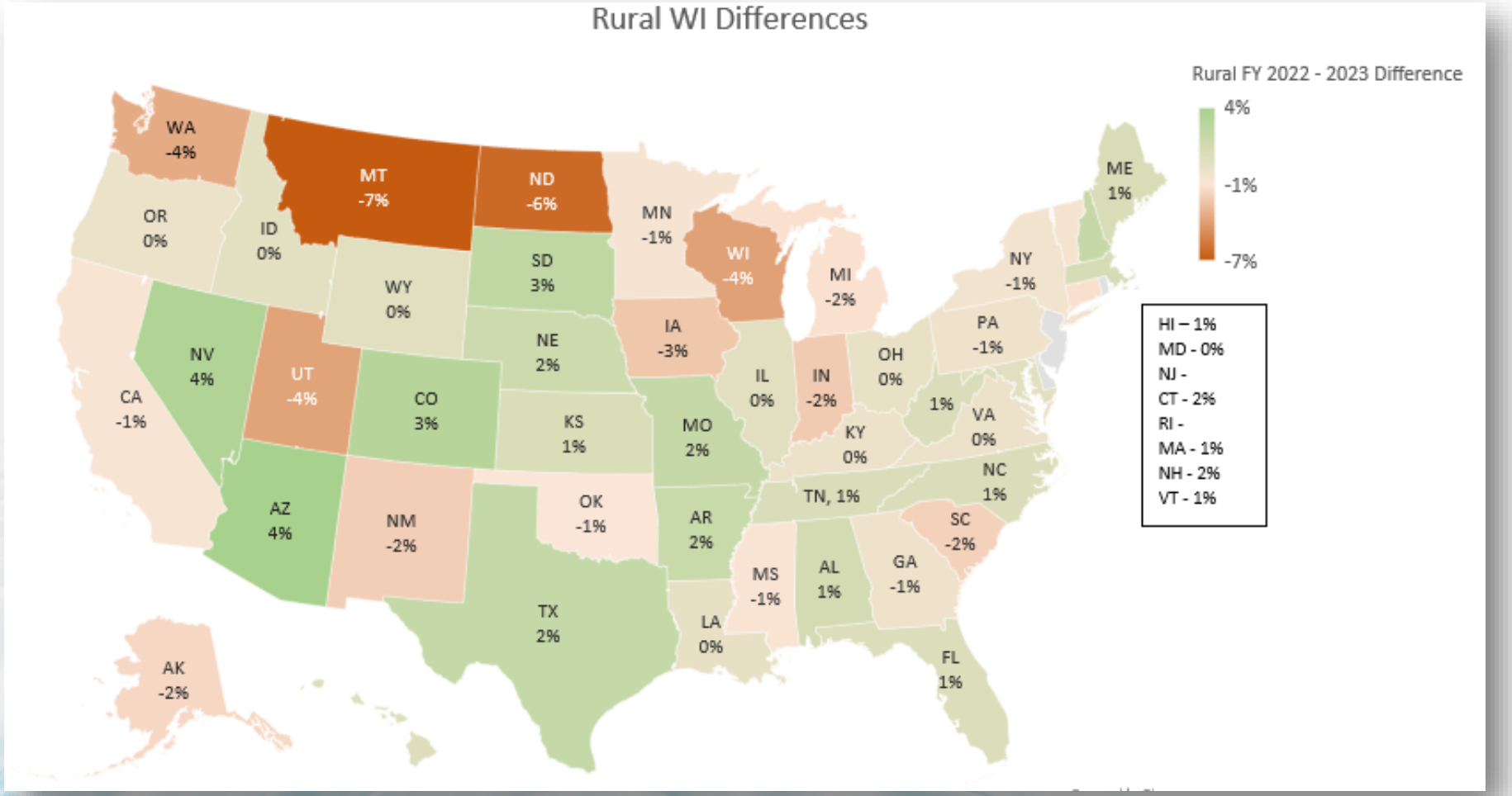
- **Wage Index**
  - CMS is required to adjust the Federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate.
  - Since the inception of the SNF PPS, CMS has used hospital inpatient wage data in developing a wage index to be applied to SNFs. CMS will continue this practice for FY 2023,
  - CMS continues to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS.
  - The final wage index data for FY 2023 can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex
  - CMS recognizes that changes to the wage index have the potential to create instability and significant negative impacts on certain providers even when labor market areas do not change. In addition, year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as the COVID–19 public health emergency (PHE).
  - For FY 2023 and subsequent years, CMS is finalizing 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. **Subsequent year adjustments will be based on any applicable 5% cap from the prior year.**
  - The wage index adjusts the labor related portion of the case mix adjusted base rate.

FY 2022 to 2023 WI Changes (Urban)



45% of counties will experience a reduction in their wage index. 5% of counties will be capped at 5%.

FY 2022 to 2023 WI Changes (Rural))



40% of states will have a negative WI adjustment. And 4% will be capped at 5%

County		State		2023 WI			2022 WI			2222/2023 WI % Change			
Urban	MD, Frederick C	Rural		0.9577			0.9755			-1.82%			
Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR	Total $$	WI Rate	ADR	Total $$	2023-2022 WI Daily Rate Diff:	2023-2022 Avg. DR Diff:	2023-2022 Daily Tot. $$ Diff:	2023-2022 % Rate Change
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 967.16	$ 967.16	$ 967.16	$ 954.87	$ 954.87	$ 954.87	$ 12.29	$ 12.29	$ 12.29	1.29%
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 967.16	$ 967.16	$ 1,934.32	$ 954.87	$ 954.87	$ 1,909.74	$ 12.29	$ 12.29	$ 24.58	1.29%
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 967.16	$ 967.16	$ 2,901.48	$ 954.87	$ 954.87	$ 2,864.61	$ 12.29	$ 12.29	$ 36.87	1.29%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 891.73	$ 3,566.92	$ 656.08	$ 880.17	$ 3,520.69	$ 9.36	$ 11.56	$ 46.23	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 846.47	$ 4,232.36	$ 656.08	$ 835.35	$ 4,176.77	$ 9.36	$ 11.12	$ 55.59	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 816.30	$ 4,897.80	$ 656.08	$ 805.48	$ 4,832.85	$ 9.36	$ 10.83	$ 64.95	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 794.75	$ 5,563.24	$ 656.08	$ 784.13	$ 5,488.93	$ 9.36	$ 10.62	$ 74.31	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 778.59	$ 6,228.68	$ 656.08	$ 768.13	$ 6,145.01	$ 9.36	$ 10.46	$ 83.67	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 766.01	$ 6,894.12	$ 656.08	$ 755.68	$ 6,801.09	$ 9.36	$ 10.34	$ 93.03	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 755.96	$ 7,559.56	$ 656.08	$ 745.72	$ 7,457.17	$ 9.36	$ 10.24	$ 102.39	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 747.73	$ 8,225.00	$ 656.08	$ 737.57	$ 8,113.25	$ 9.36	$ 10.16	$ 111.75	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 740.87	$ 8,890.44	$ 656.08	$ 730.78	$ 8,769.33	$ 9.36	$ 10.09	$ 121.11	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 735.07	$ 9,555.88	$ 656.08	$ 725.03	$ 9,425.41	$ 9.36	$ 10.04	$ 130.47	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 730.09	$ 10,221.32	$ 656.08	$ 720.11	$ 10,081.49	$ 9.36	$ 9.99	$ 139.83	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 725.78	$ 10,886.76	$ 656.08	$ 715.84	$ 10,737.57	$ 9.36	$ 9.95	$ 149.19	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 722.01	$ 11,552.20	$ 656.08	$ 712.10	$ 11,393.65	$ 9.36	$ 9.91	$ 158.55	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 718.68	$ 12,217.64	$ 656.08	$ 708.81	$ 12,049.73	$ 9.36	$ 9.88	$ 167.91	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 715.73	$ 12,883.08	$ 656.08	$ 705.88	$ 12,705.81	$ 9.36	$ 9.85	$ 177.27	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 713.08	$ 13,548.52	$ 656.08	$ 703.26	$ 13,361.89	$ 9.36	$ 9.82	$ 186.63	1.43%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 665.44	$ 710.70	$ 14,213.96	$ 656.08	$ 700.90	$ 14,017.97	$ 9.36	$ 9.80	$ 195.99	1.43%

County		State		2023 WI Capped -5%			2022 WI			2222/2023 WI % Change			
Urban	AL, Calhoun Cou	Rural		0.6647			0.6997			-6.33%			
Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR	Total $$	WI Rate	ADR	Total $$	2023-2022 WI Daily Rate Diff:	2023-2022 Avg. DR Diff:	2023-2022 Daily Tot. $$ Diff:	2023-2022 % Rate Change
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 760.35	$ 760.35	$ 760.35	$ 766.22	$ 766.22	$ 766.22	$ (5.87)	$ (5.87)	$ (5.87)	-0.77%
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 760.35	$ 760.35	$ 1,520.70	$ 766.22	$ 766.22	$ 1,532.44	$ (5.87)	$ (5.87)	$ (11.74)	-0.77%
$ 103.12	$ 705.89	$ 291.13	$ 997.02	$ 760.35	$ 760.35	$ 2,281.05	$ 766.22	$ 766.22	$ 2,298.66	$ (5.87)	$ (5.87)	$ (17.61)	-0.77%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 701.05	$ 2,804.19	$ 526.45	$ 706.28	$ 2,825.11	$ (3.31)	$ (5.23)	$ (20.92)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 665.47	$ 3,327.33	$ 526.45	$ 670.31	$ 3,351.56	$ (3.31)	$ (4.85)	$ (24.23)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 641.75	$ 3,850.47	$ 526.45	$ 646.34	$ 3,878.01	$ (3.31)	$ (4.59)	$ (27.54)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 624.80	$ 4,373.61	$ 526.45	$ 629.21	$ 4,404.46	$ (3.31)	$ (4.41)	$ (30.85)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 612.09	$ 4,896.75	$ 526.45	$ 616.36	$ 4,930.91	$ (3.31)	$ (4.27)	$ (34.16)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 602.21	$ 5,419.89	$ 526.45	$ 606.37	$ 5,457.36	$ (3.31)	$ (4.16)	$ (37.47)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 594.30	$ 5,943.03	$ 526.45	$ 598.38	$ 5,983.81	$ (3.31)	$ (4.08)	$ (40.78)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 587.83	$ 6,466.17	$ 526.45	$ 591.84	$ 6,510.26	$ (3.31)	$ (4.01)	$ (44.09)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 582.44	$ 6,989.31	$ 526.45	$ 586.39	$ 7,036.71	$ (3.31)	$ (3.95)	$ (47.40)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 577.88	$ 7,512.45	$ 526.45	$ 581.78	$ 7,563.16	$ (3.31)	$ (3.90)	$ (50.71)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 573.97	$ 8,035.59	$ 526.45	$ 577.83	$ 8,089.61	$ (3.31)	$ (3.86)	$ (54.02)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 570.58	$ 8,558.73	$ 526.45	$ 574.40	$ 8,616.06	$ (3.31)	$ (3.82)	$ (57.33)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 567.62	$ 9,081.87	$ 526.45	$ 571.41	$ 9,142.51	$ (3.31)	$ (3.79)	$ (60.64)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 565.00	$ 9,605.01	$ 526.45	$ 568.76	$ 9,668.96	$ (3.31)	$ (3.76)	$ (63.95)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 562.68	$ 10,128.15	$ 526.45	$ 566.41	$ 10,195.41	$ (3.31)	$ (3.74)	$ (67.26)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 560.59	$ 10,651.29	$ 526.45	$ 564.31	$ 10,721.86	$ (3.31)	$ (3.71)	$ (70.57)	-0.63%
$ 103.12	$ 485.67	$ 200.31	$ 685.98	$ 523.14	$ 558.72	$ 11,174.43	$ 526.45	$ 562.42	$ 11,248.31	$ (3.31)	$ (3.69)	$ (73.88)	-0.63%

Methodology for Recalibrating the PDPM / Parity Adjustment

- **Parity Adjustment**
  - **In the FY 2022 Final Rule**, CMS determined, through budget neutrality analysis, that even absent COVID related cases in 2020, i.e., active COVID dx. and or use of the 3-day stay waiver, there was a 5.0% increase in aggregate spending under the PDPM for FY 2020 due to the shift in case mix utilization, compared to FY 2019.
  - **For the FY 2022 SNF** proposed rule, CMS defined the COVID-19 population to include: stays that have either the interim COVID-19 code B97.29 recorded as a primary or secondary diagnosis in addition to one of the symptom codes J12.89, J20.8, J22, or J80, or the new COVID-19 code U07.1 recorded as a primary or secondary diagnosis on their SNF claims or MDS 5-day admission assessments.
  - **For the FY 2023 SNF proposed/final rule**, CMS defines the COVID-19 population to include: stays that have the interim COVID-19 code B97.29 from January 1, 2020 to March 31, 2020 or the new COVID-19 code U07.1 from April 1, 2020 onward recorded as a primary or secondary diagnosis on their SNF claims, MDS 5-day admission assessments, or MDS interim payment assessments.
  - These definitions of the COVID-19 population also exclude stays that used a section 1812(f) of the Act modification (DR), as well as transitional stays.

Methodology for Recalibrating the PDPM / Parity Adjustment

- Due to concerns that there were other factors complicating the data in the previous and revised COVID-19 definitions, CMS has introduced a 1-year “control period” derived from both FY 2020 and FY 2021 data. Specifically, 6 months of FY 2020 data from October 2019 through March 2020 and 6 months of FY 2021 data from April 2021 through September 2021 (which our data suggests were periods with relatively low COVID-19 prevalence) to create a full 1-year period with no repeated months to account for seasonality effects.
- CMS believes that this combined approach provides the most accurate representation of what the SNF case-mix distribution would look like under PDPM outside of a COVID-19 PHE environment.

TABLE 11: Adjustment Factors Based on Population and Data Period

Data Period	Full SNF Population	Subset SNF Population	Difference
FY 2020-based Adjustment Factor	5.21%	4.90%	-0.31%
FY 2021-based Adjustment Factor	5.65%	5.25%	-0.40%
Control Period-based Adjustment Factor	4.58%	4.60%	0.02%

Methodology for Recalibrating the PDPM / Parity Adjustment

- **Parity Adjustment (Cont.)**
  - CMS considered whether delayed and/or phased implementation approaches were warranted to mitigate potential negative impacts on providers resulting from implementation of such a reduction in the SNF PPS rates entirely within a single year.
  - After considering comments and all options, CMS is finalizing a recalibration of the PDPM parity adjustment with a 2-year phase-in period, resulting in a 2.3 percent reduction in FY 2023 ($780 million) and a 2.3 percent reduction in FY 2024.
- **Overall Impact**
  - As a result, CMS estimates that the aggregate impact of the provisions in this final rule will result in an estimated net increase in SNF payments of 2.7 percent, or $904 million, for FY 2023.
  - This reflects a 5.1 percent increase from the final update to the payment rates and a 2.3 percent decrease from the reduction to the SNF payment rates to account for the recalibrated parity adjustment.

Methodology for Recalibrating the PDPM / Parity Adjustment

- **Parity Adjustment (Cont.)**
  - CMS has indicated that **it is also important to note** that the parity adjustment recalibration would serve to remove an unintended increase in payments from moving to a new case mix classification system, rather than decreasing an otherwise appropriate payment amount. CMS does not believe that the recalibration should negatively affect facilities, beneficiaries, and quality of care, or create an undue hardship on providers.
  - CMS continues to believe that in implementing PDPM, it is essential to stabilize the baseline as quickly as possible without creating a significant adverse effect on the industry or to beneficiaries.

Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage**
  - Annually CMS designates those specific classifiers under the case-mix classification system that represent the required SNF level of care. This designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial Medicare assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment.
  - This presumption recognizes the strong likelihood that those beneficiaries who are assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.
  - 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, including a review to confirm that any services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary.
  - See CMS Pub 100-2 Ch. 8 for detailed explanation of the Administrative level of Care Presumption of Coverage.
  - See the CMS PDPM website for a detailed Administrative Level of Care Presumption of Coverage FAQ.

Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage (Cont.)**
  - For services furnished on or after October 1, 2019, the following are the designated case-mix classifiers under the Patient Driven Payment Model (PDPM) relative to the administrative presumption of coverage:
    - **Nursing** groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
    - **PT and OT** groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
    - **SLP** groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
    - **NTA** component's uppermost (12+) comorbidity group.

Changes in PDPM ICD-10 Code Mappings

- CMS has finalized several changes to the PDPM ICD-10 code mappings and lists.
- CMS notes that, in the case of any diagnoses that are either currently mapped to “Return to Provider” or that were proposed to be classified into this category, this is not intended to reflect any judgment on the importance of recognizing and treating these conditions, but merely that there are more specific diagnoses than those mapped to “Return to Provider” or that they do not believe that the diagnosis should serve as the primary diagnosis for a Part-A covered SNF stay.

D75.839 “Thrombocytosis”

Change from “Cardiovascular and Coagulations” to “Return to Provider

On October 1, 2021, D75.839 “Thrombocytosis, unspecified,” took effect and was map pedto the clinical category of “Cardiovascular and Coagulations.”

However, there are more specific codes to indicate why a patient with thrombocytosis would require SNF care.

If the cause is unknown, the SNF could use D47.3, “Essential (hemorrhagic) thrombocythemia” or D75.838, “other thrombocytosis” which is a new code that took effect on October 1, 2021.

Further, elevated platelet count without other symptoms is not reason enough for SNF skilled care so this would not be used as a primary diagnosis.

For this reason, CMS has finalized a change to the assignment of D75.839 to “Return to Provider.”

F32.A, “Depression, unspecified”

Change from “Medical Management” to “Return to Provider”

On October 1, 2021, F32.A, “Depression, unspecified” went into effect and was mapped to “Medical Management.”

However, there are more specific codes that would more adequately capture the diagnosis of depression.

Further, while CMS believes that SNFs serve an important role in providing services to those beneficiaries suffering from mental illness, the SNF setting is not the setting that would be most appropriate to treat a patient whose primary diagnosis is depression.

For this reason, CMS has finalized a change to the assignment of F32.A to “Return to Provider.”

Change from
“Medical Management”
to
“Return to Provider”

D89.44, “Hereditary alpha tryptasemia”

On October 1, 2021, D89.44, “Hereditary alpha tryptasemia” went into effect and was mapped to the clinical category, “Medical Management.”

However, this is not a diagnosis that would be treated as a primary condition in the SNF, rather it would be treated in the outpatient setting.

Therefore, CMS has finalized a change to the assignment of D89.44 to “Return to Provider.”.”

Change from
“Acute Neurologic”
to
“Return to Provider”

G92.9, “Unspecified toxic encephalopathy”

On October 1, 2021, G92.9, “Unspecified toxic encephalopathy” took effect and was mapped to the clinical category of “Acute Neurologic.”

However, there are more specific codes that should be used to describe encephalopathy treated in a SNF.

Therefore, CMS has finalized a change to the assignment of G92.9 to “Return to Provider.”

Change from "Non-surgical Orthopedic/ Musculoskeletal" To "Return to Provider"

M54.50, "Low back pain, unspecified"

On October 1, 2021, M54.50, "Low back pain, unspecified" went into effect and was mapped to the clinical category of "Non-surgical Orthopedic/Musculoskeletal."

However, if low back pain were the primary diagnosis, the SNF should have a greater understanding of what is causing the pain. There are more specific codes to address this condition.

Therefore, CMS has finalized a change to the assignment of M54.50 to "Return to Provider."

Change from "Return to Provider" To "Medical Management"

Esophageal Based Codes

In the 2022 proposed rule, a commenter suggested that we frequently require SNF skilled care, from "Return to Provider" to "Medical Management":

K22.11, "Ulcer of esophagus with bleeding;" **K25.0**, "Acute gastric ulcer with hemorrhage;" **K25.1**, "Acute gastric ulcer with perforation;" **K25.2,** "Acute gastric ulcer with both hemorrage and perforation;" **K26.0**, "Acute duodenal ulcer with hemorrhage;" **K26.1**, "Acute duodenal ulcer with perforation;" K26.2, "Acute duodenal ulcer with both hemorrhage and perforation;" **K27.0** "Acute peptic ulcer, site unspecified with hemorrhage;" **K27.1**, "Acute peptic ulcer, site unspecified with perforation;" **K27.2**, "Acute peptic ulcer, site unspecified with both hemorrhage and perforation;" **K28.0**, "Acute gastrojejunal ulcer with hemorrhage;" **K28.1**, "Acute gastrojejunal ulcer with perforation;" **K28.2**, "Acute gastrojejunal ulcer with both hemorrhage and perforation;" and **K29.0**1, "Acute gastritis with bleeding." Upon review of these codes,

CMS recognized that these represent conditions with more specificity than originally considered because of the bleeding (or perforation) that is part of the conditions and that they would more likely be found in SNF patients." Therefore, CMS has finalized a change to the assignment of these ICD-10 codes to "Medical Management."

Generalized Muscle Weakness

No Change from "Return to Provider" To "Non-Orthopedic Surgery"

In the FY 2022 proposed rule a commenter requested that CMS consider remapping M62.81, "Muscle weakness (generalized)" from "Return to Provider" to "Non-orthopedic Surgery" with the rationale that there is currently no sequela or late-effects ICD-10 code available when patients require skilled nursing and therapy due to late effects of resolved infections such as pneumonia or urinary tract infections.

CMS considered the request and determined that muscle weakness (generalized) is nonspecific and if the original condition is resolved, but the resulting muscle weakness persists because of the known original diagnosis, there are more specific codes that exist that would account for why the muscle weakness is on-going, such as muscle wasting or atrophy.

Therefore, CMS did not finalize a change to the assignment of this ICD-10 code to "Non-Orthopedic Surgery."

No Change from "Return to Provider" To "Medical Management"

Adult Failure to Thrive

In the FY 2022 proposed rule a commenter also requested that that CMS consider remapping R62.7, "Adult failure to thrive" from "Return to Provider" to "Medical Management."

According to this commenter, physicians often diagnose adult failure to thrive when a resident has been unable to have oral intake sufficient for survival. Typically, this diagnosis is appended when the physician has determined that a feeding tube should be considered to provide sufficient intake for survival.

According to the commenter, it would then appropriately become the primary diagnosis for a skilled stay.

CMS considered this request and has indicated that R6.2 is a nonspecific code and SNF primary diagnoses should be coded to the highest level of specificity. If the patient has been unable to have oral intake, the primary diagnosis (for example, Ulcerative Colitis) for admission to a SNF should explain why the patient is unable to have oral intake sufficient for survival.

Therefore, CMS did not finalize a change to the assignment of this ICD-10 code to "Medical Management."

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Act, and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospital (CAH) swing-bed rural hospitals.
- Section 1888(e)(6)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual market basket percentage update applicable to a SNF for a fiscal year, after application of the productivity adjustment in the case of a SNF that does not submit 100% of the data necessary to calculate the SNF QRP measures on at least 80% of the MDS assessments submitted.
- **Resources:**
  - SNF QRP
  - Reporting tables for FY 2023
  - SNF QRP Technical Specifications and Addendum
  - HAI Draft Specifications
  - COVID-19 Vaccination Among HCP Specifications
  - Influenza Vaccination Coverage Among HCP
  - TOH Measures and SPADEs
  - Claims Based Measures DTC and PPR
  - MSPB

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- For consistency in regulations, CMS has finalized conforming revisions to the Requirements under the SNF QRP Specifically, CMS has finalized adding new language for the SNF QRP data completeness thresholds. The new language would reflect all data completion thresholds required for SNFs to meet or exceed in order to avoid receiving a 2-percentage point reduction to their annual payment update for a given fiscal year.
- CMS has finalized adding new language to state that SNFs must meet or exceed two separate data completeness thresholds:
  - One threshold set at 80 percent for completion of required quality measures data **and standardized patient assessment data** collected using the MDS submitted through the CMS-designated data submission system, beginning with FY 2018 and for all subsequent payment updates. SNF QRP MDS Items.
  - A second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN, beginning with FY 2023 and for all subsequent payment updates (Including COVID-19 FY 2023 and Influenza Vaccination Measures FU 2024).
- CMS has finalized adding new language to state that these thresholds (80 percent for completion of required quality measures data **and standardized patient assessment data** on the MDS; 100 percent for CDC NHSN data) will apply to all measures and standardized patient assessment data requirements adopted into the SNF QRP.
- CMS has finalized adding new language to state that a SNF must meet or exceed both thresholds to avoid receiving a 2-percentage point reduction to their annual payment update for a given fiscal year.

Current QRP Measures

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

TABLE 15: Quality Measures Currently Adopted for the FY 2023 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider*	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC).
TOH-Patient*	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC).
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) (NQF #3481).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
NHSN	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

*In response to the public health emergency (PHE) for the Coronavirus Disease 2019 (COVID-19), CMS released an Interim Final Rule (85 FR 27595 through 27597) which 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.

New QRP Measures

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- CMS has finalized the adoption of one new measure for the SNF QRP beginning with the FY 2024 SNF QRP: the **Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #0431) measure**.
  - The measure reports on the percentage of HCP who receive influenza vaccination. The term "healthcare personnel" refers to all paid and unpaid persons working in a health care setting, contractual staff not employed by the health care facility, and persons not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP.
  - **To meet the minimum data submission requirements**, SNFs would enter a single influenza vaccination summary report at the conclusion of the measure reporting period. If SNFs submit data more frequently, such as on a monthly basis, the information would be used to calculate one summary score for this measure which would be publicly reported on Care Compare.

Initiation of Delayed QRP Measures

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- In addition, CMS finalized a revision to the compliance date for the collection of the Transfer of Health (TOH) Information to the Provider-PAC measure, the TOH Information to the Patient-PAC measure, and the **six categories of standardized patient assessment data elements** on the **MDS v1.18.11** from October 1st of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE to October 1, 2023.
- CMS believes this date is sufficiently far in advance for SNFs to make the necessary preparations to begin reporting these data elements and the TOH Information measures and that the need for the standardized patient assessment data elements and TOH Information measures have been shown to be even more pressing with issues of health inequities, exacerbated by the COVID-19 PHE.
- CMS has indicated that they will provide training and education for SNFs to be prepared for this implementation date and will release a draft of the updated version of the MDS 3.0 v1.18.11 in early 2023 with sufficient lead time to prepare for the October 1, 2023 start date.

QRP Measures Under Consideration

RFI - SNF QRP Quality Measures under Consideration for Future Years

- CMS requested input on the following potential future SNF QRP Measures;
  - A cross-setting functional measure that would incorporate the domains of self-care and mobility.
  - Measures of health equity, such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities.
  - A COVID-19 Vaccination Coverage measure that would assess whether SNF patients were up to date on their COVID-19 vaccine.

TABLE 16: Future Measures and Measure Concepts Under Consideration for the SNF QRP

Quality Concepts
Cross-Setting Function
Health Equity Measures
PAC – COVID-19 Vaccination Coverage among Patients

RFI - Infection Isolation

- During the COVID-19 PHE, a number of stakeholders raised concerns with the definition of “infection isolation”, as it relates to the treatment of SNF patients being cohorted due to either the diagnosis or suspected diagnosis of COVID-19.
- Specifically, stakeholders took issue with Isolation criterion 1, which requires that the patient have an active infection, rather than suspicion of an active infection, and Isolation criterion 3, which requires that the patient be in the room alone, rather than being cohorted with other patients.
- CMS considered comments made related to this RFI about isolation due to active infection, how the PHE has affected the relative staff time resources necessary for treating these patients, and whether or not the relative increase in resource utilization for each of the patients within a cohorted room, all with an active infection, is the same or comparable to that of the relative increase in resource utilization associated with a patient that is isolated due to an active infection. CMS has indicated that they will take these comments into consideration in future rule making decisions.

RFI- Health Equity

- CMS is committed to achieving equity in health care outcomes for our beneficiaries. In this RFI, we provide an update on the equity work that is occurring across CMS.
- Included are:
  - CMS' plans to expand quality reporting programs to allow provision of more actionable, comprehensive information on health care disparities;
  - measuring health care disparities through quality measurement and reporting these results to providers;
  - and providing an update on methods and research around measure development and disparity reporting.
  - As CMS continue assessing the SNF VBP Program's policies in light of its operation and its expansion as directed by the Consolidated Appropriations Act, CMS requested public comments on policy changes that they should consider on the topic of health equity.
  - CMS specifically requested comments on whether we should consider incorporating adjustments into the SNF VBP Program to reflect the varied patient populations that SNFs serve around the country and tie health equity outcomes to SNF payments under the Program.

RFI - Health Equity Data Considerations

- CMS believes that a focused health equity measure would provide specific equity data that will help providers develop innovative and targeted interventions for impacted groups and would additionally provide transparency for beneficiaries.
- CMS also believes that by leveraging measures to give providers access to disparity information, they would be able to use this data to make informed decisions about their quality improvement initiatives.
- In the proposed rule RFI, CMS requested feedback from stakeholders on the development and inclusion of health equity quality measures for the SNF QRP.
- The goal of the request for information was to describe some key principles and approaches that CMS would consider when advancing the use of quality measure development and stratification to address healthcare disparities and advance health equity across our programs. CMS invited general comments on the principles and approaches as well as additional thoughts about disparity measurement guidelines suitable for overarching consideration across CMS's QRP programs.

RFI - Health Equity Data Considerations

- Specifically, CMS invited comment on the following:
  - Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs
  - Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting
  - Principles for SRF and Demographic Data Selection and Use
  - Identification of Meaningful Performance Differences
  - Guiding Principles for Reporting Disparity Measures
  - Measures Related to Health Equity
- CMS did not respond to specific comments but will consider them in future rule making decisions.

RFI-CoreQ Survey Instrument

- In FY 2023 proposed rule, CMS requested stakeholder feedback on future adoption and implementation of the CoreQ: Short Stay Discharge Measure (CoreQ) into the SNF QRP.
- Specifically, CMS sought comment on the following:
  - Would you support utilizing the CoreQ to collect patient-reported outcomes (PROs)?
  - Do SNFs believe the questions asked in the CoreQ would add value to their patient engagement and quality-of-care goals?
  - Should CMS establish a minimum number of surveys to be collected per reporting period or a waiver for small providers?
  - How long would facilities and customer satisfaction vendors need to accommodatedata collection and reporting for all participating SNFs?
  - What specific challenges do SNFs anticipate for collecting the CoreQ measure?
  - What are potential solutions for those challenges?
- The CoreQ survey instrument is used to assess the level of satisfaction among SNF patients.

CoreQ Specifics

- The CoreQ: Short Stay Discharge Measure calculates the percentage of individuals discharged in a six-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay.
- This patient-reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items:
  1. In recommending this facility to your friends and family, how would you rate it overall;
  2. Overall, how would you rate the staff;
  3. How would you rate the care you receive;
  4. How would you rate how well your discharge needs were met.
- The CoreQ questionnaire uses a 5-point Likert Scale: Poor (1); Average (2); Good (3); Very Good (4); and Excellent (5).

Why is CoreQ's addition an important consideration for QRP?

- SNF QRP furthers CMS's mission to improve the quality of healthcare for beneficiaries through measurement, transparency and public reporting of data. The SNF QRP and CMS's other quality programs are foundational for contributing to improvements in healthcare, enhancing patient outcomes and informing consumer choice.
- In October 2017, CMS launched the Meaningful Measures Framework. This framework captures their vision to address healthcare quality priorities and gaps, including emphasizing digital quality measurement, reducing measurement burden, and promoting patient perspectives, while also focusing on modernization and innovation.
- Meaningful Measures 2.0 builds on the initial framework by establishing a goal of increasing Patient Reported Outcomes Measures (PROMs) by 50%.

What is Meaningful Measures 2.0

- Collection of patient experience data aligns with the person-centered care domain of CMS's Meaningful Measures 2.0 Framework and addresses an aspect of patient experience that is not currently included in the SNF QRP.
- CMS believes collecting and assessing satisfaction data from SNF patients is important for understanding patient experiences and preferences, while ensuring the patient can easily and discretely share their information and provide information to help consumers choose a trusted SNF.
- CMS did not respond to specific comments submitted related to the CoreQ RFI in this final rule, but indicated that they intend to use this input to inform future measure development efforts.

Patient Reported Outcomes

- Patient Reported Outcome (PRO) is any report of the status of a patient's health condition or health behavior that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else.
- Therefore, they are an important component of assessing whether healthcare providers are improving the health and well-being of patients.

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

- **Value Based Purchasing**
  - CMS has indicated that they concerned about the effects of the PHE for COVID-19 on their ability to assess performance on the SNFRM in the SNF VBP Program, namely how the measure's reliability changed, how its current risk-adjustment model does not factor in COVID-19, and how the PHE affected different regions of the country at different times. Therefore, CMS is proposing to once again suppress the SNFRM data for program year FY 2023.
  - CMS has developed several Measure Suppression Factors that they believe should guide their determination of whether to suppress the SNF readmission measure for one or more program years that overlap with the PHE for COVID-19 and will continue to use suppression factor 4.
    - **(1)** Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years.
    - **(2)** Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.
    - **(3)** Rapid or unprecedented changes in:
      - Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
      - The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.
    - **(4)** Significant national shortages or rapid or unprecedented changes in:
      - Healthcare personnel;
      - Medical supplies, equipment, or diagnostic tools or materials; or
      - Patient case volumes or facility-level case mix.

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

- **Value Based Purchasing (Cont.)**
  - For the FY 2023 SNF VBP Program CMS would use the previously finalized performance period (FY 2021) and baseline period (FY 2019) to calculate each SNF's RSRR for the SNFRM. Then, they would suppress the use of SNF readmission measure data for purposes of scoring and payment adjustments.
  - CMS would assign all participating SNFs a performance score of zero in the FY 2023 SNF VBP Program Year. This assignment would result in all participating SNFs receiving an identical performance score, as well as an identical incentive payment multiplier.
  - CMS would reduce each participating SNF's adjusted Federal per diem rate for FY 2023 by 2 percentage points and award each participating SNF 60 percent of that 2 percent withhold, resulting in a 1.2 percent payback for the FY 2023 SNF VBP Program Year.
  - CMS believe this continued application of the 2 percent withhold is required under statute and that a payback percentage that is spread evenly across all participating SNFs is the most equitable way to reduce the impact of the withhold in light of our proposal to award a performance score of zero to all SNFs.
  - Under this proposal, SNFs that do not report a minimum of 25 eligible stays for the SNFRM for the FY 2023 program year would not be included in the SNF VBP for that program year. As a result, the payback percentage for FY 2023 would remain at 60.00 percent.

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

- **Value Based Purchasing (Cont.)**
  - CMS will provide quarterly confidential feedback reports to SNFs and to publicly report the SNFRM rates for the FY 2023 SNF VBP Program Year. However, they would make clear in the public presentation of those data that the measure has been suppressed for purposes of scoring and payment adjustments because of the effects of the PHE for COVID-19 on the data used to calculate the measure. The public presentation would be limited to SNFs that reported the minimum number of eligible stays.
  - Because this was not intended to be an indefinite application but a short-term, equitable approach during the unprecedented PHE, CMS intends to resume the use of the SNFRM for scoring and payment adjustment purposes beginning with the FY 2024 program year. In other words, for FY 2024, for each SNF, CMS would calculate measure scores in the SNF VBP Program and would then calculate a SNF performance score for each SNF and convert the SNF performance scores to value-based incentive payments.
  - CMS examined whether they should should develop an adjustment to the SNFRM that would properly account for COVID-19 patients. After careful examination of each of the four modification options, CMS has finalized its decision to modify the technical specifications of the SNFRM such that beginning with the FY 2023 SNF VBP program year a risk-adjustment variable for both COVID-19 during the PPH and patients with a history of COVID-19 will be added. These cases will remain in the measure's cohort, but CMS will add a variable to the risk adjustment model that accounts for the clinical differences in outcomes for these patients.

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

TABLE 30: Quality Measures Under Consideration for an Expanded Skilled Nursing Facility Value-Based Purchasing Program

Meaningful Measure Area	NQF	Quality Measure
Minimum Data Set		
Functional Outcomes	A2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients*
Functional Outcomes	A2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients*
Preventable Healthcare Harm	0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)**
Preventable Healthcare Harm	0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Ability to Move Independently Worsened (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)**
Transfer of Health Information and Interoperability	N/A	Transfer of Health Information to the Provider–Post Acute Care *
Medication Management	N/A	Percentage of Long-Stay Residents who got an Antipsychotic Medication**

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

Medicare Fee-For-Service Claims Based Measures		
Community Engagement	3481	Discharge to Community Measure-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Patient-focused Episode of Care	N/A	Medicare Spending per Beneficiary (MSPB)-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Healthcare-Associated Infections	N/A	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure~
Admissions and Readmissions to Hospitals	N/A	Number of hospitalizations per 1,000 long-stay resident days (Long Stay)**
Patient-Reported Outcome-Based Performance Measure		
Functional Outcomes	N/A	Patient-Reported Outcomes Measurement Information System [PROMIS]-PROMIS Global Health, Physical
Survey Questionnaire (similar to Consumer Assessment of Healthcare Providers and Systems (CAHPS))		
Patient's Experience of Care	2614	CoreQ: Short Stay Discharge Measure
Payroll Based Journal		
N/A	N/A	Nurse staffing hours per resident day: Registered Nurse (RN) hours per resident per day; Total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day**

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

- **Value Based Purchasing Expansion with QRP Measures**
  - On December 27, 2020, Congress enacted the Consolidated Appropriations Act, 2021 which allows the Secretary to add up to nine new measures to the SNF VBP Program with respect to payments for services furnished on or after October 1, 2023.
  - CMS has finalized the adoption of two new quality measures for the SNF VBP Program beginning with the FY 2026 program year:
    - (1) Skilled Nursing Facility (SNF) Healthcare Associated Infections (HAI) Requiring Hospitalization (SNF HAI) measure (Patient Safety Domain – Meaningful Measures 2.0 Framework);
      - This measure estimates the risk-standardized rate of HAIs that are acquired during SNF care and result in hospitalization using 1 year of Medicare FFS claims data. A HAI is defined, for the purposes of this measure, as an infection that is likely to be acquired during SNF care and severe enough to require hospitalization, or an infection related to invasive (not implanted) medical devices (for example, catheters, insulin pumps, and central lines).

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

- **Value Based Purchasing <u>Performance and Baseline Period Proposals</u>**
  - **SNF HAI Measure**
    - CMS has finalized a 1-year performance period for the SNF HAI measure would be operationally feasible for the SNF VBP Program and would provide sufficiently accurate and reliable SNF HAI measure rates and resulting performance scores.
    - CMS has finalized FY 2024 (**October 1, 2023 through September 30, 2024**) as the performance period for the SNF HAI measure for the FY 2026 SNF VBP Program.
    - CMS has finalized FY 2022 (**October 1, 2021 through September 30, 2022**) as the baseline period for the SNF HAI measure for the FY 2026 SNF VBP Program.
    - CMS has also finalized that SNFs must have a minimum of 25 eligible stays during the applicable 1-year performance period in order to be eligible to receive a score on the measure.

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

- **Value Based Purchasing Expansion with QRP Measures**
  - (2) Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure (Person Centered Care Domain – Meaningful Measures 2.0 Framework).
    - Case mix adjusted hours will be calculated the same as for 5-Star (Hours Adjusted = (Hours Reported/Hours CaseMix) * Hours National Average)
    - The **numerator** for the measure is total nursing hours (RN + LPN + NA hours). RN hours include the RN director of nursing, RNs with administrative duties, and RNs.
    - The **denominator** for the measure is a count of daily resident census derived from MDS resident assessments.
    - CMS is proposing to report the measure rate for the SNF VBP Program for each SNF as a simple average rate of total nurse staffing per resident day across available quarters in the 1-year performance period.

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

- **Value Based Purchasing <u>Performance and Baseline Period Proposals</u>**
  - **Total Nursing Hours per Resident Day Staffing Measure and**
    - CMS has finalized FY 2024 (**October 1, 2023 through September 30, 2024**), as the performance period for the Total Nurse Staffing measure for the FY 2026 SNF VBP program year.
    - CMS has finalized FY 2022 (**October 1, 2021 through September 30, 2022**) as the baseline period for the Total Nurse Staffing measure for the FY 2026 SNF VBP Program.
    - CMS has finalized that SNFs must have a minimum of 25 residents, on average, across all available quarters during the applicable 1-year performance period in order to be eligible to receive a score on the measure.

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

- **Value Based Purchasing Expansion with QRP Measures**
  - CMS finalized the adoption of an additional quality measure for the SNF VBP Program beginning with the FY 2027 program year:
    - Discharge to Community (DTC) – Post-Acute Care (PAC) Measure for Skilled Nursing Facilities (NQF #3481).
      - This measure reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home or selfcare, with or without home health services.
  - CMS is also currently reviewing measures of patient falls and functional status, to determine whether any of them would be appropriate for the SNF VBP Program.

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

- **Value Based Purchasing <u>Performance and Baseline Period Proposals</u>**
  - **Discharge to Community – PAC SNF QRP Measure**
    - CMS has finalized calculating the performance period for the DTC PAC SNF measure using <u>two consecutive years of data by proposing to adopt FY 2024 through FY 2025 (**October 1, 2023 through September 30, 2025**</u>) as the performance period for the DTC PAC SNF measure for the FY 2027 SNF VBP Program.
    - In addition, has finalized the adoption of FY 2021 through FY 2022 (**October 1, 2020 through September 30, 2022**) as the baseline period for the DTC PAC SNF measure for the FY 2027 SNF VBP Program.
    - CMS is also proposing that SNFs must have a minimum of 25 eligible stays during the applicable 2-year performance period in order to be eligible to receive a score on the measure.

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

- **Value Based Purchasing <u>Performance and Baseline Period Proposals</u>**
  - **SNFRM**
    - To avoid COVID related effects, CMS finalized its decision to use a baseline period of FY 2019 for the FY 2025 program year.
    - CMS has finalized the decision that beginning with the FY 2023 program year, SNFs must have a case minimum of 25 eligible stays for the SNFRM during the applicable 1-year performance period in order to be eligible to receive a score on that measure under the SNF VBP Program. This will also affect what data is displayed on Care Compare.

TABLE 17: Final FY 2025 SNF VBP Program Performance Standards

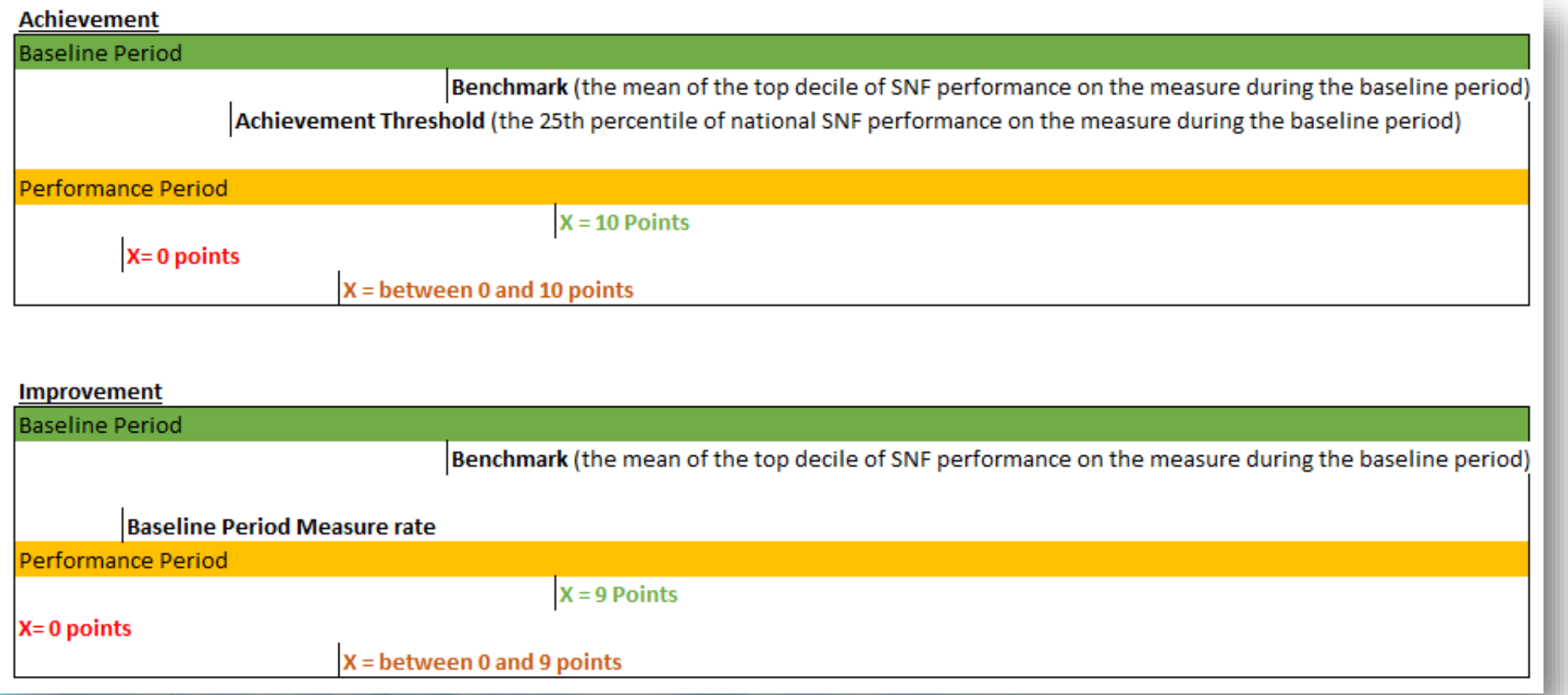
Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79139	0.82912

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

- **Value Based Purchasing Expanded Measure <u>Performance Scoring</u>**
  - CMS is finalizing a policy for FY 2026 that SNFs must have the minimum number of cases for two of the three measures during the performance period to receive a performance score and value-based incentive payment, and for FY 2027 that SNFs must have the minimum number of cases for three of the four measures during a performance period to receive a performance score and value-based incentive payment.
  - CMS has also finalized the application of the current policy that scores SNFs based only on their achievement, not on their improvement, during the performance period for any program year for which they do not have sufficient baseline period data, which CMS defines as SNFs with fewer than 25 eligible stays during the baseline period for a fiscal year to the expanded VBP measures.
  - CMS has finalized updating the achievement and improvement scoring methodology, applicable to all expanded VBP measures, to allow a SNF to earn a maximum of 10 points on each measure for achievement, and a maximum of 9 points on each measure for improvement.
  - For purposes of determining these points, CMS has finalized the following definitions:
  - **Benchmark:** The mean of the top decile of SNF performance on the measure during the baseline period; and
  - **Achievement threshold:** The 25th percentile of national SNF performance on the measure during the baseline period.

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

- **Value Based Purchasing Expanded Measure <u>Performance Scoring</u>**



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

- **Value Based Purchasing Expanded Measure <u>Performance Scoring</u>**
  - CMS will score SNFs' performance on achievement and improvement for each measure and award them the higher of the two scores for each measure to be included in the SNF performance score, except in the instance that the SNF does not meet the case minimum threshold for the measure during the applicable baseline period, in which case SNFs would only be scored on achievement.
  - CMS will then sum each SNFs' measure points and normalize them to arrive at a SNF performance score that ranges between 0 and 100 points.
  - This policy is intended to appropriately recognizes the best performers on each measure and reserves the maximum points for their performance levels while also recognizing that improvement over time is important and should also be rewarded.

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

- **Value Based Purchasing Expanded Measure <u>LV Public Reporting</u>**
  - As a result of these policies, and in order to implement them for purposes of clarity and transparency in our public reporting, CMS is revising a data suppression policy as follows:
  - (1) If a SNF does not have the minimum number of cases during the baseline period that applies to a measure for a program year, we would publicly report the SNF's measure rate and achievement score if the SNF had minimum number of cases for the measure during the performance period for the program year;
  - (2) If a SNF does not have the minimum number of cases during the performance period that applies to a measure for a program year, we would not publicly report any information on the SNF's performance on that measure for the program year;
  - (3) If a SNF does not have the minimum number of measures during the performance period for a program year, we would not publicly report any data for that SNF for the program year.

RFI- Staffing Turnover Measures in a Future SNF VBP Program Year

- As a part of CMS' goals to build a robust and comprehensive measure set for the SNF VBP Program and in alignment with stakeholder recommendations, CMS intends to propose to adopt a staffing turnover measure in the SNF VBP Program in the FY 2024 SNF PPS proposed rule. Specifically, the measure CMS intends to include in the SNF VBP program is the percent of total nurse staff that have left the facility over the last year. Total nurse staff include RNs, LPNs, and nurse aides.
- In addition, CMS is interested in whether we should explore the development of a composite measure that would capture multiple aspects of staffing, including both total nurse hours and the staff turnover measure rather than having separate but related measures related to nursing home staffing, such a measure could potentially replace the initial measure we intend to propose to include in SNF VBP for FY 2024.
- CMS has indicated that they will take stakeholder feedback in response to this proposal into consideration as they develop policies for the FY 2024 SNF PPS proposed rule.

RFI- COVID-19 Vaccination Coverage among Healthcare Personnel Measure in a Future SNF VBP Program Year

- CMS is also considering the inclusion of the National Healthcare Safety Network (NHSN) COVID-19 Vaccination Coverage among Healthcare Personnel measure, which measures the percentage of healthcare personnel who receive a complete COVID-19 vaccination course.
- CMS has indicated that they will take stakeholder feedback into consideration as they develop policies for future rulemaking.

Request for comments - Updating the SNF VBP Program Exchange Function

- CMS requested stakeholders' feedback on whether they should consider proposing either a new functional form or modified logistic exchange function for the SNF VBP Program.
- In the context of a value-based purchasing program employing multiple measures, CMS is considering whether a new functional form or modifications to the existing logistic exchange function may provide the best incentives to SNFs to improve on the Program's measures
- Specifically, CMS requested comments on whether the addition of new quality measures in the Program should weigh in favor of a new exchange function form, a modified logistic exchange function, or no change to the existing exchange function, whether stakeholders believe that the increased incentive payment percentages for top performers offered by the logistic function should outweigh the simplicity of the linear function, and whether we should further consider either the cube, cube root, or other functional forms.
- CMS Indicated that they will take this feedback into consideration as they develop policies for future rulemaking.

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

- As CMS continues assessing the SNF VBP Program's policies in light of its operation and its expansion as directed by the Consolidated Appropriations Act, CMS requested public comments on policy changes that they should consider on the topic of health equity.
- CMS specifically requested comments on whether they should consider incorporating adjustments into the SNF VBP Program to reflect the varied patient populations that SNFs serve around the country and tie health equity outcomes to SNF payments under the Program.
- These adjustments could occur at the measure level in forms such as stratification (for example, based on dual status or other metrics) or including measures of social determinants of health (SDOH).
- These adjustments could also be incorporated at the scoring or incentive payment level in forms such as modified benchmarks, points adjustments, or modified incentive payment multipliers (for example, peer comparison groups based on whether the facility includes a high proportion of dual eligible beneficiaries or other metrics).
- CMS requested commenters' views on which of these adjustments, if any, would be most effective for the SNF VBP Program at accounting for any health equity issues that we may observe in the SNF population.
- CMS has indicated that they will take stakeholder feedback into consideration as they develop our policies for future rulemaking.

Request for comments - on the Validation of SNF Measures and Assessment Data

- CMS has adopted measures for the SNF VBP Program that are calculated using data from a variety of sources, including Medicare FFS claims, the minimum data set (MDS), and the PBJ system, and CMS is seeking feedback on the adoption of additional validation procedures. In addition, section 1888(h)(12) of the Act requires the Secretary to apply a process to validate SNF VBP program measures, quality measure data, and assessment data as appropriate.
- Although the MDS data sets are assessed for accuracy, CMS is interested in ensuring the validity of the data reported by skilled nursing facilities because use of this data would have payment implications under the SNF VBP Program.
- Accordingly, CMS requested stakeholder feedback on the feasibility and need to select SNFs for validation via a chart review to determine the accuracy of elements entered into MDS 3.0 and PBJ.
- Additionally, CMS requested feedback on data validation methods and procedures that could be utilized to ensure data element validity and accuracy.

Request for comments - on the Validation of SNF Measures and Assessment Data

- CMS requested feedback on the volume of facilities to select for validation under the SNF VBP Program.
- CMS also requested stakeholder's feedback on the use of both random and targeted selection of facilities for validation.
- Finally, CMS requested stakeholder feedback on the implementation timeline for additional SNF VBP Program validation processes, as well as validation processes for other quality measures and assessment data.
- CMS believes it may be feasible to implement additional validation procedures beginning with data from the FY 2026 program year, at the earliest.

RFI- Revising the Requirements for Long-Term Care (LTC) Facilities to Establish Mandatory Minimum Staffing Levels

- CMS intends to propose in future rulemaking the minimum standards for staffing adequacy that nursing homes would be required to meet.
- CMS will conduct a new research study to help inform policy decisions related to determining the level and type of staffing needed to ensure safe and quality care and expect to issue proposed rules within one year.
- CMS solicited public comments on opportunities to improve health and safety standards to promote thoughtful, informed staffing plans and decisions within LTC facilities that aim to meet resident needs, including maintaining or improving resident function and quality of life. CMS stated that such an approach is essential to effective person-centered care and that they are considering policy options for future rulemaking to establish specific minimum direct care staffing standards and sought stakeholder input to inform policy decisions.
- Specifically, CMS solicited stakeholder input on options for future rulemaking regarding adequate staffing levels and asked questions that should be considered as they evaluate future policy options

RFI- Revising the Requirements for Long-Term Care (LTC) Facilities to Establish Mandatory Minimum Staffing Levels

- CMS received 3,129 comments from a variety of interested parties involved in long-term care issues, including advocacy groups, long-term care ombudsmen, industry associations (providers), labor unions and organizations, nursing home staff and administrators, industry experts and other researchers, family members and caretakers of nursing home residents.
- CMS noted in response to comments that staff levels in nursing homes have a substantial impact on the quality of care and outcomes residents experience and that the input received will be used in conjunction with a new research study being conducted by CMS to determine the level and type of nursing home staffing needed to ensure safe and quality care.
- **CMS intends to issue proposed rules on a minimum staffing level measure within one year. CMS will consider the feedback that received on this RFI for the upcoming rulemaking and changes to the LTC facility requirements for participation.**
- This feedback from a wide range of interested parties will help to **establish minimum staffing requirements** that ensure all residents are provided safe, quality care, and that workers have the support they need to provide high-quality care.

Revision of Requirements for the Director of Food and Nutrition Services

- CMS has withdrawn a former proposal and has finalized revised requirements for the director of food and nutrition services.

- The director of food and nutrition services must meet the following requirements, some of which remain unchanged from current regulations:
  - In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers (**existing** §483.60(a)(2)(ii)); and
  - Receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional (existing §483.60(a)(2)(iii)). **In addition, the director will need to meet the conditions of one of the following five options, four of which are retained from the existing rule:**
  - Have 2 or more years of experience in the position of a director of food and nutrition services, and have completed a minimum course of study in food safety, by no later than 1 year following the effective date of this rule **(Oct. 1, 2023)**, that includes topics integral to managing dietary operations such as, but not limited to, foodborne illness, sanitation procedures, food purchasing/receiving, etc. (**new** §483.60(a)(2)(i)(E)) (we note that this would essentially be the equivalent of a ServSafe Food Manager certification); **or**
  - Be a certified dietary manager (**existing** § 483.60(a)(2)(i)(A)); **or**
  - Be a certified food service manager (**existing** § 483.60(a)(2)(i)(B)); **or**
  - Have similar national certification for food service management and safety from a national certifying body(**existing** § 483.60(a)(2)(i)(C)); **or**
  - Have an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning (**existing** § 483.60(a)(2)(i)(D)).

Revision of Requirements for Physical Environmental Requirements; Life Safety Code

- CMS has finalized a proposal to allow those existing LTC facilities (those that were Medicare or Medicaid certified before July 5, 2016) that have previously used the FSES to determine equivalent fire protection levels, to use an alternate scoring methodology to meet the requirements.
- Specifically, CMS proposed to have facilities use the mandatory values provided in the proposed regulations text at § 483.90(a)(1)(iii) when determining compliance for containment, extinguishment and people movement requirements.
- In the proposed rule, CMS noted that allowing the use of the provided mandatory scoring values will continue to provide the same amount of safety for residents and staff as has been provided since CMS began utilizing the score values set out in the FSES.
- CMS also indicated that the proposed values would allow existing LTC facilities that previously met the FSES requirements to continue to do so without incurring great expense to change their construction types.

TABLE 18: Final Mandatory Values—Nursing Homes

	Containment (Sa)		Extinguishment (Sb)		People Movement (Sc)	
Zone Location	New	Exist.	New	Exist.	New	Exist.
1st story	11	5	15(12)*	4	8(5)*	1
2nd or 3rd story	15	9	17(14)*	6	10(7)*	3
4th story or higher	18	9	19(16)*	6	11(8)*	3

* Use ( ) in zones that do not contain patient sleeping rooms.

Financial Impact SNF PPS FY 2023

TABLE 19: Impact to the SNF PPS for FY 2023

Impact Categories	Number of Facilities	Parity Adjustment Recalibration	Update Wage Data	Total Change
Group				
Total	15,541	-2.3%	0.0%	2.7%
Urban	11,216	-2.3%	0.0%	2.7%
Rural	4,325	-2.2%	-0.3%	2.5%
Hospital-based urban	378	-2.3%	0.3%	3.0%
Freestanding urban	10,847	-2.3%	0.0%	2.7%
Hospital-based rural	410	-2.2%	-0.5%	2.3%
Freestanding rural	3,906	-2.2%	-0.3%	2.5%
Urban by region	-	-	-	
New England	753	-2.3%	-0.7%	2.0%
Middle Atlantic	1,492	-2.4%	0.3%	2.9%
South Atlantic	1,948	-2.3%	-0.4%	2.3%
East North Central	2,155	-2.3%	-0.3%	2.4%
East South Central	556	-2.2%	-0.4%	2.3%
West North Central	957	-2.3%	-0.5%	2.2%
West South Central	1,413	-2.3%	0.3%	3.1%
Mountain	552	-2.3%	-0.1%	2.5%
Pacific	1,393	-2.4%	1.0%	3.6%
Outlying	6	-2.0%	-1.5%	1.4%
Rural by region	-	-	-	
New England	115	-2.3%	0.3%	3.0%
Middle Atlantic	210	-2.2%	-0.5%	2.2%
South Atlantic	499	-2.2%	-0.2%	2.6%
East North Central	935	-2.2%	-0.9%	1.8%
East South Central	489	-2.2%	-0.3%	2.5%
West North Central	1,038	-2.2%	0.0%	2.7%
West South Central	723	-2.2%	0.6%	3.4%
Mountain	211	-2.3%	-0.3%	2.4%
Pacific	95	-2.4%	-1.0%	1.6%
Outlying	1	-2.3%	0.0%	2.7%
Ownership	-	-	-	
For profit	10,901	-2.3%	0.1%	2.7%
Non-profit	3,638	-2.3%	-0.2%	2.5%
Government	1,002	-2.3%	-0.1%	2.6%

Note: The Total column includes the FY 2023 5.1 percent market basket update factor. The values presented in this table may not sum due to rounding.

Financial Impact

Influenza Vaccination Data Gathering

FY 2023

TABLE 20: U.S. Bureau of Labor and Statistics' May 2020 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Administrative Assistant	43-6013	$18.75	$18.75	$37.50

Financial Impact

TOH Data Gathering starting

FY 2024

TABLE 21: U.S. Bureau of Labor and Statistics' May 2020 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse	29-1141	$38.47	$38.47	$76.94
Licensed Vocational Nurse (LVN)	29-2061	$24.08	$24.08	$48.16

Financial Impact

Payment Update, VBP, QRP

TABLE 1: Cost and Benefits

Provision Description	Total Transfers/Costs
FY 2023 SNF PPS payment rate update	The overall economic impact of this final rule is an estimated increase of $904 million in aggregate payments to SNFs during FY 2023.
FY 2023 SNF QRP changes	The overall economic impact of this final rule is an estimated increase in aggregate cost to SNFs of $30,949,079.36.
FY 2023 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $185.55 million in aggregate payments to SNFs during FY 2023.

Financial Impact

VBP 2023

TABLE 22: Estimated SNF VBP Program Impacts for FY 2023

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive multiplier	Percent of total payment
Group					
Total*	10,707	19.74	0.0000	0.99200	100.00
Urban	8,352	19.77	0.0000	0.99200	87.09
Rural	2,355	19.64	0.0000	0.99200	12.91
Hospital-based urban**	208	19.45	0.0000	0.99200	1.79
Freestanding urban**	8,132	19.78	0.0000	0.99200	85.28
Hospital-based rural**	88	19.19	0.0000	0.99200	0.35
Freestanding rural**	2,197	19.65	0.0000	0.99200	12.42
Urban by region					
New England	617	19.83	0.0000	0.99200	5.46
Middle Atlantic	1,246	19.56	0.0000	0.99200	17.97
South Atlantic	1,626	19.86	0.0000	0.99200	17.71
East North Central	1,486	19.95	0.0000	0.99200	12.62
East South Central	446	19.91	0.0000	0.99200	3.52
West North Central	544	19.79	0.0000	0.99200	3.74
West South Central	874	20.05	0.0000	0.99200	6.82
Mountain	379	19.30	0.0000	0.99200	3.84
Pacific	1,131	19.48	0.0000	0.99200	15.42
Outlying	3	21.41	0.0000	0.99200	0.00
Rural by region					
New England	81	18.99	0.0000	0.99200	0.58
Middle Atlantic	161	19.42	0.0000	0.99200	0.92
South Atlantic	342	19.81	0.0000	0.99200	2.09
East North Central	568	19.50	0.0000	0.99200	3.02
East South Central	388	19.86	0.0000	0.99200	2.19
West North Central	298	19.55	0.0000	0.99200	1.19
West South Central	350	20.14	0.0000	0.99200	1.76
Mountain	101	19.11	0.0000	0.99200	0.55
Pacific	66	18.54	0.0000	0.99200	0.63
Outlying	0	-	-	-	-
Ownership					
Government	453	19.50	0.0000	0.99200	2.89
Profit	7,738	19.79	0.0000	0.99200	75.02
Non-Profit	2,516	19.62	0.0000	0.99200	22.08

* The total group category excludes 4,213 SNFs who failed to meet the proposed measure minimum policy.
** The group category which includes hospital-based/freestanding by urban/rural excludes 82 swing bed SNFs which satisfied the proposed case minimum policy.

Financial Impact VBP 2026

TABLE 23: Estimated SNF VBP Program Impacts for FY 2026

Characteristic	Number of facilities	Mean Risk-Standardized Rate of Hospital-Acquired Infections (SNF HAI) (%)	Mean Total Nursing Hours per Resident Day (Total Nurse Staffing)	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Group							
Total*	13,188	5.93	3.83	19.97	35.4559	0.99144	100.00
Urban	9,851	5.88	3.85	20.02	35.7219	0.99158	85.97
Rural	3,337	6.09	3.77	19.83	34.6706	0.99102	14.03
Hospital-based urban**	250	4.50	5.25	19.68	57.6328	1.00449	1.85
Freestanding urban**	9,582	5.92	3.81	20.03	35.1215	0.99122	84.09
Hospital-based rural**	126	4.94	4.88	19.30	53.2646	1.00219	0.41
Freestanding rural**	3,106	6.20	3.72	19.85	33.2724	0.99020	13.46
Urban by region							
New England	697	5.48	3.89	20.27	37.2305	0.99201	5.31
Middle Atlantic	1,385	5.77	3.63	19.76	35.5796	0.99174	17.26
South Atlantic	1,795	5.90	3.96	20.11	36.1595	0.99164	17.12
East North Central	1,803	5.85	3.64	20.19	32.7999	0.99002	12.64
East South Central	522	5.98	3.87	20.24	33.6477	0.99035	3.48
West North Central	740	5.79	4.18	20.01	39.3962	0.99374	3.94
West South Central	1,182	6.21	3.61	20.33	29.2867	0.98803	7.32
Mountain	460	5.32	4.00	19.43	44.0399	0.99642	3.85
Pacific	1,262	6.15	4.19	19.63	40.2634	0.99407	15.04
Outlying	5	4.84	4.83	21.00	44.0008	0.99456	0.00
Rural by region							
New England	106	5.30	4.13	19.02	48.9337	0.99981	0.61
Middle Atlantic	191	5.71	3.45	19.27	36.2703	0.99190	0.91
South Atlantic	425	6.06	3.61	19.97	31.9994	0.98959	2.11
East North Central	752	5.94	3.59	19.68	34.0636	0.99061	3.20
East South Central	455	6.34	3.84	20.20	34.1364	0.99085	2.18
West North Central	637	6.15	4.04	19.77	36.7251	0.99187	1.69
West South Central	546	6.57	3.68	20.35	28.4586	0.98762	2.09
Mountain	148	5.60	3.93	19.21	41.2598	0.99468	0.63
Pacific	77	5.50	4.22	18.71	49.2824	0.99987	0.62
Outlying	0	-	-	-	-	-	-
Ownership							
Government	617	5.75	4.07	19.79	40.2540	0.99434	3.05
Profit	9,507	6.13	3.66	20.04	31.9439	0.98935	74.88
Non-Profit	3,064	5.38	4.32	19.81	45.3868	0.99731	22.06

* The total group category excludes 2,144 SNFs who failed to meet the proposed measure minimum policy.
** The group category which includes hospital-based/freestanding by urban/rural excludes 124 swing bed SNFs which satisfied the proposed measure minimum policy.

Financial Impact VBP 2027

TABLE 24: Estimated SNF VBP Program Impacts for FY 2027

Characteristic	Number of facilities	Mean Risk-Standardized Rate of Hospital-Acquired Infections (SNF HAI) (%)	Mean Total Nursing Hours per Resident Day (Total Nurse Staffing)	Mean Risk-Standardized Discharge to Community Rate (DTC PAC) (%)	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive multiplier	Percent of total payment
Total*	12,929	5.94	3.82	53.39	19.97	36.3098	0.99067	100.00
Urban	9,675	5.89	3.84	54.02	20.02	37.0070	0.99107	86.03
Rural	3,254	6.10	3.76	51.54	19.83	34.2368	0.98950	13.97
Hospital-based urban**	222	4.54	5.13	64.29	19.69	61.4924	1.00497	1.74
Freestanding urban**	9,436	5.92	3.81	53.75	20.03	36.3859	0.99072	84.27
Hospital-based rural**	117	4.98	4.75	57.06	19.30	52.2485	0.99924	0.40
Freestanding rural**	3,035	6.20	3.72	50.71	19.84	32.5035	0.98851	13.41
Urban by region								
New England	690	5.47	3.89	57.59	20.27	40.3491	0.99250	5.34
Middle Atlantic	1,365	5.78	3.61	51.75	19.75	35.1747	0.99015	17.30
South Atlantic	1,781	5.90	3.94	54.31	20.11	37.5012	0.99120	17.19
East North Central	1,776	5.86	3.63	54.87	20.20	35.2015	0.99021	12.64
East South Central	516	5.99	3.86	52.97	20.24	34.6611	0.98973	3.49
West North Central	720	5.79	4.18	53.70	20.01	39.3350	0.99230	3.93
West South Central	1,125	6.23	3.60	51.21	20.35	30.1480	0.98761	7.22
Mountain	450	5.32	3.98	60.00	19.42	47.5690	0.99682	3.85
Pacific	1,247	6.16	4.18	53.90	19.64	40.9666	0.99318	15.07
Outlying	5	4.84	4.83	65.19	21.00	53.3254	1.00110	0.00
Rural by region								
New England	106	5.30	4.13	56.39	19.02	48.3424	0.99732	0.61
Middle Atlantic	188	5.72	3.45	49.69	19.26	34.0341	0.98928	0.91
South Atlantic	416	6.04	3.61	50.48	19.97	31.8067	0.98829	2.11
East North Central	740	5.94	3.59	53.62	19.68	34.9419	0.98974	3.20
East South Central	450	6.36	3.84	50.57	20.21	33.5263	0.98947	2.18
West North Central	615	6.17	4.05	50.05	19.77	34.4533	0.98918	1.67
West South Central	518	6.57	3.67	50.02	20.35	28.6480	0.98679	2.04
Mountain	144	5.62	3.83	54.57	19.21	40.8260	0.99289	0.63
Pacific	77	5.50	4.22	57.20	18.71	49.3633	0.99804	0.62
Outlying	0	-	-	-	-	-	-	-
Ownership								
Government	591	5.77	4.03	53.36	19.78	40.0316	0.99271	3.01
Profit	9,331	6.13	3.66	52.15	20.04	32.7939	0.98874	74.96
Non-Profit	3,007	5.39	4.30	57.25	19.81	46.4886	0.99629	22.03

* The total group category excludes 2,403 SNFs who failed to meet the proposed measure minimum policy.
** The group category which includes hospital-based/freestanding by urban/rural excludes 119 swing bed SNFs which satisfied the proposed measure minimum policy.

Cumulative Financial Impact 2023

Consider Cumulative Financial Impact (revised for FY 2023)

Sequestration: -2% rate adjustment
Value Based Purchasing: -2% rate adjustment (-0.8 FY 2023)
Quality Reporting: -2% adjustment to the APU for reporting non-compliance **plus** the additional cost of reporting new data **plus** non-compliance enforcement actions related to reporting as well as staff vaccination mandate
Parity Adjustment: -2.3% CMI adjustment FY 2023 and 2.3% CMI adjustment for FY 2024
Wage Index Adjustments: Location Specific FY 2023 ranges
Rural: -0.10% to -7.03% (Capped at 5%). 40% of states negative WI adjustment, 4% capped at 5%
Urban: -0.01 to -8.69 (Capped at 5%) 45% of counties negative WI adjustment, 5% capped at 5%
Staffing: 5-star adjustments July 2022, SOM revisions to survey guidance with potential CMP's and possible future staffing mandates.

QUESTIONS?

Find Out More

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