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BROAD RIVER REHAB

SNF PPS FY 2025 Proposed 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 30 days

Agenda

FY 2025 SNF PPS Proposed Rule

- FY 2025 Updates to the SNF Payment Rates
- Wage Index Adjustments
- 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 update
- RFI's
- Nursing Home Enforcement Proposals
- Financial Impact

Proposed FY 2025 Updated 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 FY 2025, CMS has proposed an update to the Market Basket of 2.8% which has been adjusted upward to 4.5% due to a 1.7% forecast error adjustment (>0.5% threshold).

TABLE 2: Difference Between the Actual and Forecasted Market Basket Increases for FY 2023

Index	Forecasted FY 2023 Increase*	Actual FY 2023 Increase**	FY 2023 Difference
SNF	3.9	5.6	1.7

  - Forecast data based on second quarter 2022 IGI forecast (2018-based SNF market basket).
  - Actual data based on the fourth quarter 2023 IGI forecast (2018-based SNF market basket), with historical data through third quarter 2023.
  - Finally, CMS has proposed reducing the FY 2025 Market Basket update to **4.1%** due to a 0.4% productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity).

FY 2025 Proposed SNF Payment Rates

FY 2024 Corrected Base Rates

FY 2025 Proposed Base Rates

TABLE 3—FY 2024 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$70.26	$65.40	$26.23	$122.47	$92.40	$109.68

TABLE 4—FY 2024 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$80.09	$73.56	$33.05	$117.01	88.28	$111.71

TABLE 3: Proposed FY 2025 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$73.16	$68.10	$27.31	$127.52	$96.21	$114.20

TABLE 4: Proposed FY 2025 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$83.39	$76.59	$34.41	$121.83	$91.92	$116.31

FY 2025 Proposed 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

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$106.08	1.41	$96.02	0.64	$17.48	ES3	3.84	$489.68	3.06	$294.40
B	1.61	$117.79	1.54	$104.87	1.72	$46.97	ES2	2.90	$369.81	2.39	$229.94
C	1.78	$130.22	1.60	$108.96	2.52	$68.82	ES1	2.77	$353.23	1.74	$167.41
D	1.81	$132.42	1.45	$98.75	1.38	$37.69	HDE2	2.27	$289.47	1.26	$121.22
E	1.34	$98.03	1.33	$90.57	2.21	$60.36	HDE1	1.88	$239.74	0.91	$87.55
F	1.52	$111.20	1.51	$102.83	2.82	$77.01	HBC2	2.12	$270.34	0.68	$65.42
G	1.58	$115.59	1.55	$105.56	1.93	$52.71	HBC1	1.76	$224.44	-	-
H	1.10	$80.48	1.09	$74.23	2.7	$73.74	LDE2	1.97	$251.21	-	-
I	1.07	$78.28	1.12	$76.27	3.34	$91.22	LDE1	1.64	$209.13	-	-
J	1.34	$98.03	1.37	$93.30	2.83	$77.29	LBC2	1.63	$207.86	-	-
K	1.44	$105.35	1.46	$99.43	3.50	$95.59	LBC1	1.35	$172.15	-	-
L	1.03	$75.35	1.05	$71.51	3.98	$108.69	CDE2	1.77	$225.71	-	-
M	1.20	$87.79	1.23	$83.76	-	-	CDE1	1.53	$195.11	-	-
N	1.40	$102.42	1.42	$96.70	-	-	CBC2	1.47	$187.45	-	-
O	1.47	$107.55	1.47	$100.11	-	-	CA2	1.03	$131.35	-	-
P	1.02	$74.62	1.03	$70.14	-	-	CBC1	1.27	$161.95	-	-
Q	-	-	-	-	-	-	CA1	0.89	$113.49	-	-
R	-	-	-	-	-	-	BAB2	0.98	$124.97	-	-
S	-	-	-	-	-	-	BAB1	0.94	$119.87	-	-
T	-	-	-	-	-	-	PDE2	1.48	$188.73	-	-
U	-	-	-	-	-	-	PDE1	1.39	$177.25	-	-
V	-	-	-	-	-	-	PBC2	1.15	$146.65	-	-
W	-	-	-	-	-	-	PA2	0.67	$85.44	-	-
X	-	-	-	-	-	-	PBC1	1.07	$136.45	-	-
Y	-	-	-	-	-	-	PA1	0.62	$79.06	-	-

FY 2025 Proposed 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

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

Proposed FY 2025 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 2025,
  - 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 proposed wage index data for FY 2025 can be found at:

    https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/wage-index
  - The applicable SNF PPS wage index is assigned to the labor related portion of the rate using the area hospital labor market.
  - On July 21, 2023, OMB issued Bulletin No. 23-01 which updates CBSA data from Bulletin No. 20-01 based upon the 2020 Standards for Delineating Core Based Statistical Areas.

Proposed FY 2025 Wage Index Adjustments

- **Wage Index (cont.)**
  - The revisions OMB published on July 21, 2023 contain a number of significant changes. For example, under the proposed revised OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would split apart.
  - 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.
  - In the FY 2023 final rule, CMS finalized 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.**
  - Additionally, CMS finalized a policy 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.

Proposed FY 2025 Wage Index Adjustments

Impact of FY 2025 Proposed Wage Index Changes

Impact	Stats
All Counties (3222)	
Counties that changed from Uban to Rural or from Rural to Urban	108 or 3.3%
Urban Counties that would become Rural	54 or 1.7%
Rural Counties that would become Urban	54 or 1.7%
Counties that would experience a CBSA name change	360 or 11.0%
Counties that would change CBSAs	197 or 6.0%
5% Capped	195 or 6%
Negative WI change	1335 or 41%
Positive WI change	1887 or 59%
WI diff Spread	50.28% to -37.73
Urban Counties (1252)	
5% Capped	82 or 7%
Negative WI change	568 or 45%
Positive WI change	684 or 55%
WI diff Spread	50.28 to -20.17
Rural Counties (1970)	
5% Capped	113 or 6%
Negative WI change	767 or 39%
Positive WI change	1203 or 61%
WI diff Spread	16.25 to -37.73

Proposed FY 2025 Wage Index Adjustments

- **Labor Related Share of the Rate**
  - The wage index adjusts the labor related portion of the case mix adjusted base rate.
  - CMS defines the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, CMS calculates a revised labor related share based on the relative importance of labor-related cost categories in the input price index.
  - For FY 2025, CMS has proposed a labor-related share to reflect the relative importance of the 2022-based SNF market basket cost categories that they believe are labor-intensive and vary with, or are influenced by, the local labor market. These are:
    - (1) Wages and Salaries (including allocated contract labor costs as described above);
    - (2) Employee Benefits (including allocated contract labor costs as described above);
    - (3) Professional fees: Labor-related;
    - (4) Administrative and Facilities Support Services;
    - (5) Installation, Maintenance, and Repair Services;
    - (6) All Other: Labor-Related Services; and
    - (7) Capital-related expenses

Wage Index Adjustments

Proposed FY 2025 Labor Related Share of the PPS Rate

TABLE 20: FY 2024 and FY 2025 SNF Labor-Related Share

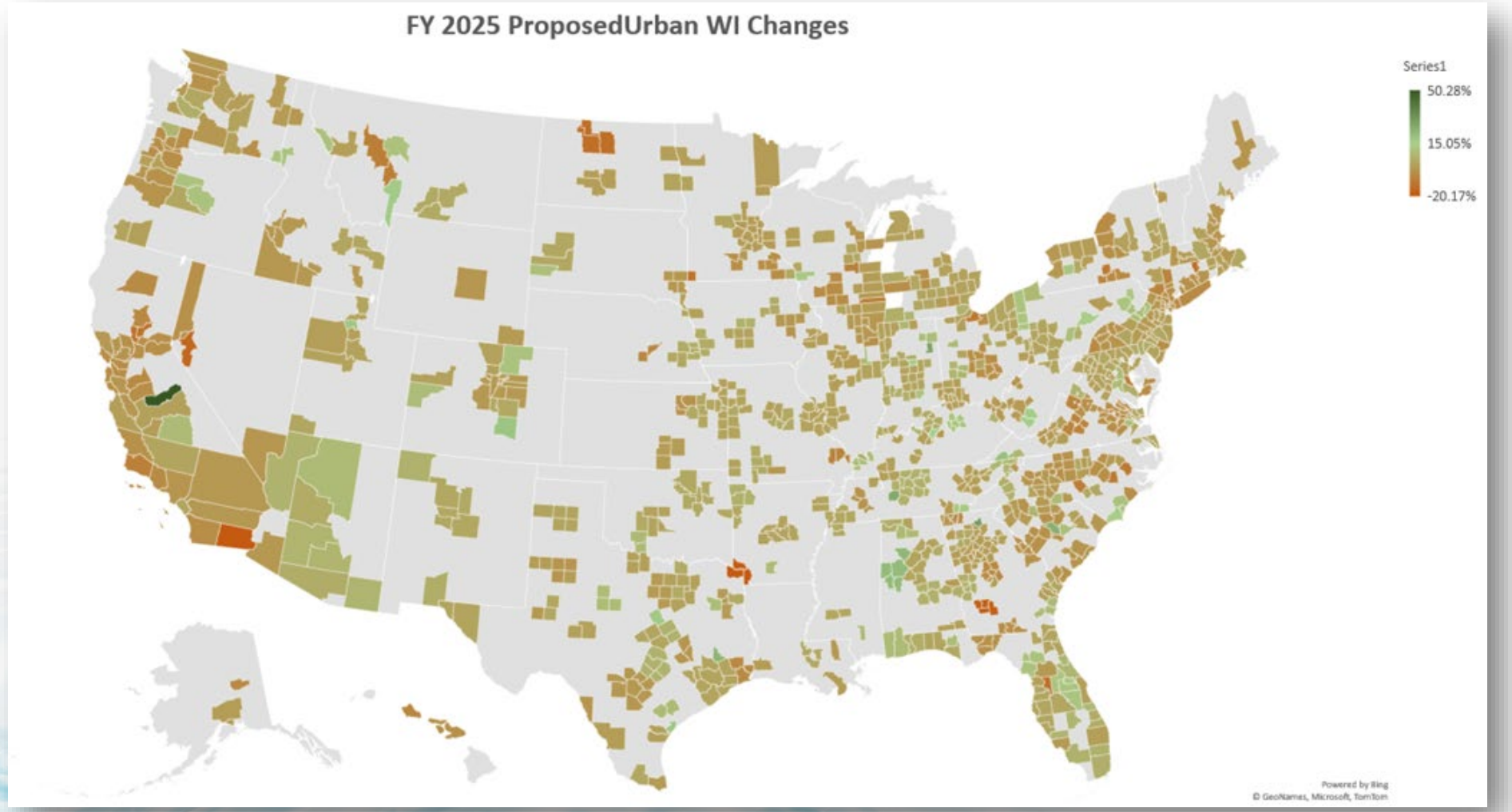
	Relative importance, labor-related share, FY 2024 23:2 forecast [1]	Relative importance, labor-related share, FY 2025 23:4 forecast [2]
Wages and Salaries [3]	52.5	53.2
Employee Benefits [3]	9.3	9.1
Professional Fees: Labor-Related	3.4	3.5
Administrative & Facilities Support Services	0.6	0.4
Installation, Maintenance & Repair Services	0.4	0.5
All other: Labor-Related services	2.0	2.0
Capital-Related (.391)	2.9	3.2
Total	71.1	71.9

[1] Published in the **Federal Register** (88 FR 53213); based on the second quarter 2023 IHS Global Inc. forecast of the 2018-based SNF market basket, with historical data through first quarter 2023.

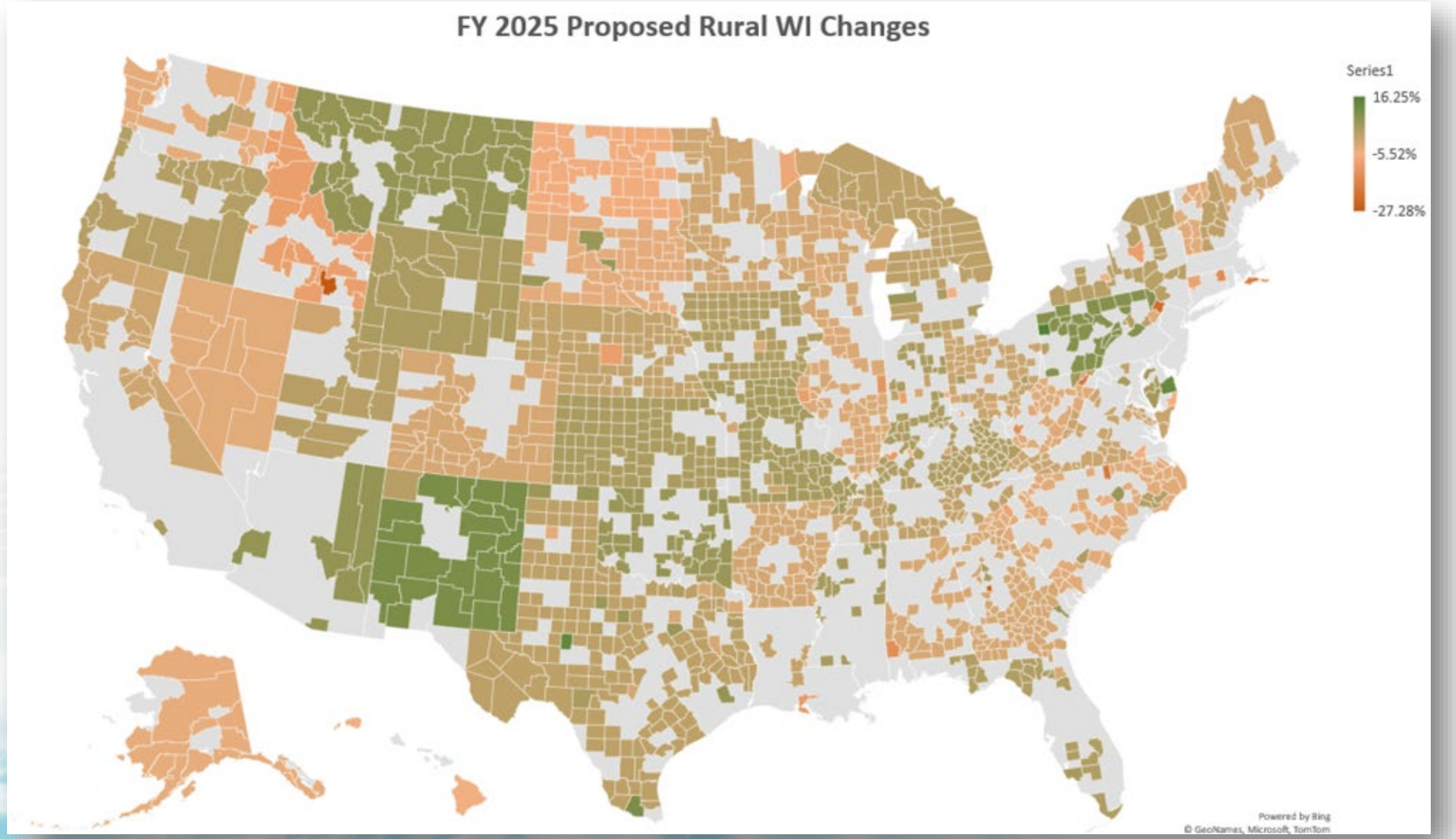
[2] Based on the fourth quarter 2023 IHS Global Inc. forecast of the proposed 2022-based SNF market basket, with historical data through third quarter 2023.

[3] The Wages and Salaries and Employee Benefits cost weight reflect contract labor costs as described above.

Proposed FY 2024 to 2025 Urban WI Changes



Proposed FY 2024 to 2025 WI Rural Changes



Proposed FY 2025 Wage Index Adjustments

Proposed FY 2025 PDPM Variable Perdiem Adjustment Rate Table

County	CBSA	FY 25 WI	FY 2024 WI	24/25 Diff	5% Cap
MD, FREDERICK County	Urban	0.9918	0.9637	2.92%	

Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR	Total $$
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 1,070.39	$ 1,070.39	$ 1,070.39
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 1,070.39	$ 1,070.39	$ 2,140.78
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 1,070.39	$ 1,070.39	$ 3,211.17
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 987.18	$ 3,948.72
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 937.25	$ 4,686.27
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 903.97	$ 5,423.82
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 880.20	$ 6,161.37
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 862.37	$ 6,898.92
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 848.50	$ 7,636.47
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 837.40	$ 8,374.02
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 828.32	$ 9,111.57
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 820.76	$ 9,849.12
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 814.36	$ 10,586.67
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 808.87	$ 11,324.22
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 737.55	$ 804.12	$ 12,061.77

HIPPS: NHNC1

FY 2024 WI Rate	FY 2024 ADR	FY 2024 Total $$	2024-2025 WI Daily Rate Diff:	2024-2025 Avg. DR Diff:	2024-2025 Daily Tot. $$ Diff:	2024-2025 % Rate Change
$ 1,007.41	$ 1,007.41	$ 1,007.41	$ 62.98	$ 62.98	$ 62.98	6.25%
$ 1,007.41	$ 1,007.41	$ 2,014.82	$ 62.98	$ 62.98	$ 125.96	6.25%
$ 1,007.41	$ 1,007.41	$ 3,022.23	$ 62.98	$ 62.98	$ 188.94	6.25%
$ 694.15	$ 929.10	$ 3,716.38	$ 43.40	$ 58.09	$ 232.34	6.25%
$ 694.15	$ 882.11	$ 4,410.53	$ 43.40	$ 55.15	$ 275.74	6.25%
$ 694.15	$ 850.78	$ 5,104.68	$ 43.40	$ 53.19	$ 319.14	6.25%
$ 694.15	$ 828.40	$ 5,798.83	$ 43.40	$ 51.79	$ 362.54	6.25%
$ 694.15	$ 811.62	$ 6,492.98	$ 43.40	$ 50.74	$ 405.94	6.25%
$ 694.15	$ 798.57	$ 7,187.13	$ 43.40	$ 49.93	$ 449.34	6.25%
$ 694.15	$ 788.13	$ 7,881.28	$ 43.40	$ 49.27	$ 492.74	6.25%
$ 694.15	$ 779.58	$ 8,575.43	$ 43.40	$ 48.74	$ 536.14	6.25%
$ 694.15	$ 772.47	$ 9,269.58	$ 43.40	$ 48.30	$ 579.54	6.25%
$ 694.15	$ 766.44	$ 9,963.73	$ 43.40	$ 47.92	$ 622.94	6.25%
$ 694.15	$ 761.28	$ 10,657.88	$ 43.40	$ 47.60	$ 666.34	6.25%
$ 694.15	$ 756.80	$ 11,352.03	$ 43.40	$ 47.32	$ 709.74	6.25%

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Proposed FY 2025 Wage Index Adjustments

Proposed FY 2025 PDPM Variable Perdiem Adjustment Rate Table

County		CBSA	FY 25 WI	FY 2024 WI	24/25 Diff	5% Cap
PA, PIKE County		Rural	1.0724	1.1288	-22.42%	Yes

Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR	Total $$	FY 2024 WI Rate	FY 2024 ADR	FY 2024 Total $$	2024-2025 WI Daily Rate Diff:	2024-2025 Avg. DR Diff:	2024-2025 Daily Tot. $$ Diff:	2024-2025 % Rate Change
$ 116.31	$ 786.33	$ 307.31	$ 1,093.64	$ 1,150.54	$ 1,150.54	$ 1,150.54	$ 1,146.56	$ 1,146.56	$ 1,146.56	$ 3.98	$ 3.98	$ 3.98	0.35%
$ 116.31	$ 786.33	$ 307.31	$ 1,093.64	$ 1,150.54	$ 1,150.54	$ 2,301.08	$ 1,146.56	$ 1,146.56	$ 2,293.12	$ 3.98	$ 3.98	$ 7.96	0.35%
$ 116.31	$ 786.33	$ 307.31	$ 1,093.64	$ 1,150.54	$ 1,150.54	$ 3,451.62	$ 1,146.56	$ 1,146.56	$ 3,439.68	$ 3.98	$ 3.98	$ 11.94	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 1,066.41	$ 4,265.64	$ 811.21	$ 1,062.72	$ 4,250.89	$ 2.81	$ 3.69	$ 14.75	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 1,015.93	$ 5,079.66	$ 811.21	$ 1,012.42	$ 5,062.10	$ 2.81	$ 3.51	$ 17.56	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 982.28	$ 5,893.68	$ 811.21	$ 978.89	$ 5,873.31	$ 2.81	$ 3.40	$ 20.37	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 958.24	$ 6,707.70	$ 811.21	$ 954.93	$ 6,684.52	$ 2.81	$ 3.31	$ 23.18	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 940.22	$ 7,521.72	$ 811.21	$ 936.97	$ 7,495.73	$ 2.81	$ 3.25	$ 25.99	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 926.19	$ 8,335.74	$ 811.21	$ 922.99	$ 8,306.94	$ 2.81	$ 3.20	$ 28.80	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 914.98	$ 9,149.76	$ 811.21	$ 911.82	$ 9,118.15	$ 2.81	$ 3.16	$ 31.61	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 905.80	$ 9,963.78	$ 811.21	$ 902.67	$ 9,929.36	$ 2.81	$ 3.13	$ 34.42	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 898.15	$ 10,777.80	$ 811.21	$ 895.05	$ 10,740.57	$ 2.81	$ 3.10	$ 37.23	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 891.68	$ 11,591.82	$ 811.21	$ 888.60	$ 11,551.78	$ 2.81	$ 3.08	$ 40.04	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 886.13	$ 12,405.84	$ 811.21	$ 883.07	$ 12,362.99	$ 2.81	$ 3.06	$ 42.85	0.35%
$ 116.31	$ 556.33	$ 217.43	$ 773.76	$ 814.02	$ 881.32	$ 13,219.86	$ 811.21	$ 878.28	$ 13,174.20	$ 2.81	$ 3.04	$ 45.66	0.35%

HIPPS: NHNC1

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Proposed FY 2025 Wage Index Adjustments

Proposed FY 2025 PDPM Variable Perdiem Adjustment Rate Table

County	CBSA	FY 25 WI	FY 2024 WI	24/25 Diff	5% Cap
VA, FRANKLIN County	Urban	0.8358	0.8414	-0.67%	

Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR	Total $$
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 949.62	$ 949.62	$ 949.62
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 949.62	$ 949.62	$ 1,899.24
$ 114.20	$ 774.18	$ 302.56	$ 1,076.74	$ 949.62	$ 949.62	$ 2,848.86
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 875.80	$ 3,503.19
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 831.50	$ 4,157.52
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 801.98	$ 4,811.85
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 780.88	$ 5,466.18
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 765.06	$ 6,120.51
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 752.76	$ 6,774.84
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 742.92	$ 7,429.17
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 734.86	$ 8,083.50
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 728.15	$ 8,737.83
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 722.47	$ 9,392.16
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 717.61	$ 10,046.49
$ 114.20	$ 533.44	$ 208.48	$ 741.92	$ 654.33	$ 713.39	$ 10,700.82

HIPPS: NHNC1

FY 2024 WI Rate	FY 2024 ADR	FY 2024 Total $$	2024-2025 WI Daily Rate Diff:	2024-2025 Avg. DR Diff:	2024-2025 Daily Tot. $$ Diff:	2024-2025 % Rate Change
$ 917.49	$ 917.49	$ 917.49	$ 32.13	$ 32.13	$ 32.13	3.50%
$ 917.49	$ 917.49	$ 1,834.98	$ 32.13	$ 32.13	$ 64.26	3.50%
$ 917.49	$ 917.49	$ 2,752.47	$ 32.13	$ 32.13	$ 96.39	3.50%
$ 632.19	$ 846.17	$ 3,384.66	$ 22.14	$ 29.63	$ 118.53	3.50%
$ 632.19	$ 803.37	$ 4,016.85	$ 22.14	$ 28.13	$ 140.67	3.50%
$ 632.19	$ 774.84	$ 4,649.04	$ 22.14	$ 27.13	$ 162.81	3.50%
$ 632.19	$ 754.46	$ 5,281.23	$ 22.14	$ 26.42	$ 184.95	3.50%
$ 632.19	$ 739.18	$ 5,913.42	$ 22.14	$ 25.89	$ 207.09	3.50%
$ 632.19	$ 727.29	$ 6,545.61	$ 22.14	$ 25.47	$ 229.23	3.50%
$ 632.19	$ 717.78	$ 7,177.80	$ 22.14	$ 25.14	$ 251.37	3.50%
$ 632.19	$ 710.00	$ 7,809.99	$ 22.14	$ 24.86	$ 273.51	3.50%
$ 632.19	$ 703.52	$ 8,442.18	$ 22.14	$ 24.64	$ 295.65	3.50%
$ 632.19	$ 698.03	$ 9,074.37	$ 22.14	$ 24.45	$ 317.79	3.50%
$ 632.19	$ 693.33	$ 9,706.56	$ 22.14	$ 24.28	$ 339.93	3.50%
$ 632.19	$ 689.25	$ 10,338.75	$ 22.14	$ 24.14	$ 362.07	3.50%

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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.

Proposed FY 2025 Clinical Category Changes for New ICD-10 Codes

- Each year, CMS reviews the clinical category assigned to new ICD-10 diagnosis codes and proposes changing the assignment to another clinical category if warranted.
- This year, CMS is proposing changing the clinical category assignment for the following four new ICD-10 codes that were effective on October 1, 2023:

E88.10 Metabolic Syndrome

Change from

Medical Management

to

Return to Provider

- **E88.10** Metabolic Syndrome was initially mapped to the clinical category of Medical Management.
- The root causes of metabolic syndrome are overweight/obesity, physical inactivity, and genetic factors.
- Given this, treatment for Metabolic Syndrome typically occurs outside of a Part A SNF stay and CMS does not believe it would serve appropriately as the primary diagnosis for a Part A-covered SNF stay.
- For this reason, CMS is proposing to change the mapping of this code from Medical Management to the clinical category of Return to Provider.

Change from
Medical Management
to
Return to Provider

E88.811 Insulin Resistance Syndrome, Type A

- **E88.811** Insulin Resistance Syndrome, Type A was initially mapped to the clinical category of Medical Management.
- Type A insulin resistance syndrome (TAIRS) is a rare disorder characterized by severe insulin resistance due to defects in insulin receptor signaling and treatment typically occurs outside of a Part A SNF stay.
- For this reason, CMS is proposing to change the mapping of this code from Medical Management to the clinical category of Return to Provider.

Change from

Medical Management

to

Return to Provider

E88.818 Other Insulin Resistance

- **E88.818** Other Insulin Resistance was initially mapped to the clinical category of Medical Management.
- Other Insulin Resistance is used to specify a medical diagnosis of other insulin resistance such as Insulin resistance, Type B.
- Treatment typically occurs outside of a Part A SNF stay.
- For this reason, CMS is proposing to change the mapping of this code from Medical Management to the clinical category of Return to Provider.

Change from

Medical Management

to

Return to Provider

E88.819 Insulin Resistance

- **E88.819** Insulin Resistance, Unspecified was initially mapped to the clinical category of Medical Management.
- This dx. Code is utilized to indicate when a specific type of insulin resistance has not been specifically identified.
- Treatment typically occurs outside of a Part A SNF stay.
- For this reason, CMS is proosing to change the mapping of this code from Medical Management to the clinical category of Return to Provider.

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

- CMS stated in the FY 2019 SNF PPS final rule that they would consider revisiting both the list of included NTA comorbidities, and the points assigned to each condition or extensive service based on changes in the patient population and care practices over time
- A request for information (RFI) in the FY 2025 proposed rule solicits comment on the methodology CMS is currently considering for updating the NTA component.
- **1. Updates to the Study Population and Methodology.**
  - CMS is considering updating the years used for data corresponding to Medicare Part A SNF stays, including claims, assessments, and cost reports. To develop PDPM, CMS used a study population of Medicare Part A SNF stays with admissions from FY 2014 through FY 2017.
  - The updated study population will instead use Medicare Part A SNF stays with admissions from FY 2019 through FY 2022. Since data from much of this time period was affected by the national COVID-19 PHE with significant impacts on nursing homes, CMS is considering using the same subset population used for the PDPM parity adjustment recalibration by excluding stays with either a COVID-19 diagnosis or stays using a COVID-19 PHE-related modification.

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

- **2. Updates to the Study Population and Methodology (cont.)**
  - Next, CMS is considering making certain methodological changes to reflect more accurate and reliable coding of NTA conditions and extensive services on SNF Part A claims and the MDS after PDPM implementation.
  - Initially, the NTA list was created using data from a variety of different sources, including using Medicare inpatient, outpatient, and Part B claims to identify the presence of condition categories from the Medicare Parts C and D risk adjustment models
  - Given that CMS now has several years of post-PDPM implementation data, they believe it would more accurately reflect the coding of conditions and extensive services under PDPM to rely exclusively upon SNF PPS Part A claims and the MDS.
  - CMS is therefore considering updating the methodology to only utilize SNF Part A claims and the MDS, and not claim types from other Medicare settings.

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

- **3. Updates to the Study Population and Methodology (cont.)**
  - Additionally, CMS is considering modifying the overlap methodology to rely more upon the MDS items that use a checkbox to record the presence of conditions and extensive services whenever possible, while allowing for potentially more severe or specific diagnoses to be indicated on MDS item I8000 when it would be useful for more accurate patient classification under PDPM.
  - Since the implementation of PDPM, CMS believes that patient conditions and extensive services are now more accurately and reliably reported by providers using MDS items.
  - CMS is considering prioritizing the reporting of conditions on the MDS by raising the cost threshold for selecting the overlapping CC or RxCC (where inpatient, outpatient, and Part B claims identify the presence of condition categories from the Medicare Parts C and D risk adjustment models) definitions from any additional cost to 5 dollars in average NTA cost per day, which is the amount that is observed to be generally associated with a 1-point NTA increase.

Request for Information: Update to PDPM NTA Component

- **Updates to Conditions and Extensive Services Used for NTA Classification (cont.)**

RFI 16 NTA Removal Considerations	RFI 17 NTA Addition Considerations
Bladder and Bowel Appliances: Ostomy, Active Diagnoses: Malnutrition Code, Immune Disorders, End-Stage Liver Disease, Proliferative Diabetic Retinopathy and Vitreous Hemorrhage, Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage, Aseptic Necrosis of Bone, Cardio-Respiratory Failure and Shock, Systemic Lupus Erythematosus, Other Connective Tissue Disorders, Inflammatory Spondylopathies, Severe Skin Burn or Condition, Intractable Epilepsy, Respiratory Arrest, Pulmonary Fibrosis and Other Chronic Lung Disorders, Nutritional Approaches While a Resident: Feeding Tube, Special Treatments/Programs: Tracheostomy Post-admit Code, Special Treatments/Programs: Radiation Post-admit Code, Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Codes M1040A, M1040C.	B0100: Comatose, GG0120D: Mobility Devices: Limb prosthesis, I0600: Active Diagnoses: Heart Failure, I5700: Active Diagnoses: Anxiety Disorder, I5900: Active Diagnoses: Bipolar Disorder, I6100: Active Diagnoses: Post Traumatic Stress Disorder, I6300: Active Diagnoses: Respiratory Failure, RxCC: Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis, RxCC: Venous Thromboembolism, RxCC: Atrial Arrhythmias, RxCC: Sickle Cell Anemia, RxCC: Rheumatoid Arthritis and Other Inflammatory Polyarthropathy, RxCC: Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease - Except: CC: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, RxCC: Aplastic Anemia and Other Significant Blood Disorders, RxCC: Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders, RxCC: Chronic Viral Hepatitis, Except Hepatitis C, M1040E: Other Skin Problems: Surgical Wound(s) Code

In this revision, 9 retained NTAs have decreased in point values, some significantly.
For example:
Special Treatments/Programs: Ventilator or Respirator Post-admit Code is would be revised from 4 points to 1 point **and**
Section K: Parenteral IV Feeding: Level High would be revised from 7 points to 5.

Conversely, there are 4 items with point values that have increased as well.
For example:
Lung Transplant Status is would be revised from 3 points to 5 and
Cystic Fibrosis wouldbe revised from 1 point to 3.

Proposed SNF QRP Updates

Current SNF QRP Measures:

In this proposed rule, CMS is not proposing to adopt any new measures for the SNF QRP.

TABLE 28: Quality Measures Currently Adopted for the SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (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)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
National Healthcare Safety Network	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

Proposed SNF QRP Updates – New MDS Items

- CMS is proposing to require SNFs to collect and submit four new items in the MDS as standardized patient assessment data elements under the SDOH category because these items would collect information not already captured by the current SDOH items beginning with the FY 2027 SNF QRP.
- Specifically, CMS believes the ongoing identification of SDOH would have three significant benefits.
  - First, promoting screening for these SDOH could serve as evidence-based building blocks for supporting healthcare providers in actualizing their commitment to address disparities that disproportionately impact underserved communities.
  - Second, screening for SDOH improves health equity through identifying potential social needs so the SNF may address those with the resident, their caregivers, and community partners during the discharge planning process, if indicated.
  - Third, these SDOH items could support CMS' ongoing SNF QRP initiatives by providing data with which to stratify SNF's performance on measures and or in future quality measures.

Proposed SNF QRP Updates – New MDS Items

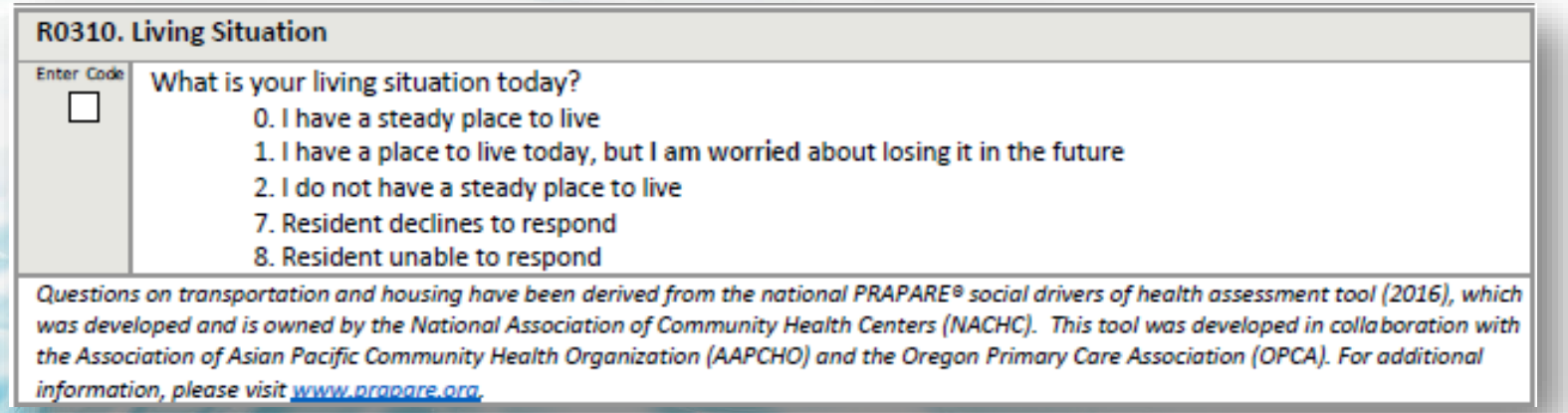
- CMS' definition of SDOH: SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30 to 55 percent of health outcomes.
- Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjustors or in future quality measures.
- These items have the capacity to take into account treatment preferences and care goals of residents and their caregivers, to inform CMS' understanding of resident complexity and SDOH that may affect care outcomes and ensure that SNFs are in a position to impact them through the provision of services and supports, such as connecting residents and their caregivers with identified needs with social support programs.

Proposed SNF QRP Updates – New MDS Items

- **Health-related social needs (HRSNs)** are individual-level, adverse social conditions that negatively impact a person's health or health care, and are the resulting effects of SDOH.
- Examples of HRSNs include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.
- Certain HRSNs can directly influence an individual's physical, psychosocial, and functional status. This is particularly true for food security, housing stability, utilities security, and access to transportation.
- Additional collection of SDOH items would permit CMS to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries.
- As CMS continues to standardize data collection across PAC settings, they believe using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between SNFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process.

Proposed SNF QRP Updates – New MDS Items

- **Living Situation**
  - Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.
  - These experiences may negatively affect one's physical health and access to health care.
  - Housing instability can also lead to homelessness, which is housing deprivation in its most severe form.
  - CMS believes that SNFs can use information obtained from the Living Situation item during a resident's discharge planning.
  - Due to the potential negative impacts housing instability can have on a resident's health, CMS is proposing to adopt the Living Situation item as a new standardized patient assessment data element under the SDOH category.



R0310. Living Situation

Enter Code ☐

What is your living situation today?

0. I have a steady place to live
1. I have a place to live today, but I am worried about losing it in the future
2. I do not have a steady place to live
7. Resident declines to respond
8. Resident unable to respond

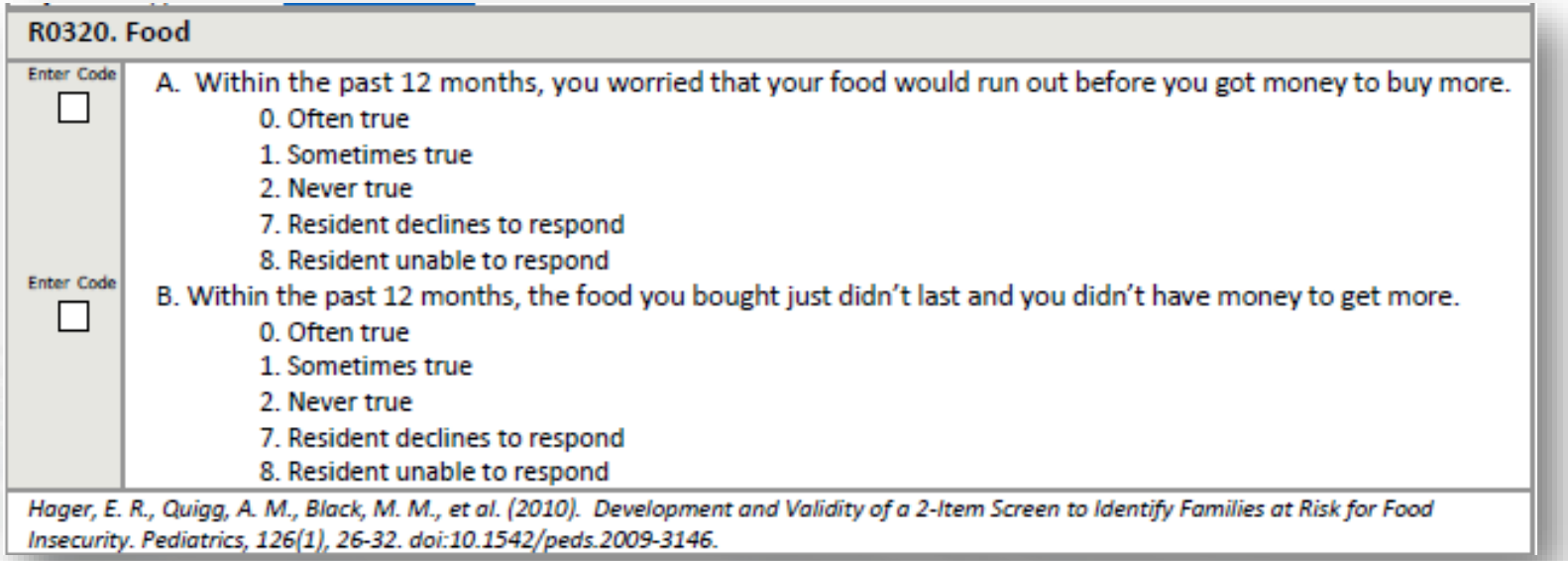
Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.

Proposed SNF QRP Updates – New MDS Items

- **Food (2 items)**
  - The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.
  - Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities like obesity, and higher probability of death from any cause or cardiovascular disease.
  - Having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.
  - CMS believes that adopting items to collect and analyze information about a resident's food security at home could provide additional insight to their health complexity and help facilitate coordination with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a resident's food security are not lost during vulnerable transition periods.
  - CMS is proposing to adopt two Food items as new standardized patient assessment data elements under the SDOH category.

Proposed SNF QRP Updates – New MDS Items

- **Food (2 items) cont.**



R0320. Food

Enter Code ☐

A. Within the past 12 months, you worried that your food would run out before you got money to buy more.

0. Often true
1. Sometimes true
2. Never true
7. Resident declines to respond
8. Resident unable to respond

Enter Code ☐

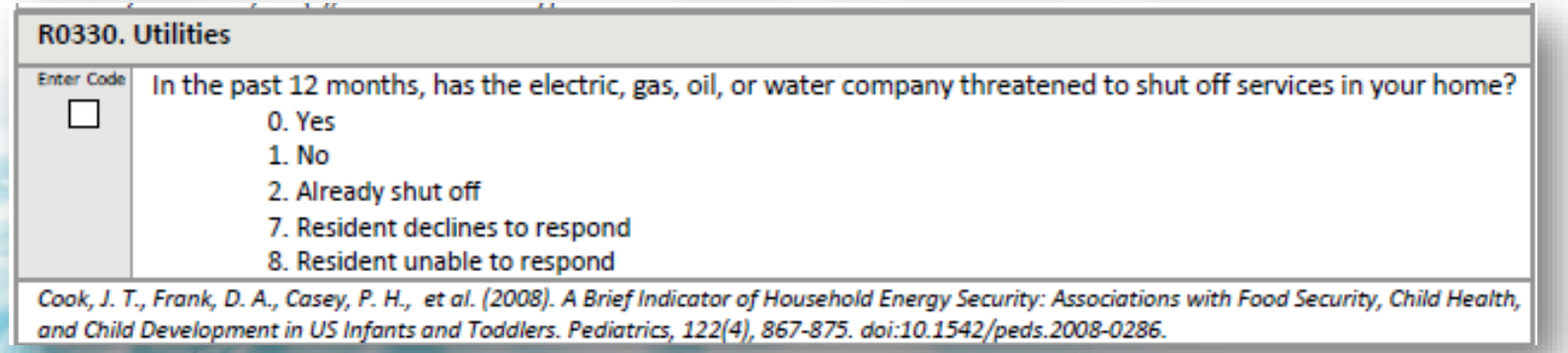
B. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

0. Often true
1. Sometimes true
2. Never true
7. Resident declines to respond
8. Resident unable to respond

Hager, E. R., Quigg, A. M., Black, M. M., et al. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

Proposed SNF QRP Updates – New MDS Items

- **Utilities**
  - A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.46 According to the United States Department of Energy, one in three households in the U.S. are unable to adequately meet basic household energy needs.
  - The consequences associated with a lack of utility security are represented by three primary dimensions: economic; physical; and behavioral. The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have a direct impact on a person's health.
  - CMS believes that adopting an item to collect information about a resident's utility security would facilitate the identification of residents who may not have utility security and who may benefit from engagement efforts.
  - CMS is proposing to adopt a new item, Utilities, as a new standardized patient assessment data element under the SDOH category



R0330. Utilities

Enter Code ☐

In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

0. Yes
1. No
2. Already shut off
7. Resident declines to respond
8. Resident unable to respond

Cook, J. T., Frank, D. A., Casey, P. H., et al. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286.

Proposed SNF QRP Updates – New MDS Items

- **Transportation (Revised)**
  - Beginning October 1, 2023, SNFs began collecting seven items adopted as standardized patient assessment data elements under the SDOH category on the MDS.57 One of these items, A1250. Transportation, collects data on whether a lack of transportation has kept a resident from getting to and from medical appointments, meetings, work, or from getting things they need for daily living.
  - First, the proposed modification of the Transportation item would use a defined 12-month look back period, while the current Transportation item uses a look back period of six to 12 months. CMS believes the distinction of a 12-month look back period would reduce ambiguity for both residents and clinicians, and therefore, improve the validity of the data collected.
  - Second, CMS is proposing to simplify the response options, as shown below, as they believe reliable transportation services are fundamental to a person's overall health, and as a result, the burden of collecting this information separately outweighs its potential benefit.

Current

A1250. Transportation (from NACHC©) QRP

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ **Check all that apply**

- ☐ A. Yes, it has kept me from medical appointments or from getting my medications ♠
- ☐ B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need ♠
- ☐ C. No ♠
- ☐ X. Resident unable to respond ♠
- ☐ Y. Resident declines to respond ♠

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Proposed

R0340. Transportation

Enter Code ☐

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

0. Yes
1. No
7. Resident declines to respond
8. Resident unable to respond

Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.

Proposed SNF QRP Updates – New MDS Items Timing

- CMS is proposing that SNFs would be required to report these new items and the modified Transportation item using the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP.
- Starting in CY 2026, SNFs would be required to submit data for the entire calendar year for each program year.
- CMS is proposing that SNFs would be required to submit the Living Situation, Food, and Utilities items proposed for adoption as standardized patient assessment data elements under the SDOH category at admission only (and not at discharge) because it is unlikely that the assessment of those items at admission would differ from the assessment of the same item at discharge.
- CMS is also proposing to require SNFs to collect and submit the proposed modified standardized patient assessment data element, Transportation, at admission only.

Proposed SNF QRP Updates – Removed MDS Items

- As outlined in the FY 2019 SNF PPS final rule several MDS items are not needed in case-mix adjusting the per diem payment for PDPM. However, they were not accounted for in the FY 2019 SNF PPS final rule.
- Therefore, CMS is removing all O0400 A, B, C and E Therapies items from the 5-day Medicare required assessment beginning October 1, 2025.

Proposed SNF QRP Updates – Validation

MDS-based Measures

- CMS is proposing to adopt a similar validation process for the SNF QRP that CMS has adopted for the SNF Value-Based Purchasing (VBP) program in the FY 2024 SNF PPS final rule beginning with the FY 2027 SNF QRP.
- CMS is proposing that the validation contractor would select, on an annual basis, up to 1,500 SNFs that submit at least one MDS record in the calendar year (CY) 3 years prior to the applicable FY SNF QRP.
- CMS is proposing that our validation contractor would request up to 10 medical records from each of the selected SNFs. The selected SNFs be required to submit the medical records within 45 days of the date of the request (as documented on the request).
- CMS is also proposing that if a SNF does not submit the requested number of medical records within 45 days of the initial request, they would reduce the SNF's otherwise applicable annual market basket percentage update by 2 percent which would be applied to the payment update 2 fiscal years after the fiscal year for which the validation contractor requested records.
- CMS also intends to propose in future rulemaking the process by which they would evaluate the submitted medical records against the MDS to determine the accuracy of the MDS data that the SNF reported and that CMS used to calculate the measure results.

Proposed SNF QRP Updates – Validation

Claims-based Measures

- Beginning with the FY 2027 SNF QRP, CMS is proposing to apply the process that is currently use to ensure the accuracy of the Medicare fee-for-service claims to validate claims-based measures under the SNF QRP.
- Specifically, information reported through Medicare Part A fee-for-service claims are validated for accuracy by Medicare Administrative Contractors (MACs) to ensure accurate Medicare payments.
- CMS believes that adopting the MAC's existing process of validating claims for medical necessity through targeted and random audits would satisfy the statutory requirement to adopt a validation process for data submitted under the SNF QRP for claims-based measures.

Proposed SNF QRP Updates – Measures Under Consideration

- In the FY 2024 SNF PPS proposed rule CMS published a request for information (RFI) on a set of principles for selecting and prioritizing SNF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps.
- Subsequently, the measure development contractor convened a Technical Expert Panel (TEP) on December 15, 2023 to obtain expert input on the future measure concepts that could fill the measurement gaps identified in our FY 2024 RFI.
- The TEP also discussed the alignment of PAC measures with CMS' "Universal Foundation" of quality measures.
- The Universal Foundation aims to focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for comparisons across programs, and help identify measurement gaps.
- In consideration of the feedback that has been received through these activities, CMS is seeking input on four concepts for the SNF QRP.

Proposed SNF QRP Updates – Measures Under Consideration

TABLE 29: Future Measure Concepts Under Consideration for the SNF QRP

Quality Measure Concepts
Vaccination Composite
Pain Management
Depression
Patient Experience of Care/Patient Satisfaction

- While CMS will not be responding to specific comments in response to this RFI in the FY 2025 SNF PPS final rule, they intend to use this input to inform future measure development efforts.

Proposed SNF VBP Updates – National Quality Strategy

Proposed SNF VBP Updates – National Quality Strategy

- As part of the CMS National Quality Strategy, CMS is committed to aligning measures across quality programs and ensuring measurement quality across the entire care continuum in a way that promotes the **best, safest, and most equitable** care for all individuals.
- CMS believes that improving alignment of measures across the CMS quality programs will reduce provider burden while also improving the effectiveness of quality programs.
- However, CMS also recognizes that a one-size-fits-all approach would fail to capture important aspects of quality in healthcare systems across populations and care settings.
- To move towards a more streamlined approach that does not lose sight of important aspects of quality, CMS is implementing a building-block approach: a "Universal Foundation" of quality measures across as many of our quality reporting and value-based care programs as possible, with additional measures added on depending on the population or setting ("add-on sets")

Proposed SNF VBP Updates – National Quality Strategy

- CMS selects measures for the Universal Foundation that are:
  - of high national impact,
  - can be benchmarked nationally and globally,
  - are applicable to multiple populations and settings,
  - are appropriate for stratification to identify disparity gaps,
  - have scientific acceptability,
  - support the transition to digital measurement, and
  - have no anticipated unintended consequences with widespread measure implementation.

Current SNF VBP Measures

TABLE 30: SNF VBP Program Measures and Timeline for Inclusion in the Program

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

Program Performance Standards (achievement threshold and benchmarks) have been updated.

TABLE 31: Estimated FY 2027 SNF VBP Program Performance Standards

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

TABLE 32: Estimated FY 2028 SNF VBP Program Performance Standards

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

Current SNF VBP Measures

- CMS is proposing to adopt a policy that would allow updates to previously finalized SNF VBP measure specifications using subregulatory processes to incorporate technical measure updates like, updates to the case-mix or risk adjustment methodology, changes in exclusion criteria, or updates required to accommodate changes in the content and availability of assessment data.
- CMS is also proposing to use sub-regulatory processes to update the numerical values of the performance standards for a measure if that measure's specifications have been technically updated.
- CMS also recognizes that some updates to measures are substantive in nature and may not be appropriate to adopt without further rulemaking, i.e., changes are so significant that the measure is no longer the same measure. In those instances, CMS would continue to use rulemaking to adopt substantive updates to SNF VBP measures.
- CMS is also proposing to expand the performance standards correction policy beginning with the FY 2025 program year such that to update the numerical values for the performance standards for a measure for a program year if a measure's specifications were technically updated between the time that CMS published the performance standards for a measure and the time that they calculated SNF performance on that measure at the conclusion of the applicable performance period.

Proposed SNF VBP Updates – Measure Addition and Removal

- CMS believes it is appropriate to adopt a policy that governs the retention of measures in the Program, as well as criteria used to consider whether a measure should be removed from the Program.
- These policies would help ensure that the Program's measure set remains focused on the best and most appropriate metrics for assessing care quality in the SNF setting.
- CMS also believes that the measure removal policy would streamline the rulemaking process by providing a sub-regulatory process utilized to remove measures from the Program that raise safety concerns while also providing sufficient opportunities for the public to consider, and provide input on, future proposals to remove a measure.

Proposed SNF VBP Updates – Measure Addition and Removal

- First, CMS is proposing that when measures are adopted for the SNF VBP Program for a particular program year, that measure would be automatically retained for all subsequent program years unless a proposal is made to remove or replace the measure.
- Second, CMS is proposing to use notice and comment rulemaking to remove or replace a measure in the SNF VBP Program to allow for public comment. And use specific measure removal factors to determine whether a measure should be considered for removal or replacement.
- Third, upon a determination by CMS that the continued requirement for SNFs to submit data on a measure raises specific resident safety concerns, CMS is proposing that to immediately remove the measure from the SNF VBP measure set.

Proposed SNF VBP Updates – Future Measure Considerations and Health Equity

- As part of the National Quality Strategy, CMS has stated in previous rule making that the goal of explicitly incorporating health equity-focused components into the Program was to both measure and incentivize equitable care in SNFs.
- Although the Health Equity Adjustment rewards high performing SNFs that care for high proportions of SNF residents with underserved populations, it does not explicitly measure or reward high provider performance among the disadvantaged or underserved population.
- CMS remains committed to achieving equity in health outcomes for residents by promoting SNF accountability for addressing health disparities, supporting SNFs' quality improvement activities to reduce these disparities, and incentivizing better care for all residents.

Proposed SNF VBP Updates – Future Measure Considerations and Health Equity

- CMS is currently exploring the feasibility of proposing future health equity-focused metrics for the Program.
- Specifically, CMS is considering different ways of measuring health equity that could be incorporated into the program as either a new measure, combined to form a composite measure, or as an opportunity for SNFs to earn bonus points on their SNF performance score.
- These performance metrics would utilize the existing SNF HAI, DC Function, DTC PAC SNF, and SNF WS PPR measures that have been adopted in the Program.
- CMS is considering the development of health-equity-focused versions of these measures because they are either cross-setting or could be implemented in multiple programs.

Proposed SNF VBP Updates – Future Measure Considerations and Health Equity

- The health-equity focused measures or metrics for bonus points could include:
  - **A high-social risk factor (SRF) measure** that utilizes an existing Program measure where the denominator of the measure only includes residents with a given SRF, which would allow for comparisons of care for underserved populations across SNFs;
  - **A worst-performing group measure** that utilizes an existing Program measure and compares the quality of care among residents with and without a given SRF on that measure and places greater weight on the performance of the worst-performing group with the goal of raising the quality floor at every facility; **and**
  - **A within-provider difference measure** that assesses performance differences between residents (those with and without a given SRF) within a SNF on an existing Program measure, creating a new measure of disparities within SNFs.

Proposed SNF VBP Updates – Future Measure Considerations and Health Equity

- CMS is testing these various measure concepts to determine:
  - where current across- and within-provider disparities exist in performance,
  - how to best incentivize SNFs to improve their quality of care for all residents, including those who may be underserved, **and**
  - the feasibility of incorporating a health equity-focused measure into the Program.
- As CMS explores these and other options, they will be focusing on approaches that:
  - Include as many SNFs as possible and are feasible to implement;
  - Integrate feedback from interested parties;
  - Encourage high quality performance for all SNFs among all residents and discourage low quality performance;
  - Are simple enough for SNFs to understand and can be used to guide SNFs in improvement; **and**
  - Meet the goal of incentivizing equitable care to ensure all residents in all SNFs receive high quality care
  - Display opportunities to align with other CMS programs to minimize provider burden.

Proposed SNF VBP Updates – Nursing Home Enforcement

- The proposed rule includes revisions to CMS' existing nursing home enforcement authority to enhance the safety and quality of care provided in nursing homes.
- CMS is proposing to expand its ability to impose financial penalties to drive sustained correction of health and safety deficiencies.
- These revisions will allow CMS to expand the mix and number of penalties in response to situations that put residents' health and safety at risk and, therefore, encourage facilities to promptly correct and maintain lasting compliance with CMS's health and safety requirements.
- CMS' current enforcement authority allows imposition of civil money penalties (CMPs) for noncompliance. Penalties can currently be imposed per day (PD) or per instance (PI) depending on the health and safety deficiencies identified, with PD CMPs applied until the noncompliance is corrected and PI CMPs for isolated instances.
- However, PD and PI penalties may not be imposed during the same survey, and PI penalties may not be imposed concurrently for the same deficiency.

Proposed SNF VBP Updates – Nursing Home Enforcement

- The severity of enforcement sanctions is based on the harm or potential harm to residents caused by non-compliance.
- This regulatory limitation prevents CMS and the State from imposing CMPs commensurate with the identified noncompliance by restricting the use of multiple penalties for one deficiency, which prevents full use of CMPs to encourage faster correction and sustain compliance with health and safety requirements.
- In this proposed rule, CMS proposes to expand the penalties that can be imposed through regulatory revision to allow for more per instance and per day CMPs to be imposed.
- The proposals in this rule will permit both types of penalties to be imposed, not to exceed the statutory daily limits, providing CMS with greater flexibility to impose penalties in a manner that more directly reflects the health and safety impact to residents and incentivizes permanent correction.

Estimated Financial Impact of SNF PPS FY 2025

TABLE 38: Impact to the SNF PPS for FY 2025

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

Note: The Total column includes the FY 2025 4.1 percent market basket update. The values presented in Table 38 may not sum due to rounding.

Proposed SNF QRP Financial Impact

TABLE 39: Estimated Impacts for the FY 2027 SNF QRP

Estimated burden for the FY2027 SNF QRP	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden associated with Proposal to Collect Four New SDOH Assessment Items and Modify One SDOH Assessment Item beginning with the FY 2027 SNF QRP	+2.31	+$150.88	+35,561.81	+$2,322,541.48
	Per Selected SNF		All Selected SNFs	
Estimated Change in Burden associated with Proposal to Adopt a Validation Process for SNFs Participating in the SNF QRP beginning with the FY 2027 SNF QRP	+5.12	+$542.05	+7,680	+$813,067.95

TABLE 40: Estimated Impacts for the Proposed Changes to the MDS Data Set Collection and Submission Beginning October 1, 2025

Estimated change in burden for the MDS removal of assessment items	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden associated with Removal of MDS items O0400A, O0400B, O0400C, and O0400E effective October 1, 2025	-14.05	-$917.87	-216,332.82	-$14,128,696.47

Estimated SNF VBP Financial Impact

TABLE 41: Estimated SNF VBP Program Impacts for FY 2025

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Group					
Total*	10,858	20.21	31.8725	0.99154	100.00
Urban	8,509	20.32	30.4525	0.99093	86.41
Rural	2,349	19.81	37.0163	0.99375	13.59
Hospital-based urban**	181	19.64	41.4823	0.99545	1.51
Freestanding urban**	8,319	20.33	30.1971	0.99082	84.88
Hospital-based rural**	71	19.36	43.5091	0.99626	0.27
Freestanding rural**	2,223	19.81	36.9289	0.99374	13.19
Urban by region					
New England	610	20.31	30.3760	0.99108	5.59
Middle Atlantic	1,259	20.03	34.4195	0.99264	19.04
South Atlantic	1,662	20.58	27.9590	0.99001	16.85
East North Central	1,543	20.63	25.7922	0.98890	11.47
East South Central	448	20.33	30.6263	0.99112	3.26
West North Central	573	19.86	36.0210	0.99327	3.82
West South Central	894	20.92	21.0260	0.98683	6.72
Mountain	385	19.62	40.0497	0.99492	3.70
Pacific	1,135	19.80	37.3699	0.99366	15.96
Outlying	0	.	.	.	.
Rural by region					
New England	69	18.64	56.1674	1.00285	0.52
Middle Atlantic	159	19.23	46.9484	0.99845	1.06
South Atlantic	340	20.32	29.8026	0.99065	2.01
East North Central	566	19.66	38.5666	0.99422	3.29
East South Central	371	19.98	34.4449	0.99282	2.06
West North Central	345	19.67	37.5009	0.99383	1.52
West South Central	332	20.65	24.5102	0.98828	1.84
Mountain	97	18.88	51.9212	1.00002	0.57
Pacific	69	17.94	68.9668	1.00744	0.72
Outlying	1	22.54	0.0000	0.98025	0.00
Ownership					
Government	432	19.95	33.9489	0.99235	2.86
Profit	8,065	20.31	30.2597	0.99085	78.39
Non-Profit	2,361	19.88	37.0019	0.99376	18.74

* The total group category excludes 3,842 SNFs that did not meet the finalized measure minimum policy. The total group category includes 19 SNFs that did not have historical payment data used for this analysis.

** The group category which includes hospital-based/freestanding by urban/rural excludes 64 swing bed SNFs that satisfied the current measure minimum policy.

Proposed SNF VBP Updates – Comment Period

To be assured consideration, comments must be received at one of the addresses provided below, **by May 28, 2024**. Comments, must be submitted in one of the following three ways (please choose only one of the ways listed):

- **Electronically.** You may submit electronic comments on this regulation to http://www.regulations.gov Follow the "Submit a comment" instructions.
- **By regular mail**. You may mail written comments to the following address ONLY:
- Centers for Medicare & Medicaid Services,
- Department of Health and Human Services,
- Attention: CMS-1802-P,
- P.O. Box 8016,
- Baltimore, MD 21244-8016.
- **By express or overnight mail**. You may send written comments to the following address ONLY:
- Centers for Medicare & Medicaid Services,
- Department of Health and Human Services,
- Attention: CMS-1802-P,
- Mail Stop C4-26-05,
- 7500 Security Boulevard,
- Baltimore, MD 21244-1850.

QUESTIONS?

Find Out More

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