

§ 413.321

(a) Establishing the prospectively determined payment rates for routine services; and

(b) Explaining the basis on which the prospectively determined payment rates are calculated.

§ 413.321 Simplified cost report for SNFs.

SNFs electing to be paid under the prospectively determined payment rate system may file a simplified cost report. The cost report contains a simplified method of cost finding to be used in lieu of cost methods described in § 413.24(d). This method is specified in the instructions for Form CMS-2540S, contained in sections 3000–3027.3 of Part 2 of the Provider Reimbursement Manual. This form may not be used by hospital-based SNFs or SNFs that are part of a health care complex. Those SNFs must file a cost report that reflects the shared services and administrative costs of the hospital and any other related facilities in the health care complex.

Subpart J—Prospective Payment for Skilled Nursing Facilities

SOURCE: 63 FR 26309, May 12, 1998, unless otherwise noted.

§ 413.330 Basis and scope.

(a) *Basis.* This subpart implements section 1888(e) of the Act, which provides for the implementation of a prospective payment system for SNFs for cost reporting periods beginning on or after July 1, 1998.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for SNFs, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules.

§ 413.333 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the resident classification system.

Market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods

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and services included in covered skilled nursing services.

Resident classification system means a system for classifying SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria. For purposes of this subpart, this term refers to the current version of the resident classification system, as set forth in the annual publication of Federal prospective payment rates described in § 413.345.

Rural area means, for services provided on or after July 1, 1998, but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii) of this chapter. For services provided on or after October 1, 2005, *rural area* means an area as defined in § 412.64(b)(1)(ii)(C) of this chapter.

Urban area means, for services provided on or after July 1, 1998, but before October 1, 2005, an area as defined in § 412.62(f)(1)(ii) of this chapter. For services provided on or after October 1, 2005, *urban area* means an area as defined in §§ 412.64(b)(1)(ii)(A) and 412.64(b)(1)(ii)(B) of this chapter.

[63 FR 26309, May 12, 1998; 63 FR 53307, Oct. 5, 1998, as amended at 73 FR 46440, Aug. 8, 2008; 82 FR 36633, Aug. 4, 2017]

§ 413.335 Basis of payment.

(a) *Method of payment.* Under the prospective payment system, SNFs receive a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. The per diem payments are made on the basis of the Federal payment rate described in § 413.337 and, during a transition period, on the basis of a blend of the Federal rate and the facility-specific rate described in § 413.340. These per diem payment rates are determined according to the methodology described in §§ 413.337 and 413.340.

(b) *Payment in full.* (1) The payment rates represent payment in full (subject to applicable coinsurance as described in subpart G of part 409 of this chapter) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to Medicare beneficiaries other than costs associated with approved educational activities as described in § 413.85.

(2) In addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare beneficiaries, as specified in §413.89 of this part.

[63 FR 26309, May 12, 1998, as amended at 73 FR 46440, Aug. 8, 2008]

§413.337 Methodology for calculating the prospective payment rates.

(a) *Data used.* (1) To calculate the prospective payment rates, CMS uses—

(i) Medicare data on allowable costs from freestanding and hospital-based SNFs for cost reporting periods beginning in fiscal year 1995. SNFs that received “new provider” exemptions under §413.30(e)(2) are excluded from the data base used to compute the Federal payment rates. In addition, allowable costs related to exceptions payments under §413.30(f) are excluded from the data base used to compute the Federal payment rates;

(ii) An appropriate wage index to adjust for area wage differences;

(iii) The most recent projections of increases in the costs from the SNF market basket index;

(iv) Resident assessment and other data that account for the relative resource utilization of different resident types; and

(v) Medicare Part B SNF claims data reflecting amounts payable under Part B for covered SNF services (other than those services described in §411.15(p)(2) of this chapter) furnished during SNF cost reporting periods beginning in fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services.

(b) *Methodology for calculating the per diem Federal payment rates—*(1) *Determining SNF costs.* In calculating the initial unadjusted Federal rates applicable for services provided during the period beginning July 1, 1998 through September 30, 1999, CMS determines each SNF’s costs by summing its allowable costs for the cost reporting period beginning in fiscal year 1995 and its estimate of Part B payments (described in paragraphs (a)(1)(i) and (a)(1)(v) of this section).

(2) *Use of market basket index.* The SNF market basket index is used to adjust the SNF cost data to reflect cost increases occurring between cost re-

porting periods represented in the data and the initial period (beginning July 1, 1998 and ending September 30, 1999) to which the payment rates apply. For each year, the cost data are updated by a factor equivalent to the annual market basket index percentage minus 1 percentage point.

(3) *Calculation of the per diem cost.* For each SNF, the per diem cost is computed by dividing the cost data for each SNF by the corresponding number of Medicare days.

(4) *Standardization of data for variation in area wage levels and case-mix.* The cost data described in paragraph (b)(2) of this section are standardized to remove the effects of geographic variation in wage levels and facility variation in case-mix.

(i) The cost data are standardized for geographic variation in wage levels using the wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in §413.333.

(ii) Starting on October 1, 2022, CMS applies a cap on decreases to the wage index such that the wage index applied to a SNF is not less than 95 percent of the wage index applied to that SNF in the prior FY.

(iii) The cost data are standardized for facility variation in case-mix using the case-mix indices and other data that indicate facility case-mix.

(5) *Calculation of unadjusted Federal payment rates.* CMS calculates the national per diem unadjusted payment rates by urban and rural classification in the following manner:

(i) By computing the average per diem standardized cost of freestanding SNFs weighted by Medicare days.

(ii) By computing the average per diem standardized cost of freestanding and hospital-based SNFs combined weighted by Medicare days.

(iii) By computing the average of the amounts determined under paragraphs (b)(5)(i) and (b)(5)(ii) of this section.

(c) *Calculation of adjusted Federal payment rates for case-mix and area wage levels.* The Federal rate is adjusted to account for facility case-mix using a resident classification system and associated case-mix indices that account for the relative resource utilization of

different patient types. This classification system utilizes the resident assessment instrument completed by SNFs as described at § 483.20 of this chapter, according to the assessment schedule described in § 413.343(b). The Federal rate is also adjusted to account for geographic differences in area wage levels using an appropriate wage index.

(d) *Annual updates of Federal unadjusted payment rates.* CMS updates the unadjusted Federal payment rates on a fiscal year basis.

(1) *Update formula.* The unadjusted Federal payment rate shall be updated as follows:

(i) For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the unadjusted Federal payment rate is equal to the rate computed under paragraph (b)(5)(iii) of this section increased by a factor equal to the SNF market basket index percentage change for such period minus 1.0 percentage point.

(ii) For fiscal year 2000, the unadjusted Federal payment rate is equal to the rate computed for the initial period described in paragraph (d)(1)(i) of this section increased by a factor equal to the SNF market basket index percentage change for that period minus 1.0 percentage point.

(iii) For fiscal year 2001, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year.

(iv) For fiscal years 2002 and 2003, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved minus 0.5 percentage points.

(v) For each subsequent fiscal year, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved, except as provided in paragraphs (d)(1)(vi) and (vii) of this section.

(vi) For fiscal year 2018, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF

market basket index percentage change of 1 percent (after application of paragraphs (d)(2) and (3) of this section).

(vii) For fiscal year 2019, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF market basket index percentage change of 2.4 percent (after application of paragraphs (d)(2) and (3) of this section).

(2) *Forecast error adjustment.* Beginning with fiscal year 2004, an adjustment to the annual update of the previous fiscal year's rate will be computed to account for forecast error. The initial adjustment (in fiscal year 2004) to the update of the previous fiscal year's rate will take into account the cumulative forecast error between fiscal years 2000 and 2002. Subsequent adjustments in succeeding fiscal years will take into account the forecast error from the most recently available fiscal year for which there is final data. The forecast error adjustment applies whenever the difference between the forecasted and actual percentage change in the SNF market basket index exceeds the following threshold:

(i) 0.25 percentage points for fiscal years 2004 through 2007; and

(ii) 0.5 percentage points for fiscal year 2008 and subsequent fiscal years.

(3) *Multifactor productivity (MFP) adjustment.* For fiscal year 2012 and each subsequent fiscal year, the SNF market basket index percentage change for the fiscal year (as modified by any applicable forecast error adjustment under paragraph (d)(2) of this section) shall be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The reduction of the market basket index percentage change by the MFP adjustment may result in the market basket index percentage change being less than zero for a fiscal year, and may result in the unadjusted Federal payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

(4) *Penalty for failure to report quality data.* For fiscal year 2018 and subsequent fiscal years—

(i) In the case of a SNF that does not meet the requirements in § 413.360, for a

fiscal year, the SNF market basket index percentage change for the fiscal year (as specified in paragraph (d)(1)(v) of this section, as modified by any applicable forecast error adjustment under paragraph (d)(2) of this section, reduced by the MFP adjustment specified in paragraph (d)(3) of this section, and as specified for FY 2018 in section 1888(e)(5)(B)(iii) of the Act), is further reduced by 2.0 percentage points.

(ii) The application of the 2.0 percentage point reduction specified in paragraph (d)(4)(i) of this section to the SNF market basket index percentage change may result in such percentage being less than zero for a fiscal year, and may result in payment rates for that fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Any 2.0 percentage point reduction applied pursuant to paragraph (d)(4)(i) of this section will apply only to the fiscal year involved and will not be taken into account in computing the payment amount for a subsequent fiscal year.

(e) Pursuant to section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) as revised by section 314 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), using the best available data, the Secretary will issue a new regulation with a newly refined case-mix classification system to better account for medically complex patients. Upon issuance of the new regulation, the temporary increases in payment for certain high cost patients will no longer be applicable.

(f) *Adjustments to payment rates under the SNF Value-Based Purchasing Program.* Beginning with payment for services furnished on October 1, 2018, the adjusted Federal per diem rate (as defined in § 413.338(a)) otherwise applicable to a SNF for the fiscal year is reduced by the applicable percent (as defined in § 413.338(a)). The resulting amount is then adjusted by the value-based incentive payment amount (as defined in § 413.338(a)) based on the SNF

performance score calculated for the SNF for that fiscal year under § 413.338.

[63 FR 26309, May 12, 1998, as amended at 66 FR 39600, July 31, 2001; 68 FR 46070, Aug. 4, 2003; 76 FR 48539, Aug. 8, 2011; 82 FR 36633, Aug. 4, 2017; 83 FR 39289, Aug. 8, 2018; 87 FR 47616, Aug. 3, 2022; 89 FR 64160, Aug. 6, 2024]

§ 413.338 Skilled nursing facility value-based purchasing program.

(a) *Definitions.* As used in this section:

Achievement threshold (or achievement performance standard) means the 25th percentile of SNF performance on a measure during the baseline period for a fiscal year.

Adjusted Federal per diem rate means the payment made to SNFs under the skilled nursing facility prospective payment system (as described under section 1888(e)(4)(G) of the Act).

Applicable percent means for FY 2019 and subsequent fiscal years, 2.0 percent.

Baseline period means the time period used to calculate the achievement threshold, benchmark, and improvement threshold that apply to a measure for a fiscal year.

Benchmark means, for a fiscal year, the arithmetic mean of the top decile of SNF performance on a measure during the baseline period for that fiscal year.

Eligible stay means, for purposes of the SNF readmission measure, an index SNF admission that would be included in the denominator of that measure.

Health equity adjustment (HEA) bonus points means the points that a SNF can earn for a fiscal year based on its performance and proportion of SNF residents who are members of the underserved population.

Improvement threshold (or improvement performance standard) means an individual SNF's performance on a measure during the applicable baseline period for that fiscal year.

Logistic exchange function means the function used to translate a SNF's performance score into a value-based incentive payment percentage.

Low-volume SNF means a SNF with fewer than 25 eligible stays included in the SNF readmission measure denominator during the performance period

for each of fiscal years 2019 through 2022.

Measure performance scaler means, for a fiscal year, the sum of the points assigned to a SNF for each measure on which the SNF is a top tier performing SNF.

Performance period means the time period during which SNF performance on a measure is calculated for a fiscal year.

Performance standards are the levels of performance that SNFs must meet or exceed to earn points on a measure under the SNF VBP Program for a fiscal year.

Ranking means the ordering of SNFs based on each SNF's performance score under the SNF VBP Program for a fiscal year.

SNF performance score means the numeric score ranging from 0 to 100 awarded to each SNF based on its performance under the SNF VBP Program for a fiscal year.

SNF readmission measure means, prior to October 1, 2027, the SNF 30-Day All-Cause Readmission Measure (SNFRM) specified under section 1888(g)(1) of the Social Security Act. Beginning October 1, 2027, the term SNF readmission measure means the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) Measure specified under section 1888(g)(2) of the Social Security Act.

SNF Value-Based Purchasing (VBP) Program means the program required under section 1888(h) of the Act.

Top tier performing SNF means a SNF whose performance on a measure during the applicable fiscal year meets or exceeds the 66.67th percentile of SNF performance on the measure during the same fiscal year.

Underserved multiplier means the mathematical result of applying a logistic function to the number of SNF residents who are members of the underserved population out of the SNF's total Medicare population, as identified from the SNF's Part A claims, during the performance period that applies to the 1-year measures for the applicable fiscal year.

Underserved population means Medicare beneficiaries who are SNF residents in a Medicare Part A stay who

are also dually eligible, both partial and full, for Medicaid.

Value-based incentive payment adjustment factor is the number that will be multiplied by the adjusted Federal per diem rate for services furnished by a SNF during a fiscal year, based on its performance score for that fiscal year, and after such rate is reduced by the applicable percent.

Value-based incentive payment amount is the portion of a SNF's adjusted Federal per diem rate that is attributable to the SNF VBP Program.

(b) *Applicability of the SNF VBP Program.* The SNF VBP Program applies to SNFs, including facilities described in section 1888(e)(7)(B) of the Act. Beginning with fiscal year 2023, the SNF VBP Program does not include a SNF, with respect to a fiscal year, if:

(1) The SNF does not have the minimum number of cases that applies to each measure for the fiscal year, as specified by CMS; or

(2) The SNF does not have the minimum number of measures for the fiscal year, as specified by CMS.

(c) *Process for reducing the adjusted Federal per diem rate and applying the value-based incentive payment adjustment factor under the SNF VBP Program—*(1) *General.* CMS will make value-based incentive payments to each SNF based on its performance score for a fiscal year under the SNF VBP Program under the requirements and conditions specified in this paragraph.

(2) *Value-based incentive payment amount—*(i) *Total amount available for a fiscal year.* The total amount available for value-based incentive payments for a fiscal year is at least 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS, and will be increased as appropriate for each fiscal year to account for the assignment of a performance score to low-volume SNFs under paragraph (d)(3) of this section. Beginning with the FY 2023 SNF VBP, the total amount available for value-based incentive payments for a fiscal year is 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS. Beginning with the FY 2027 SNF VBP, the total amount available

for value-based incentive payments for a fiscal year is at least 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS, and will be increased as appropriate for each fiscal year to account for the application of the Health equity adjustment bonus points as calculated under paragraph (k) of this section.

(ii) *Calculation of the value-based incentive payment amount.* The value-based incentive payment amount is calculated by multiplying the adjusted Federal per diem rate by the value-based incentive payment adjustment factor, after the adjusted Federal per diem rate has been reduced by the applicable percent.

(iii) *Calculation of the value-based incentive payment adjustment factor.* The value-based incentive payment adjustment factor is calculated by estimating Medicare spending under the skilled nursing facility prospective payment system to estimate the total amount available for value-based incentive payments, ordering SNFs by their SNF performance scores, then assigning an adjustment factor value for each performance score subject to the limitations set by the exchange function.

(iv) *Reporting of adjustment to SNF payments.* CMS will inform each SNF of the value-based incentive payment adjustment factor that will be applied to its adjusted Federal per diem rate for services furnished during a fiscal year at least 60 days prior to the start of that fiscal year.

(d) *Performance scoring under the SNF VBP Program (applicable, as described in this paragraph, to fiscal year 2019 through and including fiscal year 2025).* (1) CMS will award points to SNFs based on their performance on the SNF readmission measure applicable to a fiscal year during the performance period applicable to that fiscal year as follows:

(i) CMS will award from 1 to 99 points for achievement to each SNF whose performance meets or exceeds the achievement threshold but is less than the benchmark.

(ii) CMS will award from 0 to 90 points for improvement to each SNF whose performance exceeds the im-

provement threshold but is less than the benchmark.

(iii) CMS will award 100 points to a SNF whose performance meets or exceeds the benchmark.

(iv) CMS will not award points for improvement to a SNF that has fewer than 25 eligible stays during the baseline period.

(2) The highest of the SNF's achievement, improvement and benchmark score will be the SNF's performance score for the fiscal year.

(3) If, with respect to a fiscal year beginning with fiscal year 2019 through and including fiscal year 2022, CMS determines that a SNF is a low-volume SNF, CMS will assign a performance score to the SNF for the fiscal year that, when used to calculate the value-based incentive payment amount (as defined in paragraph (a)(17) of this section), results in a value-based incentive payment amount that is equal to the adjusted Federal per diem rate (as defined in paragraph (a)(2) of this section) that would apply to the SNF for the fiscal year without application of §413.337(f).

(e) *Performance scoring under the SNF VBP Program beginning with fiscal year 2026.* (1) *Points awarded based on SNF performance.* CMS will award points to SNFs based on their performance on each measure for which the SNF reports the applicable minimum number of cases during the performance period applicable to that fiscal year as follows:

(i) CMS will award from 1 to 9 points for achievement to each SNF whose performance on a measure during the applicable performance period meets or exceeds the achievement threshold for that measure but is less than the benchmark for that measure.

(ii) CMS will award 10 points for achievement to a SNF whose performance on a measure during the applicable performance period meets or exceeds the benchmark for that measure.

(iii) CMS will award from 0 to 9 points for improvement to each SNF whose performance on a measure during the applicable performance period exceeds the improvement threshold but is less than the benchmark for that measure.

(iv) CMS will not award points for improvement to a SNF that does not meet the case minimum for a measure for the applicable baseline period.

(v) The highest of the SNF's achievement and improvement score for a given measure will be the SNF's score on that measure for the applicable fiscal year.

(2) *Calculation of the SNF performance score for fiscal year 2026.* The SNF performance score for FY 2026 is calculated as follows:

(i) CMS will sum all points awarded to a SNF as described in paragraph (e)(1) of this section for each measure applicable to a fiscal year to calculate the SNF's point total.

(ii) CMS will normalize the point total such that the resulting SNF performance score is expressed as a number of points earned out of a total of 100.

(3) *Calculation of the SNF performance score beginning with fiscal year 2027.* The SNF performance score for a fiscal year is calculated as follows:

(i) CMS will sum all points awarded to a SNF as described in paragraph (e)(1) of this section for each measure applicable to a fiscal year.

(ii) CMS will normalize the SNF's point total such that the resulting point total is expressed as a number of points earned out of a total of 100.

(iii) CMS will add to the SNF's point total under paragraph (e)(3)(ii) of this section any applicable health equity adjustment bonus points calculated under paragraph (k) of this section such that the resulting point total is the SNF Performance Score for the fiscal year, except that no SNF Performance Score may exceed 100 points.

(f) *Confidential feedback reports and public reporting.*

(1) CMS will provide quarterly confidential feedback reports to SNFs on their performance on each measure specified for the fiscal year. Beginning with the baseline period and performance period quality measure quarterly reports issued on or after October 1, 2021, CMS calculates the measure rates included in those reports using data that are current as of a specified date as follows:

(i) For the SNFRM, the specified date is 3 months after the last index SNF

admission in the applicable baseline period or performance period.

(ii) For the Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization ("SNF HAI"), Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities ("DTC PAC SNF"), and Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions ("SNF WS PPR") measure, the specified date is 3 months after the last SNF discharge in the applicable baseline period or performance period.

(iii) For the Number of Hospitalizations per 1,000 Long Stay Residents ("Long Stay Hospitalization") measure, the specified date is 3 months after the last day of the final quarter of the applicable baseline period or performance period.

(iv) For the Total Nursing Hours per Resident Day Staffing ("Total Nurse Staffing") measure and the Total Nursing Staff Turnover ("Nursing Staff Turnover") measure, the specified date is 45 days after the last day of each quarter of the applicable baseline period or performance period.

(v) For the Discharge Function Score for SNFs ("DC Function measure") and Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) ("Falls with Major Injury (Long Stay)") measure, the specified date is the February 15th that is approximately 4.5 months after the last day of the applicable baseline period or performance period.

(2) Beginning with the baseline period and performance period quality measure quarterly reports issued on or after October 1, 2021, which contain the baseline period and performance period measure rates, respectively, SNFs will have 30 days following the date CMS provides in each of these reports to review and submit corrections to the measure rate calculations contained in that report. The underlying data used to calculate the measure rates are not subject to review and correction under this paragraph (f)(2). Any such correction requests must include:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's name;

(iii) The correction requested; and

(iv) The reason for requesting the correction, including any available evidence to support the request.

(3) Beginning not later than 60 days prior to each fiscal year, CMS will provide reports to SNFs on their performance under the SNF VBP Program for a fiscal year. SNFs will have the opportunity to review and submit corrections to their SNF performance scores and ranking contained in these reports for 30 days following the date that CMS provides the reports. Any such correction requests must include:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's name;

(iii) The correction requested; and

(iv) The reason for requesting the correction, including any available evidence to support the request.

(4) CMS will publicly report the information described in paragraphs (f)(2) and (3) of this section on the Nursing Home Compare website or a successor website. Beginning with information publicly reported on or after October 1, 2019, and ending with information publicly reported on September 30, 2022 the following exceptions apply:

(i) If CMS determines that a SNF has fewer than 25 eligible stays during the baseline period for a fiscal year but has 25 or more eligible stays during the performance period for that fiscal year, CMS will not publicly report the SNF's baseline period SNF readmission measure rate and improvement score for that fiscal year;

(ii) If CMS determines that a SNF is a low-volume SNF with respect to a fiscal year and assigns a performance score to the SNF under paragraph (d)(3) of this section, CMS will not publicly report the SNF's performance period SNF readmission measure rate, achievement score or improvement score for the fiscal year; and

(iii) If CMS determines that a SNF has zero eligible cases during the performance period with respect to a fiscal year, CMS will not publicly report any information for that SNF for that fiscal year.

(5) Beginning with the information publicly reported on or after October 1, 2022, the following exceptions apply:

(i) If a SNF does not have the minimum number of cases during the base-

line period that applies to a measure for a fiscal year, CMS will not publicly report the SNF's baseline period measure rate for that particular measure, although CMS will publicly report the SNF's performance period measure rate and achievement score if the SNF had the minimum number of cases for the measure during the performance period of the same program year;

(ii) If a SNF does not have the minimum number of cases during the performance period that applies to a measure for a fiscal year, CMS will not publicly report any information with respect to the SNF's performance on that measure for the fiscal year;

(iii) If a SNF does not have the minimum number of measures during the performance period for a fiscal year, CMS will not publicly report any data for that SNF for the fiscal year.

(g) *Limitations on review.* There is no administrative or judicial review of the following:

(1) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under section 1888(h)(5) of the Act.

(2) The determination of the amount of funding available for value-based incentive payments under section 1888(h)(5)(C)(ii)(III) of the Act and the payment reduction under section 1888(h)(6) of the Act.

(3) The establishment of the performance standards under section 1888(h)(3) of the Act and the performance period.

(4) The methodology developed under section 1888(h)(4) of the Act that is used to calculate SNF performance scores and the calculation of such scores.

(5) The ranking determinations under section 1888(h)(4)(B) of the Act.

(h) *Special rules for the FY 2022 SNF VBP Program.* (1) CMS will calculate a SNF readmission measure rate for each SNF based on its performance on the SNF readmission measure during the performance period specified by CMS for fiscal year 2022, but CMS will not calculate a performance score for any SNF using the methodology described in paragraphs (d)(1) and (2) of this section. CMS will instead assign a performance score of zero to each SNF,

with the exception of those SNFs qualifying for the low-volume scoring adjustment described in paragraph (d)(3) of this section.

(2) CMS will calculate the value-based incentive payment adjustment factor for each SNF using a performance score of zero and will then calculate the value-based incentive payment amount for each SNF using the methodology described in paragraph (c)(2)(ii) of this section. CMS will then apply low-volume scoring adjustment described in paragraph (d)(3) of this section.

(3) CMS will provide confidential feedback reports to SNFs on their performance on the SNF readmission measure in accordance with paragraphs (e)(1) and (2) of this section.

(4) CMS will publicly report SNF performance on the SNF readmission measure in accordance with paragraph (e)(3) of this section.

(i) *Special rules for the FY 2023 SNF VBP Program.* (1) CMS will calculate a SNF readmission measure rate for each SNF based on its performance on the SNF readmission measure during the performance period specified by CMS for fiscal year 2023, but CMS will not calculate a performance score for any SNF using the methodology described in paragraphs (d)(1) and (2) of this section. CMS will instead assign a performance score of zero to each SNF.

(2) CMS will calculate the value-based incentive payment adjustment factor for each SNF using a performance score of zero and will then calculate the value-based incentive payment amount for each SNF using the methodology described in paragraph (c)(2)(ii) of this section.

(3) CMS will provide confidential feedback reports to SNFs on their performance on the SNF readmission measure in accordance with paragraphs (f)(1) and (2) of this section.

(4) CMS will publicly report SNF performance on the SNF readmission measure in accordance with paragraph (f)(3) of this section.

(j) *Validation.* (1) Beginning with the FY 2023 program year, for the SNFRM measure, and beginning with the FY 2026 program year for all other claims-based measures, the information reported through claims are validated for

accuracy by Medicare Administrative Contractors (MACs).

(2) Beginning with the FY 2026 program year, for all measures that are calculated using Payroll-Based Journal System data, information reported through the Payroll-Based Journal system is validated for accuracy by CMS and its contractors through quarterly audits.

(3) Beginning October 1, 2026, for all measures that are calculated using Minimum Data Set (MDS) information, CMS will validate the accuracy of this information. CMS will request medical records as follows:

(i) On an annual basis, a CMS contractor will randomly select up to 1,500 SNFs for validation. A SNF is eligible for selection for a year if the SNF submitted at least one MDS record in the calendar year that is 3 years prior to the applicable fiscal year or was included in the SNF VBP Program in the year prior to the applicable fiscal year.

(ii) For each SNF selected under paragraph (j)(3)(i) of this section, the CMS contractor will request in writing up to 10 medical records.

(iii) A SNF that receives a request for medical records under paragraph (j)(3)(ii) of this section must submit a digital or paper copy of each of the requested medical records within 45 days of the date of the request as documented on the request.

(k) *Calculation of the Health equity adjustment (HEA) bonus points.* CMS calculates the number of HEA bonus points that are added to a SNF's point total calculated under paragraph (e)(3)(iii) of this section by:

(1) Determining for each measure whether the SNF is a top tier performing SNF and assigning two points to the SNF for each such measure;

(2) Summing the points calculated under paragraph (k)(1) of this section to calculate the measure performance scaler;

(3) Calculating the underserved multiplier for the SNF; and

(4) Multiplying the measure performance scaler calculated under paragraph (k)(2) of this section by the underserved multiplier calculated under paragraph (k)(3) of this section.

(l) *Measure selection, retention, and removal policy.* (1) The SNF VBP measure

set for each fiscal year includes the SNF readmission measure CMS has specified under section 1888(g) of the Social Security Act for application in the SNF VBP Program.

(2) Beginning with FY 2026, the SNF VBP measure set for each fiscal year may include up to nine additional measures specified by CMS. Each of these measures remains in the measure set unless CMS removes or replaces it based on one or more of the following factors:

(i) SNF performance on the measure is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

(ii) Performance or improvement on a measure do not result in better resident outcomes.

(iii) A measure no longer aligns with current clinical guidelines or practices.

(iv) A more broadly applicable measure for the particular topic is available.

(v) A measure that is more proximal in time to the desired resident outcomes for the particular topic is available.

(vi) A measure that is more strongly associated with the desired resident outcomes for the particular topic is available.

(vii) The collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the Program.

(3) Upon a determination by CMS that the continued requirement for SNFs to submit data on a measure specified under paragraph (1)(2) of this section raises specific resident safety concerns, CMS may elect to immediately remove the measure from the SNF VBP Program. Upon removal of the measure, CMS will provide notice to SNFs and the public, along with a statement of the specific patient safety concern that would be raised if SNFs continued to submit data on the measure. CMS will also provide notice of the removal in the FEDERAL REGISTER.

(4) CMS uses rulemaking to make substantive updates to the specifications of measures used in the SNF VBP Program. CMS makes technical meas-

ure specification updates in a sub-regulatory manner and informs SNFs of measure specification updates through postings on the CMS website, listservs, and other educational outreach efforts to SNFs.

(m) *Extraordinary circumstances exception policy.* (1) A SNF may request and CMS may grant exceptions to the SNF Value-Based Purchasing Program's requirements under this section for one or more calendar months when there are certain extraordinary circumstances beyond the control of the SNF.

(2) A SNF may request an exception within 90 days of the date that the extraordinary circumstances occurred. Prior to FY 2025, the request must be submitted in the form and manner specified by CMS on the SNF VBP website at <https://www.cms.gov/Medicare/Quality/Nursing-Home-Improvement/Value-Based-Purchasing/Extraordinary-Circumstance-Exception> and include a completed Extraordinary Circumstances Request form (available on <https://qualitynet.cms.gov/>) and any available evidence of the impact of the extraordinary circumstances on the care that the SNF furnished to patients including, but not limited to, photographs and media articles. Beginning with FY 2025, a SNF may request an extraordinary circumstances exception by sending an email with the subject line "SNF VBP Extraordinary Circumstances Exception Request" to the SNF VBP Program Help Desk with the following information:

(i) The SNF's CMS Certification Number (CCN);

(ii) The SNF's business name and business address;

(iii) Contact information for the SNF's chief executive officer (CEO) or CEO-designated personnel, including all applicable names, email addresses, telephone numbers, and the SNF's physical mailing address (which cannot be a P.O. Box);

(iv) A description of the event, including the dates and duration of the extraordinary circumstance;

(v) Available evidence of the impact of the extraordinary circumstance on the care the SNF provided to its residents or the SNF's ability to report

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SNF VBP data, including, but not limited to, photographs, media articles, and any other materials that would aid CMS in determining whether to grant the exception; and

(vi) A date proposed by the SNF for when it will again be able to fully comply with the SNF VBP Program's requirements and a justification for the proposed date.

(3) Except as provided in paragraph (m)(4) of this section, CMS will not consider an exception request unless the SNF requesting such exception has complied fully with the requirements in paragraph (m)(2) of this section.

(4) CMS may grant exceptions to SNFs without a request if it determines that an extraordinary circumstance affected an entire region or locale.

(5) CMS will calculate a SNF performance score for a fiscal year for a SNF for which it has granted an exception request that does not include its performance on a quality measure during the calendar months affected by the extraordinary circumstance.

(n) *SNF VBP performance standards.*

(1) CMS announces the performance standards for each measure no later than 60 days prior to the start of the performance period that applies to the measure for the fiscal year.

(2) Beginning with FY 2021, if CMS discovers an error in the performance standard calculations subsequent to publishing their numerical values for a fiscal year, CMS will update the numerical values to correct the error. If CMS subsequently discovers one or more other errors with respect to the fiscal year, CMS will not further update the numerical values for that fiscal year.

(3) Beginning with FY 2025, CMS may update the numerical values of the performance standards for a measure if, between the time that CMS announced the performance standards for the measure for that fiscal year and the time that CMS calculates SNF performance on the measure at the conclusion of the performance period for that measure for that fiscal year, CMS has made technical updates to the

specifications for the measure that affect the measure rate calculations.

[82 FR 36633, Aug. 4, 2017, as amended at 83 FR 39289, Aug. 8, 2018; 85 FR 47633, Aug. 5, 2020; 86 FR 42524, Aug. 4, 2021; 87 FR 47616, Aug. 3, 2022; 88 FR 53346, Aug. 7, 2023; 89 FR 64160, Aug. 6, 2024]

§ 413.340 Transition period.

(a) *Duration of transition period and proportions for the blended transition rate.* Beginning with an SNF's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprising a blend of the adjusted Federal rate and a facility-specific rate. For the first cost reporting period beginning on or after July 1, 1998, payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the subsequent cost reporting period, the rate is comprised of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the final cost reporting period of the transition, the rate is comprised of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, payment is based entirely on the Federal rate.

(b) *Calculation of facility-specific rate for the first cost reporting period.* The facility-specific rate is computed based on the SNF's Medicare allowable costs from its fiscal year 1995 cost report plus an estimate of the amounts payable under Part B for covered SNF services (other than those services described in § 411.15(p)(2) of this chapter) furnished during fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services. Allowable costs associated with exceptions, as described in § 413.30(f), are included in the calculation of the facility-specific rate. Allowable costs associated with exemptions, as described in § 413.30(e)(2), are included in the calculation of the facility-specific rate but only to the extent that they do not exceed 150 percent of the routine cost limit. Low Medicare volume SNFs that were paid a prospectively determined rate under § 413.300 for their cost reporting period beginning in fiscal year 1995 will utilize that rate as the basis

for the allowable costs of routine (operating and capital-related) expenses in determining the facility-specific rate. Each SNF's allowable costs are updated to the first cost reporting period to which the payment rates apply using annual factors equal to the SNF market basket percentage minus 1 percentage point.

(c) *SNFs participating in the Multistate Nursing Home Case-Mix and Quality Demonstration.* SNFs that participated in the Multistate Nursing Home Case-Mix and Quality Demonstration in a cost reporting period that began in calendar year 1997 will utilize their allowable costs from that cost reporting period, including prospective payment amounts determined under the demonstration payment methodology.

(d) *Update of facility-specific rates for subsequent cost reporting periods.* The facility-specific rate for a cost reporting period that is subsequent to the first cost reporting period is equal to the facility-specific rate for the first cost reporting period (described in paragraph (a) of this section) updated by the market basket index.

(1) For a subsequent cost reporting period beginning in fiscal years 1998 and 1999, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage minus one percentage point.

(2) For a subsequent cost reporting period beginning in fiscal year 2000, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage.

(e) *SNFs excluded from the transition period.* SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1, 1995, are excluded from the transition period, and payment is made according to the Federal rates only.

§413.343 Resident assessment data.

(a) *Submission of resident assessment data.* SNFs are required to submit the resident assessment data described at §483.20 of this chapter in the manner necessary to administer the payment rate methodology described in §413.337.

This provision includes the frequency, scope, and number of assessments required.

(b) *Assessment schedule.* In accordance with the methodology described in §413.337(c) related to the adjustment of the Federal rates for case-mix, SNFs must submit assessments according to an assessment schedule. This schedule must include performance of an initial Medicare assessment with an assessment reference date that is set for no later than the 8th day of posthospital SNF care, and such other interim payment assessments as the SNF determines are necessary to account for changes in patient care needs.

(c) *Noncompliance with assessment schedule.* CMS pays a default rate for the Federal rate when a SNF fails to comply with the assessment schedule in paragraph (b) of this section. The default rate is paid for the days of a patient's care for which the SNF is not in compliance with the assessment schedule.

[63 FR 26309, May 12, 1998, as amended at 64 FR 41682, July 30, 1999; 84 FR 38832, Aug. 7, 2019]

§413.345 Publication of Federal prospective payment rates.

CMS publishes information pertaining to each update of the Federal payment rates in the FEDERAL REGISTER. This information includes the standardized Federal rates, the resident classification system that provides the basis for case-mix adjustment, and the factors to be applied in making the area wage adjustment. This information is published before May 1 for the fiscal year 1998 and before August 1 for the fiscal years 1999 and after.

[82 FR 36634, Aug. 4, 2017]

§413.348 Limitation on review.

Judicial or administrative review under sections 1869 or 1878 of the Act or otherwise is prohibited with regard to the establishment of the Federal rates. This prohibition includes the methodology used in the computation of the Federal standardized payment rates, the case-mix methodology, and the development and application of the wage index. This prohibition on judicial and

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administrative review also extends to the methodology used to establish the facility-specific rates but not to determinations related to reasonable cost in the fiscal year 1995 cost reporting period used as the basis for these rates.

§ 413.350 Periodic interim payments for skilled nursing facilities receiving payment under the skilled nursing facility prospective payment system for Part A services.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, SNFs receiving payment under the PPS for Part A services do not receive interim payments during the cost reporting year, and receive payment only following submission of a bill. Paragraph (d) of this section provides for accelerated payments in certain circumstances.

(b) *Periodic interim payments.* (1) An SNF receiving payment under the prospective payment system may receive periodic interim payments (PIP) for Part A SNF services under the PIP method subject to the provisions of § 413.64(h). To be approved for PIP, the SNF must meet the qualifying requirements in § 413.64(h)(3). Moreover, as provided in § 413.64(h)(5), contractor approval is conditioned upon the contractor's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* The contractor estimates an SNF's prospective payments net of estimated beneficiary coinsurance and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year. If an SNF has payment experience under the prospective payment system, the contractor estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP—(i) Request by the SNF.* An SNF receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the contractor.* An contractor terminates PIP if the SNF no longer meets the requirements of § 413.64(h).

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the contractor determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Accelerated payments—(1) General rule.* Upon request, an accelerated payment may be made to an SNF that is receiving payment under the prospective payment system and is not receiving PIP under paragraph (b) of this section if the SNF is experiencing financial difficulties because of the following:

(i) There is a delay by the contractor in making payment to the SNF.

(ii) Due to an exceptional situation, there is a temporary delay in the SNF's preparation and submittal of bills to the contractor beyond its normal billing cycle.

(2) *Approval of payment.* An SNF's request for an accelerated payment must be approved by the contractor and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by

recoupment as SNF bills are processed or by direct payment by the SNF.

[64 FR 41682, July 30, 1999]

§413.355 Additional payment: QIO reimbursement for cost of sending records electronically or by photocopy and mailing.

An additional payment is made to a skilled nursing facility in accordance with §476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[85 FR 59025, Sept. 18, 2020]

§413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

(a) *Participation start date.* Beginning with the FY 2018 program year, a SNF must begin reporting data in accordance with paragraph (b) of this section no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the SNF as operating in the CMS designated data submission system. For purposes of this section, a program year is the fiscal year in which the market basket percentage described in §413.337(d) is reduced by two percentage points if the SNF does not report data in accordance with paragraph (b) of this section.

(b) *Data submission requirement.* (1) Except as provided in paragraph (c) of this section, and for a program year, SNFs must submit to CMS data on measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Social Security Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Social Security Act, in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the SNF QRP based on one or more of the following factors:

(i) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better resident outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired resident outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired resident outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and extension requests.* (1) A SNF may request and CMS may grant exceptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the SNF.

(2) A SNF may request an exception or extension within 90 days of the date that the extraordinary circumstances occurred by sending an email to SNFQRPreconsiderations@cms.hhs.gov that contains all of the following information:

(i) SNF CMS Certification Number (CCN).

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) SNF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the SNF believes it will be able to again submit SNF QRP data and a justification for the proposed date.

(3) Except as provided in paragraph (c)(4) of this section, CMS will not consider an exception or extension request

unless the SNF requesting such exception or extension has complied fully with the requirements in this paragraph (c).

(4) CMS may grant exceptions or extensions to SNFs without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affected the ability of a SNF to submit data in accordance with paragraph (b) of this section.

(d) *Reconsideration.*

(1) SNFs that do not meet the requirements in paragraph (b) of this section for a program year will receive a notification of non-compliance sent through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). A SNF may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

(2) Reconsideration requests must be submitted to CMS by sending an email to

SNFQRPreconsiderations@cms.hhs.gov containing all of the following information:

(i) SNF CCN.

(ii) SNF Business Name.

(iii) SNF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) CMS identified reason(s) for non-compliance stated in the non-compliance letter.

(vi) Reason(s) for requesting reconsideration, including all supporting documentation.

(3) CMS will not consider a reconsideration request unless the SNF has complied fully with the requirements in paragraph (d)(2) of this section.

(4) CMS will notify SNFs, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the

United States Postal Service, or via email from the CMS Medicare Administrative Contractor (MAC).

(e) *Appeals.* A SNF that is dissatisfied with CMS' decision on a request for reconsideration may file an appeal with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

(f) *Data completion threshold.*

(1) SNFs must meet or exceed the following data completeness thresholds with respect to a program year:

(i) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the Minimum Data Set (MDS) on at least 80 percent of the assessments SNFs submit through the CMS designated data submission system for FY 2018 through FY 2025 program years.

(ii) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the MDS on at least 90 percent of the assessments SNFs submit through the CMS designated data submission system for FY 2026 and for all subsequent payment updates.

(iii) The threshold set at 100 percent for measures data collected and submitted through the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for FY 2023 and for all subsequent payment updates.

(iv) If selected for the data validation process under paragraph (g) of this section, the threshold set at 100 percent submission of medical charts.

(2) These thresholds apply to all measures and standardized patient assessment data requirements adopted into the SNF QRP.

(3) A SNF must meet or exceed each applicable threshold described in paragraph (f)(1) of this section to avoid receiving the applicable penalty for failure to report quality data set forth in § 413.337(d)(4).

(g) *Data validation process.* (1) Beginning with the FY 2027 payment year: for all measures that are calculated using Minimum Data Set (MDS) information, CMS will validate the accuracy of this information. The process by which CMS will request medical

records and by which SNFs must submit the requested medical records is as follows:

(i) On an annual basis, a CMS contractor will select up to 1,500 SNFs for validation. A SNF is eligible for selection for a year if it submitted at least one MDS record to CMS in the fiscal year that is 2 years prior to the applicable program year, and if the SNF has been randomly selected for a periodic audit for the same year under §413.338.

(ii) For each SNF selected under this paragraph (g)(1), the CMS contractor will request up to 10 medical records. Each SNF selected will only be required to submit records once in a fiscal year, for a maximum of 10 records for each SNF selected. Each requested medical record must be the same medical record that has been requested for submission by the SNF for the same year under §413.338. CMS will submit its request in writing to the selected SNF.

(iii) A SNF that receives a request for medical records under this paragraph (g)(1) must submit a digital or paper copy of each of the requested medical records within 45 days of the date of the request.

(2) Beginning with the FY 2027 payment year: the information reported through claims for all claims-based measures are validated for accuracy by Medicare Administrative Contractors (MACs).

[82 FR 36634, Aug. 4, 2017, as amended at 83 FR 39290, Aug. 8, 2018; 84 FR 38832, Aug. 7, 2019; 87 FR 47618, Aug. 3, 2022; 88 FR 53346, Aug. 7, 2023; 89 FR 64162, Aug. 6, 2024]

Subpart K—Payment for Acute Kidney Injury (AKI) Dialysis

SOURCE: 81 FR 77965, Nov. 4, 2016, unless otherwise noted.

§413.370 Scope.

This subpart implements section 1834(r) of the Act by setting forth the principles and authorities under which CMS is authorized to establish a payment amount for renal dialysis services furnished to beneficiaries with an acute kidney injury in or under the supervision of an ESRD facility that meets the conditions of coverage in

part 494 of this chapter and as defined in §413.171.

§413.371 Definition.

For purposes of the subpart, the following definition applies:

Individual with acute kidney injury. The term individual with acute kidney injury means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1881(b)(14) of the Act.

§413.372 AKI dialysis payment rate.

The amount of payment for AKI dialysis services shall be the base rate for renal dialysis services determined for such year under section 1881(b)(14), that is, the ESRD base rate as set forth in §413.220, updated by the ESRD bundled market basket percentage increase factor minus a productivity adjustment as set forth in §413.196(d)(1), adjusted for wages as set forth in §413.231, and adjusted by any other amounts deemed appropriate by the Secretary under §413.373.

§413.373 Other adjustments to the AKI dialysis payment rate.

The payment rate for AKI dialysis may be adjusted by the Secretary (on a budget neutral basis for payments under section 1834(r)) by any other adjustment factor under subparagraph (D) of section 1881(b)(14) of the Act.

§413.374 Renal dialysis services included in the AKI dialysis payment rate.

(a) The AKI dialysis payment rate applies to renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14) of the Act) furnished under Part B by a renal dialysis facility or provider of services paid under section 1881(b)(14) of the Act.

(b) Other items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in §413.171, but that are related to their dialysis treatment as a result of their AKI, would be separately payable, that is, drugs, biologicals, laboratory services, and