Medicare Program; Fiscal Year 2022 Skilled Nursing Facilities Proposed Rule
Summary

On April 8, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule updating for fiscal year (FY) 2022 the Medicare skilled nursing facility (SNF) payment rates, SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing Program (VBP). It will be published in the *Federal Register* on April 15, 2021. The proposed rule would update the federal per diem rates under the SNF Prospective Payment System (PPS) by 1.3 percent; modify the ICD-10 code mappings for patient classification; and make updates to the SNF QRP and SNF VBP Programs. No changes are proposed to the Patient Driven Payment Model (PDPM) patient classification system. CMS also discusses a methodology to recalibrate the PDPM budget neutrality adjustment (referred to as a parity adjustment). There are also several requests for information (RFI) on quality measures, interoperability and health equities. **Comments on the proposed rule are due by June 7, 2021.**

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I. Background on SNF PPS

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

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

Adoption of the PDPM was intended to be budget neutral. However, CMS provides data analysis in this proposed rule indicating that Medicare is paying more than it would have paid under the PDPM than if the RUG-IV classification model had continued. CMS believes an adjustment of -5 percent is necessary to restore budget neutral payments. While CMS is not proposing to make that adjustment for FY 2022, it notes that any delays in making the full adjustment as soon as possible allow excess payments to continue. **CMS solicits comments on its analysis and potential options for applying a parity adjustment.**

II. SNF PPS Rate Setting Methodology and FY 2022 Update

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

Summary of Key Data under Proposed SNF PPS for FY 2022	
Market basket update factor	
Market basket increase	+2.3%
Forecast error adjustment for FY 2020	-0.8%
Required multifactor productivity (MFP) adjustment	-0.2%
Net MFP-adjusted update	**+1.3%**
Wage index budget neutrality adjustment	0.9999
Labor-related share	70.1%

A. Federal Base Rates

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

B. SNF Market Basket Update

CMS proposes a market basket increase for FY 2022 of 2.3 percent based on the fourth quarter 2020 forecast from IHS Global Insight, Inc. (IGI), with historical data through the third quarter of 2020. CMS is rebasing the SNF market basket from 2014 to 2018. More information on the rebased market basket is below. The forecast addresses the percentage increase in the FY 2018-based SNF market basket index for routine, ancillary, and capital-related expenses.

For FY 2020—the most recent year for which actual data are available—CMS applied a market basket of 2.8 percent but the actual increase was 2.0 percent. As the difference (0.8 percentage points) exceeds the 0.5 percentage point threshold for making a forecast error correction, CMS proposes to apply a -0.8 percentages point adjustment to the proposed FY 2022 SNF market basket. The market basket of 2.3 percent would be reduced by 0.8 percentage points to 1.5 percentage points with this proposal. **CMS invites comments on whether it should eliminate the forecast error adjustment or raise the threshold from 0.5 to 1.0 percentage points for applying the adjustment in future rulemaking.**

The multifactor productivity (MFP) adjustment required under the Affordable Care Act (ACA) is estimated to be -0.2 percentage points. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2022, based on IGI's fourth quarter 2020 forecast.

The resulting proposed SNF market basket update equals 1.3 percent (2.3 percent less the 0.8 percentage points for forecast error and 0.2 percentage points for MFP reduction). The update may change in the final rule as more recent data and forecasts for the market basket MFP adjustment become available.

CMS also applies a 2.0 percentage point reduction to the update for SNFs that do not satisfy the reporting requirements for the FY 2022 SNF QRP. The rate update for SNFs that do not meet the SNF QRP reporting requirements would be -0.7 percent. (The rate update is applied to the unreduced FY 2020 SNF federal per diem rates).

For FY 2022, CMS notes an additional adjustment to the unadjusted per diem base rates. Section 134 in Division CC of the Consolidated Appropriations Act, 2021 included a provision to exclude blood clotting factor indicated for treatment of patients with hemophilia and other bleeding disorders from the list of items and services included in the Part A SNF PPS per diem payment effective for items and services furnished on or after October 1, 2021. The law further requires that the Secretary make a proportional reduction in SNF rates to account for blood clotting factor being excluded from the SNF per diem payments. CMS provides a detailed explanation of how it determined the SNF per diem rate adjustment of -$0.02 to the nursing and non-therapy ancillary rates only.

Based on the proposed MFP-adjusted update, CMS proposes FY 2022 unadjusted federal rates for each component of the payment for urban and rural areas that are shown in the tables below. Under the PDPM case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five of these are case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). The remaining component is a non-case-mix component, as existed under the previous RUG-IV classification system. The nursing and NTA rates below incorporate the $0.02 reduction for blood clotting factor.

Final FY 2021 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$62.04	$70.72
Occupational Therapy	$57.75	$64.95
Speech-Language Pathology	$23.16	$29.18
Nursing	$108.16	$103.34
Non-Therapy Ancillaries	$81.60	$77.96
Non-case mix adjusted	$96.85	$98.64

Proposed FY 2022 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$62.84	$71.63
Occupational Therapy	$58.49	$65.79
Speech-Language Pathology	$23.46	$29.56
Nursing	$109.55	$104.66
Non-Therapy Ancillaries	$82.64	$78.96
Non-case mix adjusted	$98.10	$99.91

C. Case-Mix Adjustment

As noted earlier, CMS replaced its previous case-mix classification methodology, the RUG-IV model, with the PDPM effective October 1, 2019. The PDPM model was designed to classify patients into payment groups based on patient characteristics, rather than the volume of therapy services provided to patients, as was done in the RUG-IV model. The proposed FY 2022 payment rates reflect the use of the PDPM classification system from October 1, 2021 through September 30, 2022. Tables 6 and 7 of the proposed rule (reproduced in the appendices of this summary) show the proposed PDPM case-mix adjusted federal rates and associated indexes.

D. Wage Index Adjustment

CMS proposes to continue to apply the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2022, CMS proposes to use updated wage data for hospital cost reporting periods in FY 2018. It notes that to use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources from CMS and the Medicare Administrative Contractors that is not feasible at this time.

As CMS is using the IPPS wage index to adjust SNF payments for the area difference in the cost of labor, it must have a policy when there is a SNF in an urban or rural area that has no hospitals, and therefore, no applicable wage index. CMS proposes to use the same policy it has used in prior years. For rural areas without hospitals, CMS would use the average wage index from all contiguous urban areas as the SNF proxy wage index. For urban areas without hospitals, CMS would use the average wage index of all urban areas within the state as the SNF proxy wage index. These policies are only applicable in one urban area—CBSA 25980, Hinesville-Fort Stewart, Georgia.

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

The wage index adjustment is applied to the labor-related share. Effective FY 2022, CMS is proposing to rebase and revise the SNF market basket from 2014 to 2018 and the resulting labor-related share. The labor-related share of the proposed 2018-based SNF market basket is the sum of the cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-related; Administrative and Facilities Support services; Installation, Maintenance, and Repair services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

CMS uses a four-step process to trend forward the base year (2018) weights to FY 2022 price levels. This process includes computing the FY 2022 price index level for the total market basket

and each cost category of the market basket. Based on this update, the proposed SNF labor-related share is 70.1 percent, compared to a FY 2020 final labor-related share of 71.3 percent. Table 8 in the proposed rule summarizes the proposed labor-related share for FY 2022 (based on the IGI fourth quarter 2020 forecast) compared with FY 2021 for each of the cost categories.

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

The change to the labor share and wage index is required by law to be budget neutral. CMS meets this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor, equal to the ratio of the weighted average wage adjustment factor for FY 2021 to the weighted average wage adjustment factor for FY 2022. For this calculation, CMS uses the same FY 2020 claims utilization data for both the numerator and denominator of this ratio. The proposed budget neutrality factor for FY 2022 is 0.9999.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

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

In the 2019 SNF PPS final rule, CMS finalized the designation of the following classifiers for purposes of applying the administrative presumption under the PDPM:

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

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

patient's condition to determine the continuing need for Part A SNF benefits after the assessment reference date of the initial Medicare assessment.

B. Consolidated Billing

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

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

The addition of blood clotting factor and related items to the above list is effective October 1, 2021 and was added as a result of section 134 in Division CC of the Consolidated Appropriations Act, 2021. As indicated earlier, CMS is proposing a $0.02 reduction to the nursing and non-therapy ancillary federal per diem rates to make this provision budget neutral.

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

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

C. Payment for SNF-level Swing-bed Services

CMS discusses the statutory requirement that critical access hospitals (CAHs) continue to be paid on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement and that all non-CAH swing-bed rural hospitals continue to be paid under the SNF PPS. As

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

discussed in the FY 2019 SNF PPS final rule, revisions were made to the swing-bed assessment in order to support implementation of PDPM. The latest changes in the MDS for swing-bed rural hospitals can be found at the SNF PPS website at: Skilled Nursing Facility PPS | CMS.

IV. Other SNF PPS Issues

A. Rebasing and Revising the SNF Market Basket

For FY 2022 and subsequent fiscal years, CMS is proposing to rebase the market basket to reflect 2018 Medicare-allowable total cost data (routine, ancillary, and capital-related) from freestanding SNFs and to revise applicable cost categories and price proxies used to determine the market basket. The proposed rule includes a lengthy and technical explanation of this process. The resulting change to the final SNF index and the individual weights for each category is minimal and illustrated below:

Fiscal Year (FY)	2014-based SNF Market Basket	Proposed 2018-based SNF Market Basket
Historical Data:		
FY 2017	2.7	2.5
FY 2018	2.6	2.6
FY 2019	2.3	2.4
FY 2020	2.0	2.1
Average FY 2017-2020	2.4	2.4
Forecast:		
FY 2021	2.4	2.4
FY 2022	2.4	2.3
FY 2023	2.7	2.6
Average FY 2021-2023	2.5	2.4

Source: IHS Global, Inc. 4th quarter 2020 forecast with historical data through the 3rd quarter 2020.

The change to the labor-related share from rebasing and revising the SNF market basket is 1.2 percentage points (71.3 percent in FY 2021 to 70.1 percent in FY 2022). The components of the labor share and their change is illustrated below:

	Relative Importance, Labor-Related Share, FY 2021 20:2 Forecast[1]	Relative Importance, Labor-Related Share, FY 2022 20:4 Forecast[2]
Wages and Salaries	51.1	51.2
Employee Benefits	9.9	9.5
Professional Fees: Labor-Related	3.7	3.5
Administrative & Facilities Support Services	0.5	0.6
Installation, Maintenance & Repair Services	0.6	0.4
All Other: Labor-Related Services	2.6	1.9
Capital-Related	2.9	3.0
Total:	71.3	70.1

[1] Published in the Federal Register (85 FR 47605); based on the second quarter 2020 IHS Global Inc. forecast of the 2014-based SNF market basket, with historical data through first quarter 2020.
[2] Based on the fourth quarter 2020 IHS Global Inc. forecast of the proposed 2018-based SNF market basket.

The proposed FY 2022 SNF labor-related share is 1.2 percentage points lower than the FY 2021 SNF labor-related share (based on the 2014-based SNF market basket). The major reason for the lower labor-related share is due to the decrease in the All Other: Labor-related services and professional fees: labor-related services cost weights, and a decrease in the compensation cost weight as a result of incorporating the 2018 Medicare cost report data.

B. Technical Updates to PDPM ICD-10 Mappings

ICD-10 diagnosis codes are used to assign ("map") SNF patients to clinical categories in the physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) components of the PDPM and to assign certain comorbidities for classification under the SLP and non-therapy ancillary (NTA) components. The ICD-10 code set also is incorporated into other aspects of SNF operations such as application of the SNF GROUPER. The code set undergoes routine annual review, after which any changes made are considered for inclusion in the PDPM. Public comments about changes are also routinely requested by CMS.

Changes in ICD-10 codes may affect the accuracy of patient classification (and payment) under the PDPM. Changes with limited effects, termed nonsubstantive, are handled through a subregulatory process, while substantive changes are addressed through notice and comment rulemaking. CMS proposes the following substantive changes to the PDPM ICD-10 code mappings and list for FY 2022.

Codes	D57.42 and D57.44: Sickle-cell thalassemia zero and beta without crisis
Original Mapping	Medical Management
Revised Mapping	Return to Provider
Rationale	Patients not in crisis are unlikely to require SNF care
Codes	K20.81, K20.91, and K21.0: Esophageal diseases with bleeding
Original Mapping	Return to Provider
Revised Mapping	Medical Management
Rationale	Added code specificity of bleeding is more likely to identify need for SNF care
Codes	M35.81: Multisystem inflammatory disease
Original Mapping	Non-Surgical Orthopedic/Musculoskeletal
Revised Mapping	Medical Management
Rationale	Multisystem disease is not limited only to musculoskeletal system
Codes	P92.821, P91.822, and P91.823: Neonatal cerebral infarction, sites specified
Original Mapping	Return to Provider
Revised Mapping	Acute Neurologic
Rationale	Diagnoses can persist and be linked to later diagnoses that need SNF care
Codes	U07.0: Vaping disorder
Original Mapping	Return to Provider

Revised Mapping	Pulmonary
Rationale	Intensive treatments (e.g., steroids) followed by SNF care required in some cases
Codes	G93.1: Anoxic brain damage, not elsewhere classified
Original Mapping	Return to Provider
Revised Mapping	Acute Neurologic
Rationale	CMS clinician review supports similarity to other codes in the revised mapping category

CMS invites comments on the proposed changes as well as comments on additional substantive and nonsubstantive changes.

C. Recalibrating the PDPM Parity Adjustment

1. Background

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

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

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

2. FY 2020 Changes in SNF Case-Mix Utilization

CMS indicates that SNF case-mix utilization changed significantly in FY 2020 because of the transition to the PDPM. It also evaluates the impact of the COVID-19 PHE on case-mix utilization. As a result of the PHE, CMS issued waivers that would allow for SNF coverage without a 3-day prior inpatient hospitalization and allowed a beneficiary to renew SNF benefits

without first having to start a new benefit period. The potential for patients not otherwise qualified for SNF coverage as a result of the PHE could have changed SNF case-mix utilization in FY 2020.

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

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

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

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

These changes in therapy provision highlight the reasons why CMS believes that the typical methodology for recalibrating a parity adjustment would not be appropriate in the context of PDPM. CMS would typically utilize claims and assessment data from a given period under the new payment system, classify patients under both the current and prior payment model using this same set of data, compare aggregate payments under each payment model, and calculate an appropriate adjustment factor to achieve budget neutrality. However, given the significant

reduction in the overall amount of therapy provided to SNF patients since PDPM implementation, as well as changes in the way that the therapy is provided (for example, increases in group and concurrent therapy), classifying SNF patients into RUG-IV payment groups using data collected under PDPM would lead to a RUG-IV case-mix distribution that contrasts significantly with historical trends under RUG-IV. This finding is precisely why CMS does not believe that the typical methodology for recalibrating the PDPM parity adjustment would result in an accurate calculation of the revised parity adjustment factor and may lead to an overcorrection.

3. Methodology for Recalibrating the PDPM Parity Adjustment

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

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

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

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

CMS' analysis identified a 5.3 percent increase in aggregate spending under PDPM as compared to expected total payments under RUG-IV for FY 2020 when considering the full SNF population. If those cases using a COVID waiver or diagnosed with COVID are eliminated, the

increase is a 5.0 percent increase in aggregate spending. CMS believes it would be more appropriate to pursue a recalibration using the subset population exclusive of COVID waiver patients or patients diagnosed with COVID.

Based on the above discussion and analysis, the resultant PDPM parity adjustment factor would be lowered from 46 percent to 37 percent for each of the PDPM case-mix adjusted components. If this adjustment were applied for FY 2022, CMS estimates that this methodology would result in a reduction in SNF spending of 5.0 percent, or approximately $1.7 billion. Tables 24 and 25 in the proposed rule provide the FY 2022 PDPM CMIs and case-mix adjusted rates if CMS applied the recalibration methodology described above in FY 2022.

CMS invites comments on all of the above analysis and methodological issues. To assist commenters with their comments, CMS posted a file on the CMS website (Skilled Nursing Facility PPS | CMS). Click on the 2nd link that is in the box titled "Spotlight." This file provides the FY 2019 RUG-IV case-mix distribution and calculation of total payments under RUG-IV, as well as PDPM case-mix utilization data at the case-mix group and component level to demonstrate the calculation of total payments under PDPM.

4. Applying the PDPM Parity Adjustment

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

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

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

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

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

V. SNF QRP

The SNF QRP was established pursuant to the IMPACT Act and is a pay-for-reporting program. Freestanding SNFs, SNFs affiliated with acute care hospitals and all non-CAH swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the annual update factor. SNFs submit specified data elements and quality measure data for each resident using the SNF resident assessment instrument known as the Minimum Data Set (MDS). Completed instruments are sent electronically to CMS through the Internet Quality Improvement & Evaluation System (iQIES).

A table at the end of this summary section (located at VI.G) displays the SNF QRP measures adopted for the FY 2022 program year and this list is not changed by the proposed rule. More information about SNF QRP measures is available on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.

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

A. New and Updated Measures for FY 2023

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

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

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

Numerator. The risk-adjusted estimate of the number of SNF stays predicted to have an HAI that results in hospitalization.

Denominator. The risk-adjusted "expected" number of SNF stays with HAI that results in hospitalization (i.e., that would occur in an "average" SNF).

Exclusions. There are several exclusions (e.g., SNF stay less than 4 days), that are fully described in the measure's specifications.

Risk adjustment. The hierarchical logistic regression risk model estimates both the average predictive effect of resident characteristics across all SNFs, and the degree to which each SNF has an effect on the outcome that differs from that of the average SNF. Multiple variables are included, such as gender, end-stage renal disease, and prior ICU stay.

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

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

Following the usual pre-rulemaking process for stakeholder input including a Technical Expert Panel (TEP), the proposed measure was placed on the December 21, 2020 Measures Under Consideration List. The Measure Applications Partnership (MAP) conditionally supported the measure contingent upon NQF endorsement and found it to be suitable for use with rural as well as urban providers. The measure showed moderate reliability and strong face validity during testing.

CMS plans to seek NQF endorsement of the measure, but proposes to adopt the measure for FY 2023 because of the serious consequences of HAIs in this vulnerable population, and having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. Existing similar measures are disease or infection-site specific. If adopted, the measure results would be publicly displayed.

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

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

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

Numerator. The cumulative number of HCP eligible to work in the SNF for at least one day in the reporting period who received a complete vaccination course against SARS-CoV-2.

Denominator. The cumulative number of HCP eligible to work in the SNF for at least one day in the reporting period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC.[2]

Risk adjustment. Adjustment is not required for this process measure.

Full specifications are available on the CDC website: https://www.cdc.gov/nhsn/nqf/index.html.
In discussing the proposed measure, CMS reviews the declaration of COVID-19 as a public health emergency (PHE), methods of viral transmission, vulnerable patient groups such as SNF residents, and guidelines for prioritizing vaccine recipients. Following the usual pre-rulemaking process for stakeholder input, the proposed measure was included on the December 21, 2020 Measures Under Consideration List. The Measure Applications Partnership (MAP) conditionally supported the measure contingent upon clarification of measure specifications, and CMS returned to the MAP with results from further measure testing and updated specifications.
CMS states its intention to seek NQF endorsement of the measure, but proposes to adopt the measure for FY 2023 given ongoing COVID-19 PHE impacts and having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. CMS notes that the measure most similar to the proposed COVID-19 HCP measure is the NQF-endorsed measure of influenza vaccination among HCP (NQF #0431), already in use in the CMS quality programs for inpatient rehabilitation facilities and long-term care hospitals.
CMS estimates the regulatory burden of data submission for this new measure would be 12 hours per year for each SNF at an annual cost ranging from approximately $330 to $550 per SNF. Aggregate burden for all SNFs is estimated to total approximately 181,000 hours and $6.625 million.

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

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

[2] Centers for Disease Control and Prevention. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, Appendix B. https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-B.

B. RFI: Future Year Quality Measures

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

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

CMS states that it will not respond to these comments through the SNF PPS FY 2022 final rule, but they will be considered in future policy making.

C. RFI: Fast Healthcare Interoperability Resources (FHIR)

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

- EHR/IT systems currently used by commenters and if they participate in a health information exchange;
- How commenters share information currently with other providers;
- Approaches by which CMS could incent or reward commenters who use health information technology (HIT) in innovative ways to reduce burden for SNFs (and other post-acute care providers);
- Resources and tools for use by SNFs (and other post-acute care providers) and HIT vendors to facilitate interoperable, fully electronic health information sharing that incorporates FHIR standards and secure application programming interfaces (APIs); and
- Willingness of HIT vendors who work with SNFs (and other post-acute care providers) to participate in pilots or models that align measure collection standards across care settings (e.g., sharing patient data via secure FHIR-based APIs for calculating and reporting digital measures).

CMS indicates that it will not respond to comments received through the FY 2022 SNF PPS final rule, but the input from commenters will be considered in future policy making.

In providing background for this RFI, CMS offers a definition for digital quality measures (dQMs): quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. CMS notes that a dQM's score includes a calculation that processes digital data; the agency also lists multiple examples of dQM data sources (e.g., electronic health records - EHRs, wearable medical devices).

CMS discusses the potential role of FHIR-based standards for efficient exchange of clinical information across clinical settings by clinicians through APIs. Exploration is underway at the

agency regarding the use of FHIR-based APIs to access quality data already being collected through its Quality Improvement and Evaluation System (QIES) and the Internet QIES (iQIES), with consideration also being given to using FHIR interfaces to access standardized assessment data from SNF EHRs.

CMS concludes the discussion of this RFI by committing to using policy levers and collaborating with stakeholders to transition to fully digital quality measurement across the agency, with staged implementation of a cohesive portfolio of dQMs and incorporation of principles from the HHS National Health Quality Roadmap.

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

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

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

CMS states that it will not respond to comments received through the FY 2022 SNF PPS final rule, but the input from commenters will be considered in future policy making.

As background for this RFI, CMS reviews multiple examples of poor health outcomes that could stem from disparate care across patient populations (e.g., higher COVID-19 complication rates for black, Latino, and Indigenous and Native Americans relative to whites). CMS adopts for purposes of this RFI a definition of equity taken from Executive Order 13985 issued on January 21, 2021: "the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality". Finally, examples are provided of ongoing efforts by CMS to enhance the transparency of information about healthcare disparities, such as the addition of SPADES for

required reporting of selected social determinants of health in the SNF QRP beginning with FY 2020.

E. Form, Manner, and Timing of Data Submission

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

SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)

The proposed SNF HAI measure is calculated using Medicare Fee-for-Service claims data, so that no new data submission is required of SNFs related to this measure. For the FY 2023 SNF QRP, CMS proposes to use the full year of claims data from FY 2019, the most recent fiscal year of data that has not been affected by data reporting exceptions related to the COVID-19 PHE. For the FY 2024 program year, CMS proposes to use the full year of claims data from FY 2021, and advance thereafter by one FY with each annual SNF QRP data refresh. The schedule as proposed avoids using data Q1 and Q2 2020 data for which a national data reporting exception was issued due to COVID-19 PHE impacts.

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

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

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

SNF QRP measure data are displayed via CMS' Care Compare and the Provider Data Catalog web pages in the *Nursing homes including rehab services* section.[3]

SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)

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

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

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

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

CMS proposes to add the new COVID-19 vaccination coverage measure to publicly reported SNF QRP data available on the Care Compare and the Provider Data Catalog web pages. Display would begin with the October 2022 Care Compare refresh, or as soon as technically feasible, based on Q4 2021 data. One additional quarter of data would be added with each subsequent refresh until four quarters are reached, after which time display would continue using a rolling four quarters of data.

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

Overview. CMS proposes temporary changes to the data collection quarters specified in prior rulemaking for SNF QRP measure results that are publicly displayed on Care Compare. The proposed collection period changes are designed to account for incomplete data reporting during the COVID-19 pandemic and to return to pre-pandemic public reporting timelines as rapidly as feasible, while preserving the usefulness and accuracy of the displayed results.

Normally four successive quarters of data are used in calculating measures derived from the SNF Minimum Data Set (MDS) patient assessment instrument and eight quarters for claims-based measures. CMS notes that its guidance memo of March 27, 2020 included an exception to extant data reporting policy that allowed all SNFs to voluntarily forgo QRP data reporting for Q4 2019, Q1 2020, and Q2 2020.

Analytic Approach and Results: Initial Steps. CMS discusses at length the data analyses used in developing the proposed changes. Analytic steps included 1) identifying all of the quarterly Care Compare refreshes of SNF QRP results that could be impacted by the suspension of data reporting; and 2) separately analyzing the data actually submitted by SNFs during Q4 2019, as those data were generated before the PHE was declared, though may have been submitted after the declaration. CMS lists the Care Compare refreshes identified as being potentially impacted by the PHE in Table 28 of the rule. The agency also found that when compared to data from FY 2018 and FY 2019, the Q4 2019 data were similar for level of reporting and for outcomes trends; therefore, the Q4 2019 data were included in the October 2020 refresh as established in prior rulemaking.

Analytic Approach and Results: Data Freeze and the COVID-19 Affected Reporting (CAR) Scenario. After reviewing the available Q1 2020 and Q2 2020 data, CMS decided not to utilize them for public display. Instead, the agency determined that the most straightforward, efficient, and equitable approach was to freeze (hold constant) the Care Compare-displayed data with the October 2020 refresh values, until reliability of the results for subsequent quarters approached pre-pandemic levels. To shorten the duration of the data freeze, CMS explored reducing the

number of data quarters used at each refresh. In this analysis, termed the CAR Scenario, data quarters were decreased from 4 to 3 for measures derived from the MDS and from 8 to 6 for claims-based measures. Reportability and reliability were found to be acceptable under the CAR scenario.

Revised and Proposed Schedules for Data Display. The combined revised (data freeze) and proposed (CAR scenario) reporting schedule for SNF QRP measures based on the MDS is shown in Table 29 of the rule. October 2020 refresh data would be frozen through the October 2021 refresh, the CAR scenario would be applied for the January 2022 refresh, and normal (4-quarter) reporting would resume with the April 2022 refresh.

The combined revised (data freeze) and proposed (CAR scenario) reporting schedule for claims-based measures is shown in Table 30 of the rule. Data would be frozen through the October 2021 refresh, the CAR scenario would be applied through the July 2023 refresh, and normal (8-quarter) reporting would resume with the September 2023 refresh.

Table 31 in section VI.H.4.c of the rule shows the display schedule for the SNF HAI measure.[4] Data would be frozen for the first two refreshes of this new claims-based measure (April 2022 and July 2022) and normal reporting would start with the October 2022 refresh. The CAR scenario would not be applied to this measure.

G. Summary Table of SNF QRP Measures

Quality Measures Currently Adopted for the FY 2022 SNF QRP

Short Name	Measure Name & Data Source
Data Source: Resident Assessment Instrument Minimum Data Set	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
Beginning in FY 2022*	Transfer of Health Information to the Provider – PAC Measure
Beginning in FY 2022*	Transfer of Health Information to the Patient – PAC Measure**
Data Source: Claims-Based	

[4] In what appears to be an inadvertent numbering error, there is also a "Table 31" in section VII.B.4 of the rule.

Short Name	Measure Name & Data Source
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
* Data collection was to begin with October 2020 for FY 2022 program use but has been delayed due to the COVID-19 PHE to begin with discharges on October 1st of the year that is at least 2 full FY after the PHE ends (85 FR 27596). **Measure denominator revision has been proposed for the FY 2023 program year.	

Source: HPA modification of Table 26 of the proposed rule

VI. SNF VBP

The SNF VBP Program was implemented for discharges beginning in FY 2019 and applies to all SNFs paid under the SNF PPS: freestanding, affiliated with acute care facilities, and non-CAH swing-bed rural facilities. Measures for the program and a performance scoring methodology were adopted in the FY 2016 and 2017 SNF PPS final rules. An Extraordinary Circumstances Exception (ECE) policy was finalized for FY 2019; the FY 2019 and FY 2020 final rules added scoring adjustments and data suppression policies for low-volume facilities. Public display of SNF VBP performance was moved to CMS' Provider Data Catalogue website beginning with FY 2021.[5,6]

In general, the SNF VBP Program withholds 2.0 percent of the payments that would be made to SNFs and redistributes approximately 60 percent of the money withheld for redistribution based on performance. Specifically, amounts redistributed are based on each facility's VBP measure performance and delivered by applying a value-based incentive adjustment to each SNF's adjusted FY federal per diem rate. The remaining 40 percent is returned as savings to the Medicare program, minus funds used for adjustments made according to low-volume facility policies.

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

A. SNF VBP Program Measures

The measures that have been adopted into the SNF VBP Program are the SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510) and the Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge (SNFPPR). Currently, only the SNFRM is in use; as required by statute, CMS intends to replace the SNFRM with the SNFPPR. Toward that end, CMS plans to submit the SNFPPR to the NQF for endorsement during the fall 2021 cycle, and timing of the measure transition will be determined thereafter. Section 111 of the Consolidated Appropriations Act of 2021 (CAA) amended Section 1888(h) of the Act, allowing the Secretary to add up to 9 additional measures, determined to be appropriate by the Secretary, to the SNF VBP Program. The new measures would apply to payments for services on or after October 1, 2023.

[5] See https://data.cms.gov/provider-data/.
[6] For Section VII of this document, a year is a calendar year unless otherwise specified.

The CAA also requires the Secretary to apply a data validation process for SNF VBP measures (and for the SNF QRP measures as noted previously in this summary). CMS indicates that the SNF validation process most likely will build on that recently established for the Hospital Inpatient Quality Reporting (IQR) Program measures.

Request for Comments on Potential Future Measures

CMS describes potential sources and clinical topics for the new measure solicitation (e.g., the SNF QRP, rates of SNF staff turnover) and provides a list of measures under consideration in Table 31 as found in section VII.B.4 of the rule[7] (reproduced below with modification). CMS believes that the added burden to providers could be minimized by adopting measures already familiar to SNFs (e.g., healthcare associated infections).

In addition to the measures in Table 31, CMS specifically invites comments about:

- Measures of SNF staffing, including staff turnover;
- Patient-reported outcome measures;
- Measure concepts or measures not included in Table 31; and
- Requiring SNF VBP measure data collection on all facility residents, regardless of payer.

Quality Measures Under Consideration for an Expanded SNF VBP Program		
NQF ID #	**Quality Measure**	**Measure Area**
Source: Minimum Data Set (MDS) SNF Patient Assessment Instrument		
A2635	Discharge Self-Care Score	Functional Outcomes
A2636	Discharge Mobility Score	Functional Outcomes
0674	Falls with Major Injury	Preventable Healthcare Harm
0679	Pressure Ulcers	Preventable Healthcare Harm
N/A	Ability to Move Independently Worsened	Functional Outcomes
N/A	Increased Assistance Needed Activities of Daily Living	Functional Outcomes
N/A	Transfer of Health Information - Provider	HIT Interoperability
N/A	Received Antipsychotic Medication	Medication Management
Type: Medicare Fee-for-Service Claims-Based Measures		
3481	Discharge to Community PAC-SNF	Community Engagement
N/A	Medicare Spending per Beneficiary – PAC SNF	Pt-focused Care Episode
N/A	Healthcare Associate Infections Requiring Hospitalization	Healthcare Assoc Infections
N/A	Hospitalizations per 1000 resident-days	Admissions/Readmissions
Type: Patient-Reported Outcome (PRO) Measure		
N/A	PROMIS Global Health, Physical	Functional Outcomes
Type: Survey Questionnaire		
2614	CoreQ: Short Stay Discharge Measure	Experience of Care
Source: CMS Payroll Based Journal		
N/A	Nurse Staffing Hours per Resident Day (RN and Total)	N/A

[7]In what appears to be an inadvertent numbering error, there is also a "Table 31" in section VI.H.4.c of the rule.

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

CMS proposes to adopt a policy for the duration of the COVID-19 PHE permitting suppression of SNFRM data from use for scoring and payment adjustments in a VBP program year, in order to avoid holding facilities accountable for distorted or skewed measure results. The proposed policy would be applied if and when CMS determines that circumstances related to the PHE have significantly compromised the measure data and performance scores based on those data.

SNF readmission rates would be calculated as usual but not be transformed into facility performance scores, nor used to rank SNFs or calculate value-based incentive payment percentages. Instead, CMS would:

- Assign a performance score of zero to all SNFs;
- Reduce each facility's adjusted federal per diem rate by 2 percent (the withhold); and
- Return 60 percent of the amount withheld to the facility as a value-based incentive payment.
    - Per policy, 100 percent of the amounts withheld would be returned to low-volume SNFs.

Having considered the extensive potential effects of the PHE on SNF patient care, CMS proposes a set of Measure Suppression Factors to guide its decision-making about suppressing SNFRM data:

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

As an alternative to the proposed policy, CMS considered extending the national ECE for quality data reporting during Q1 and Q2 2020 to include Q3 2020 data. CMS rejected this alternative because the large data gap created would have prolonged downstream effects on readmissions rate accuracy, preclude meaningful feedback for providers, and hamper development of future data-driven programmatic changes.

CMS requests comments on:

- **The proposed Measure Suppression Factors;**
- **Development of a measure suppression policy for future PHEs under which measure suppression could be activated without notice-and-comment rulemaking;**
- **Regional adjustment of measure suppression for factors such as population density;**
- **Partial rather than total suppression of measure data; and**

- **Extension of the ECE for quality data reporting to Q3 2020 data as an alternative to the proposed policy for SNFRM data suppression.**

C. Implementing Data Suppression for the FY 2022 SNF VBP Program Year

CMS proposes to make a determination to apply the proposed SNFRM data suppression policy for the FY 2022 SNF VBP program year based on proposed Measure Suppression Factor 4(iii): significant national shortages or rapid or unprecedented changes in patient case volumes or facility-level case mix. CMS reached its determination after analyzing the validity of the FY 2022 performance data using the performance period as finalized in the September 2nd COVID IFC: April 1, 2019 -December 31, 2019 (Q2, Q3, and Q4 2019 data; pre-PHE) plus July 1, 2020-September 30, 2020 (Q2 2020 data; during the PHE).

In reaching its determination, CMS considered the following findings:

- Q3 2020 SNF admissions and readmissions (from a SNF to a hospital) declined by 25 percent and 26 percent, respectively, compared to Q3 2019;
- Reliability of the SNFRM would fall by up to 15 percent;
- Other important case-mix changes including
  - an 18 percent increase in dual-eligible SNF residents,
  - a 9 percent increase in African-American SNF residents, and
  - the beginning of COVID-19 infections in SNF residents during 2020, reaching a 10 percent rate by Q3 2020, with substantial temporal and geographic variations;
- Lack of SNFRM risk-adjustment for COVID-19 infections, raising concerns about combining 2019 and 2020 data into the same performance period;
- Removing the Q3 2020 data entirely reduced the estimated measure reliability (0.367) below the usual CMS minimum threshold (0.40); and
- Substitution of data from other periods for Q3 2020 data produces undesirable consequences (e.g., delay in setting FY 2022 federal per diem rates.

If the proposed data suppression policy and its proposed application for FY 2022 are finalized, for the FY 2022 SNF VBP program year CMS would:

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

As described in the previous summary section, applying the steps above would result in a return of 60 percent of the 2 percent withhold amount to each facility as a value-based incentive payment, except that a low-volume SNF would receive 100 percent.

CMS would also provide confidential readmission feedback reports to SNFs. The SNFRM rates for FY 2022 would be publicly displayed but accompanied by material describing the effects of the COVID-19 PHE. The proposed application of the data suppression policy for FY 2022 would be codified as "special rules" for FY 2022 at § 413.338(g).

D. Risk-Adjustment Lookback Period for FY 2023

CMS proposes to revise the lookback period to be used in the SNFRM risk adjustment model for the FY 2023 SNF VBP program year from 365 days to 90 days. Per established policy, for eligible SNF admissions during the FY 2023 SNFRM performance period, the lookback period for each case covers the year prior to the initial discharge from a hospital to the SNF admission. Because the FY 2023 performance period has been previously finalized as FY 2021, the associated lookback period would include claims data from the COVID-19 PHE. The lookback would thereby be limited by the national ECE that excludes Q1 and Q2 2020 data. Analyses of FY 2019 performance data showed that risk-adjustment model performance was very similar for 90-day and 365-day periods.

CMS is considering aligning the lookback periods for the baseline and performance periods to be used for the FY 2023 SNF VBP program year. This would be done reducing the lookback period to 90 days for the applicable baseline period. CMS invites comment on this potential revision.

E. SNF VBP Performance Period Considerations

FY 2022 Program Year. The performance period had been finalized as the 12-month combination of Q2, Q3, and Q4 2019 with Q3 2020. See summary section VII.C. above for proposed changes.

FY 2023 Program Year. CMS proposes no changes to the previously finalized performance (FY 2021) and baseline (FY 2019) periods. CMS considered but rejected the alternative of substituting CY 2021 as the performance period as incentive payments would then be delayed due to operational factors at CMS. **CMS invites comment on the alternative.**

FY 2024 Program Year. Per extant policy, the performance period would be FY 2023 and the baseline period would be FY 2020. The finalized national quality reporting ECE and the proposed suppression for 2020 data taken together would leave only Q4 2019 data available for the baseline period. CMS proposes to use instead the full 12 months of FY 2019 data as the baseline period for program year FY 2024. Using FY 2021 as the baseline period was considered but rejected as operationally infeasible for CMS.

F. SNF VBP Performance Standards

CMS does not propose any changes to performance standards policies previously finalized in the FY 2017, FY 2019, and FY 2021 SNF PPS final rules nor to the final numerical performance standards values already established for the FY 2023 and FY 2024 program years. Based on the proposed use of FY 2019 data as the baseline period, CMS estimates the SNFRM (NQF #2150) numerical performance standards for FY 2024 to consist of an achievement threshold of 0.79270 and a benchmark of 0.83028.

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

CMS provides references to discussions of SNF VBP performance scoring in prior SNF PPS final rules. If the proposed SNFRM data suppression policy for the FY 2022 program year is finalized, CMS would take the following approach to performance scoring for that year:[8]

- Calculate each facility's Risk Standardized Readmission Rate (RSRR) for the SNFRM using the previously finalized performance and baseline periods for the FY 2022 program year.
- Assign all facilities a performance score of zero.
  - This step produces an identical performance score and an identical value-based incentive payment multiplier for all facilities.
- Apply the existing low-volume adjustment policies.
  - Assign a net-neutral value-based incentive payment multiplier to each SNF with fewer than 25 eligible stays during the performance period.

CMS will not rank SNFs for the FY 2022 program year.

H. SNF Value-Based Incentive Payments

Readers are referred to the FY 2018 and FY 2019 SNF PPS final rules for a description of the exchange function methodology adopted for the SNF VBP Program through which CMS calculates the incentive payment adjustments from the performance scores. The process for reducing SNFs' adjusted federal per diem rates and awarding value-based incentive payments is also described in the FY 2019 rule.

Proposal for the FY 2022 SNF VBP Program Year

CMS reiterates that the proposed SNFRM data suppression and associated policies if finalized will produce an identical performance score and value-based incentive payment multiplier for all SNFs except low-volume facilities. CMS seeks both to comply with the statutory SNF VBP program's 2 percent withhold and to equitably apportion the effect of the withhold across SNFs during a program year.

Therefore, CMS proposes to reduce the FY 2022 adjusted federal per diem rate for each SNF by 2 percentage points. CMS further proposes that low-volume SNFs would each receive back 100 percent of their withheld amounts and all other facilities would each receive 60 percent of amounts withheld in lieu of the usual SNF VBP payments that are determined by each facility's unique SNFRM performance data.

I. Public Reporting of SNF VBP Scores and Ranking for the FY 2022 Program Year

CMS provides readers with references to previously adopted policies and proposes no changes for the FY 2024 program year. CMS reiterates that the SNFRM performance scores will be publicly displayed as usual

[8] An illustrative hypothetical calculation absent the COVID-19 PHE effects (for the FY 2021 program year, FY 2019 performance period) is available at https://www.cms.gov/files/document/snf-vbp-fy-2021-ipm-infographic.pdf.

for all facilities, including the usual modifications of displayed data elements for low-volume facilities. No SNF rankings will be displayed for this program year.[9]

J. Phase One Review and Correction Policy Revision ("Snapshot" Policy)

CMS proposes to revise its policy for the Phase One review and correction process by which SNFs can review and submit corrections to their quarterly confidential SNF VBP performance reports before the performance data are publicly displayed. Under the revised policy, after a "snapshot" date, facilities would be permitted to submit corrections of calculation errors made by CMS or its contractors but not corrections to the claims data used in the calculations. The snapshot's data would be extracted by CMS from claims stored in the Medicare Provider Analysis and Review (MedPAR) file at 3 months after the date of the last index SNF admission that will be included in the upcoming baseline or performance period report.[10]

Once the snapshot is taken, its data would be held static (frozen) for purposes of SNF VBP data display and no longer open to correction by SNFs. CMS notes that the revised policy would align the SNF VBP program corrections policy with those of other value-based Medicare programs (e.g., the Hospital Readmissions Reduction Program). CMS proposes to begin the snapshot policy with baseline and performance period quarterly reports issued on or after October 1, 2021.

K. Update to Instructions for Requesting an ECE

CMS proposes several minor changes to the instructions for requesting an extraordinary circumstances exception, namely: updating the electronic mail address to which the request is to be submitted; updating the URL of CMS' QualityNet website; and removing a reference to "newspapers".

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

CMS estimates that the total reduction in payments required under the statute for the FY 2022 program year (i.e., the 2.0 percent withhold) will total $516.2 million. If the proposed SNFRM data suppression policy for the FY 2022 program year is finalized, CMS anticipates returning 100 percent of amounts withheld to low-volume SNFs and 60 percent of amounts withheld to the remaining facilities. For FY 2022, the low-volume adjustment is estimated to return $16.4 million to low-volume SNFs while $308.1 million would be returned to the remaining facilities. The total $325.4 million returned to SNFs equates to a 62.9 percent payback of withheld amounts. The remaining withheld funds, about $191.6 million, represent savings to the Medicare program.

In Table 35 of the proposed rule, CMS displays the estimated effects in FY 2022 of the SNF VBP Program by types of providers and location.

[9] Publicly displayed SNF VBP information is available on CMS' Care Compare and Provider Data Catalog websites: https://www.medicare.gov/care-compare/ and https://data.cms.gov/provider-data/ respectively.
[10] For example, if the last index SNF admission claim date is 9/30/2019, the snapshot date would be 12/31/2019.

TABLE 35: SNF VBP Program Estimated Impacts for FY 2022 (From the proposed rule with modification by HPA)					
Characteristic	**Facilities (#)**	**Mean SNFRM Risk-Standardized Readmission Rate (%)**	**Mean performance score**	**Mean incentive multiplier**	**Percent of total SNF Medicare Part A FFS payment after applying incentives**
Group					
Total	15,026	19.90	1.4545	0.99426	100.00
Urban	10,845	19.94	1.1528	0.99379	85.29
Rural	4,181	19.81	2.2371	0.99547	14.71
Hospital-based urban*	284	19.68	1.1794	0.99383	1.79
Freestanding urban*	10,520	19.95	1.1423	0.99377	83.47
Hospital-based rural*	182	19.55	2.6050	0.99604	0.43
Freestanding rural*	3,803	19.81	2.1479	0.99538	14.12
Urban by region					
New England	744	20.10	0.8104	0.99326	5.38
Middle Atlantic	1,462	19.78	0.7155	0.99311	16.57
South Atlantic	1,874	20.00	0.6407	0.99299	17.01
East North Central	2,065	20.08	1.3950	0.99417	13.32
East South Central	555	20.08	0.9471	0.99347	3.53
West North Central	923	19.92	2.1104	0.99528	4.23
West South Central	1,312	20.11	1.6811	0.99461	7.48
Mountain	523	19.56	1.4090	0.99419	3.72
Pacific	1,381	19.67	0.9702	0.99351	14.05
Outlying	6	20.96	2.5766	0.99600	0.00
Rural by region					
New England	122	19.30	1.6896	0.99462	0.64
Middle Atlantic	210	19.53	1.1779	0.99383	0.90
South Atlantic	473	19.91	1.5144	0.99435	2.11
East North Central	895	19.69	1.8310	0.99484	3.35
East South Central	495	20.06	1.1139	0.99373	2.26
West North Central	1,006	19.77	3.5653	0.99753	1.99
West South Central	689	20.13	2.5430	0.99595	2.18
Mountain	199	19.43	2.5378	0.99594	0.66
Pacific	91	19.22	1.5856	0.99446	0.60
Outlying	1	19.37	5.1533	1.0000	0.00
Ownership					
Government	877	19.77	2.5149	0.9959	3.28
Profit	10,583	19.95	1.3693	0.9941	74.38
Non-Profit	3,566	19.81	1.4466	0.9943	22.33

* The group category which includes hospital-based/freestanding by urban/rural excludes 253 swing-bed SNFs.

VII. Economic Analyses

CMS estimates that under the proposed rule in FY 2022, SNFs would experience an increase of about $444 million in payments or an average increase of 1.3 percent across all SNFs. This impact reflects a $445 million increase from the update to the payment rates and a $1.2 million decrease due to the excluding blood clotting factors (and related items and services) from the SNF PPS rates. CMS notes that these impact numbers do not incorporate the SNF VBP reductions that are estimated to reduce aggregate payments to SNFs by $191.64 million.

Table 33 of the proposed rule (reproduced below) shows the estimated impact of the proposed rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the proposed market basket update in the total change column and the proposed budget neutral updates to the wage index data. In general, CMS estimates that because of the wage index changes, payment rates for SNFs in rural areas would grow by more than the 1.3 percent overall increase.

TABLE 33: Impact to the SNF PPS for FY 2022

Provider Characteristics	# Providers	Update Wage Data	Total Change
Group			
Total	15,440	0.0%	1.3%
Urban	10,887	-0.1%	1.2%
Rural	4,553	0.4%	1.8%
Hospital-based urban	385	-0.2%	1.1%
Freestanding urban	10,502	-0.1%	1.2%
Hospital-based rural	451	0.3%	1.6%
Freestanding rural	4,102	0.4%	1.7%
Urban by region			
New England	742	-0.7%	0.6%
Middle Atlantic	1,447	-0.5%	0.8%
South Atlantic	1,820	0.4%	1.7%
East North Central	2,145	-0.2%	1.1%
East South Central	539	-0.4%	0.9%
West North Central	919	0.4%	1.7%
West South Central	1,342	-0.3%	1.0%
Mountain	536	0.1%	1.4%
Pacific	1,391	0.2%	1.5%
Outlying	6	0.4%	1.7%
Rural by region			
New England	129	-0.9%	0.4%
Middle Atlantic	245	0.5%	1.8%
South Atlantic	597	1.2%	2.5%
East North Central	909	0.5%	1.8%
East South Central	526	-0.1%	1.2%
West North Central	1,058	-0.3%	1.0%
West South Central	756	0.4%	1.7%
Mountain	222	0.5%	1.8%
Pacific	111	0.3%	1.6%

Provider Characteristics	# Providers	Update Wage Data	Total Change
Ownership			
For profit	10,809	0.0%	1.3%
Non-profit	3,637	0.0%	1.3%
Government	994	0.2%	1.5%

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

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

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

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

DPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$96.15	1.49	$87.15	0.68	$15.95	ES3	4.06	$444.77	3.24	$267.75
B	1.70	$106.83	1.63	$95.34	1.82	$42.70	ES2	3.07	$336.32	2.53	$209.08
C	1.88	$118.14	1.69	$98.85	2.67	$62.64	ES1	2.93	$320.98	1.84	$152.06
D	1.92	$120.65	1.53	$89.49	1.46	$34.25	HDE2	2.40	$262.92	1.33	$109.91
E	1.42	$89.23	1.41	$82.47	2.34	$54.90	HDE1	1.99	$218.00	0.96	$79.33
F	1.61	$101.17	1.60	$93.58	2.98	$69.91	HBC2	2.24	$245.39	0.72	$59.50
G	1.67	$104.94	1.64	$95.92	2.04	$47.86	HBC1	1.86	$203.76	-	-
H	1.16	$72.89	1.15	$67.26	2.86	$67.10	LDE2	2.08	$227.86	-	-
I	1.13	$71.01	1.18	$69.02	3.53	$82.81	LDE1	1.73	$189.52	-	-

DPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
J	1.42	$89.23	1.45	$84.81	2.99	$70.15	LBC2	1.72	$188.43	-	-
K	1.52	$95.52	1.54	$90.07	3.7	$86.80	LBC1	1.43	$156.66	-	-
L	1.09	$68.50	1.11	$64.92	4.21	$98.77	CDE2	1.87	$204.86	-	-
M	1.27	$79.81	1.30	$76.04	-	-	CDE1	1.62	$177.47	-	-
N	1.48	$93.00	1.50	$87.74	-	-	CBC2	1.55	$169.80	-	-
O	1.55	$97.40	1.55	$90.66	-	-	CA2	1.09	$119.41	-	-
P	1.08	$67.87	1.09	$63.75	-	-	CBC1	1.34	$146.80	-	-
Q	-	-	-	-	-	-	CA1	0.94	$102.98	-	-
R	-	-	-	-	-	-	BAB2	1.04	$113.93	-	-
S	-	-	-	-	-	-	BAB1	0.99	$108.45	-	-
T	-	-	-	-	-	-	PDE2	1.57	$171.99	-	-
U	-	-	-	-	-	-	PDE1	1.47	$161.04	-	-
V	-	-	-	-	-	-	PBC2	1.22	$133.65	-	-
W	-	-	-	-	-	-	PA2	0.71	$77.78	-	-
X	-	-	-	-	-	-	PBC1	1.13	$123.79	-	-
Y	-	-	-	-	-	-	PA1	0.66	$72.30	-	-

TABLE 7: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$109.59	1.49	$98.03	0.68	$20.10	ES3	4.06	$424.92	3.24	$255.83
B	1.70	$121.77	1.63	$107.24	1.82	$53.80	ES2	3.07	$321.31	2.53	$199.77
C	1.88	$134.66	1.69	$111.19	2.67	$78.93	ES1	2.93	$306.65	1.84	$145.29
D	1.92	$137.53	1.53	$100.66	1.46	$43.16	HDE2	2.40	$251.18	1.33	$105.02
E	1.42	$101.71	1.41	$92.76	2.34	$69.17	HDE1	1.99	$208.27	0.96	$75.80
F	1.61	$115.32	1.60	$105.26	2.98	$88.09	HBC2	2.24	$234.44	0.72	$56.85
G	1.67	$119.62	1.64	$107.90	2.04	$60.30	HBC1	1.86	$194.67	-	-
H	1.16	$83.09	1.15	$75.66	2.86	$84.54	LDE2	2.08	$217.69	-	-
I	1.13	$80.94	1.18	$77.63	3.53	$104.35	LDE1	1.73	$181.06	-	-
J	1.42	$101.71	1.45	$95.40	2.99	$88.38	LBC2	1.72	$180.02	-	-
K	1.52	$108.88	1.54	$101.32	3.7	$109.37	LBC1	1.43	$149.66	-	-
L	1.09	$78.08	1.11	$73.03	4.21	$124.45	CDE2	1.87	$195.71	-	-
M	1.27	$90.97	1.30	$85.53	-	-	CDE1	1.62	$169.55	-	-
N	1.48	$106.01	1.50	$98.69	-	-	CBC2	1.55	$162.22	-	-
O	1.55	$111.03	1.55	$101.97	-	-	CA2	1.09	$114.08	-	-
P	1.08	$77.36	1.09	$71.71	-	-	CBC1	1.34	$140.24	-	-
Q	-	-	-	-	-	-	CA1	0.94	$98.38	-	-
R	-	-	-	-	-	-	BAB2	1.04	$108.85	-	-
S	-	-	-	-	-	-	BAB1	0.99	$103.61	-	-
T	-	-	-	-	-	-	PDE2	1.57	$164.32	-	-
U	-	-	-	-	-	-	PDE1	1.47	$153.85	-	-
V	-	-	-	-	-	-	PBC2	1.22	$127.69	-	-
W	-	-	-	-	-	-	PA2	0.71	$74.31	-	-
X	-	-	-	-	-	-	PBC1	1.13	$118.27	-	-
Y	-	-	-	-	-	-	PA1	0.66	$69.08	-	-