DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413 and 488

[CMS–1802–P]

RIN 0938–AV30

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This rule proposes changes and updates to the policies and payment rates used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for FY 2025. First, we are proposing to rebase and revise the SNF market basket to reflect a 2022 base year. Next, we are proposing to update the wage index used under the SNF PPS to reflect data collected during the most recent decennial census. Additionally, we are proposing several technical revisions to the code mappings used to classify patients under the Patient Driven Payment Model (PDPM) to improve payment and coding accuracy. Finally, this proposed rule includes a Request for Information (RFI) on potential updates to the Non-Therapy Ancillary (NTA) component of PDPM. This rulemaking also proposes to update the requirements for the SNF Quality Reporting Program and the SNF Value-Based Purchasing Program. We are also proposing to expand CMS' enforcement authority for imposing civil money penalties (CMPs). Finally, this proposed rule includes proposals to strengthen nursing home enforcement requirements.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by May 28, 2024.

ADDRESSES: In commenting, please refer to file code CMS–1802–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1802–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1802–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: *PDPM@cms.hhs.gov* for issues related to the SNF PPS.

Heidi Magladry, (410) 786–6034, for information related to the skilled nursing facility quality reporting program.

Christopher Palmer, (410) 786–8025, for information related to the skilled nursing facility value-based purchasing program.

Celeste Saunders, (410) 786–5603, for information related to Nursing Home.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the internet on the CMS website. The wage index tables for this proposed rule can be accessed on the SNF PPS Wage Index home page, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Readers who experience any problems accessing any of these online SNF PPS wage index tables should contact Kia Burwell at (410) 786–7816.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for fiscal year (FY) 2025, as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication of certain specified information relating to the payment update (see section II.C. of this proposed rule) in the **Federal Register** before the August 1 that precedes the start of each FY. Additionally, in this proposed rule, we are proposing to rebase and revise the SNF market basket to reflect a 2022 base year. Next, we are proposing to update the wage index used under the SNF PPS to reflect data collected during the most recent decennial census. We are also proposing several technical revisions to the code mappings used to classify patients under the PDPM to improve payment and coding accuracy. This proposed rule includes an RFI on potential updates to the non-therapy ancillary (NTA) component of PDPM. This proposed rule proposes the collection of four new items as standardized patient assessment data elements and the modification of one item collected and submitted using the Minimum Data Set (MDS) beginning with the FY 2027 SNF QRP. This proposed rule also proposes that SNFs, which participate in the SNF QRP, participate in a validation process beginning with the FY 2027 SNF QRP, and also includes a request for information on quality measure concepts under consideration for future SNF QRP program years. Finally, this proposed rule proposes new requirements for the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, including a proposed measure selection, retention, and removal policy, a proposed technical measure updates policy, a proposed measure minimum for FY 2028 and subsequent years, proposed updates to the review and correction policy to include new measure data sources, proposed updates to the Extraordinary Circumstances Exception policy, and proposed SNF VBP regulation text updates. We are also proposing revisions to existing long-term care (LTC) enforcement regulations that would enable CMS and the States to impose civil money penalties to better reflect amounts that are more consistent with the type of noncompliance that occurred.

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, the Federal rates in this proposed rule would update the annual rates that we published in the SNF PPS final rule for FY 2024 (88 FR 53200, August 7, 2023). In addition, this proposed rule includes a forecast error adjustment for FY 2025. Additionally, in this proposed rule we are proposing to rebase and revise the SNF market basket to reflect a 2022 base year. Next, we are proposing to update the wage index used under the SNF PPS to reflect data collected during the most recent decennial census. We are also proposing several technical revisions to the code mappings used to classify patients under the PDPM to improve payment and coding accuracy. Finally, this proposed rule includes an RFI on potential updates to the NTA component of PDPM.

We propose revisions to CMS' existing enforcement authority to expand the number of CMPs that can be imposed on LTC facilities. The proposed revisions will allow for more per-instance (PI) CMPs to be imposed in conjunction with per-day (PD) CMPs. This proposal will also expand our authority to impose multiple PI CMPs when the same type of noncompliance is identified on more than one day. CMS' current enforcement regulation does not allow for PI and PD CMPs to be imposed for the same survey and also makes it difficult for CMS to impose multiple PI CMPs for the same type of noncompliance. Lastly, the proposed revisions will enable CMS or the States to impose a CMP for the number of days of past noncompliance since the last three standard surveys to ensure that identified noncompliance that is subject to a penalty may receive one, if that is the remedy that is imposed.

We are proposing several updates for the SNF VBP Program. We are proposing to adopt a measure selection, retention, and removal policy that aligns with policies we have adopted in other CMS quality programs. We are proposing a technical measure updates policy to allow us to update the numerical values of the performance standards for a program year if necessary to account for the implementation of non-substantive technical updates to the measure specifications between the baseline period and the performance period. We are proposing to adopt the same measure minimum we previously finalized for the FY 2027 program year for the FY 2028 program year and subsequent program years. We are proposing modifications to Phase One of our review and correction policy to account for measures that are calculated using Payroll-Based Journal (PBJ) and MDS measure data beginning with the FY 2026 and FY 2027 program years, respectively. We are proposing to update the instructions for requesting an extraordinary circumstance exception (ECE) and to allow SNFs to request an ECE if the SNF can demonstrate that, as a result of the extraordinary circumstance, it cannot report SNF VBP data on one or more measures by the specified deadline. Lastly, we are proposing several updates to the SNF VBP regulation text to align with previously finalized definitions and policies.

Beginning with the FY 2027 SNF QRP, we are proposing to require SNFs to collect and submit through the MDS four new items as standardized patient assessment data elements under the social determinants of health (SDOH) category: one item for Living Situation, two items for Food, and one item for Utilities. We are also proposing to modify the current Transportation item. We are also proposing to adopt a similar validation process for the SNF QRP that we adopted for the SNF VBP beginning with the FY 2027 SNF QRP. We are also proposing to amend regulation text at § 413.360 to implement the validation process we propose. Finally, this proposed rule also includes a Request for Information (RFI) on quality measure concepts under consideration for future SNF QRP years.

C. Summary of Cost and Benefits

TABLE 1—ESTIMATED COST AND BENEFITS

Proposals	Estimated total transfers/costs
FY 2025 SNF PPS payment rate update	The overall economic impact of this proposed rule is an estimated increase of $1.3 billion in aggregate payments to SNFs during FY 2025.
FY 2027 SNF QRP changes	The overall economic impact of this proposed rule to SNFs is an estimated cost of $2,322,541.48 annually to SNFs beginning with the FY 2027 SNF QRP.
FY 2026 Changes Due to Removal of MDS Items No Longer Needed for Case-Mix Determination.	The overall economic impact of this proposed rule to SNFs is an estimated savings of $14,128,696.47 annually to SNFs beginning with FY 2026.
FY 2027 Changes Due to Proposal for Participation in a Validation Process.	The overall economic impact of this proposed rule to SNFs is an estimated cost of $813,067.95 annually to SNFs beginning with the FY 2027 SNF QRP.
FY 2025 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $187.69 million in aggregate payments to SNFs during FY 2025.
FY 2025 Nursing Home Enforcement changes	The overall economic impact the proposed changes to CMS' enforcement authority results in an estimated additional penalty amount totaling $25 million annually to long term care facilities, and $163,800 in annual administrative costs to CMS and states.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997) (Pub. L. 105–33, enacted August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers virtually all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

Section 215(a) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93, enacted April 1, 2014) added section 1888(g) to the Act, requiring the Secretary to specify an all-cause all-condition hospital readmission measure and an all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a VBP program for SNFs. In 2014, section 2(c)(4) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113–185, enacted October 6, 2014) amended section 1888(e)(6) of the Act, which requires the Secretary to implement a QRP for SNFs under which SNFs report data on measures and resident assessment data. Finally, section 111 of the Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116–260, enacted December 27, 2020) amended section 1888(h) of the Act, authorizing the Secretary to apply up to nine additional measures to the VBP program for SNFs.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first 3 cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments for SNFs entirely on the adjusted Federal per diem rates, we no longer include adjustment factors under the transition related to facility-specific rates for the upcoming FY.

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2024 (88 FR 53200, August 7, 2023), as amended by the subsequent correction notice (88 FR 68486, October 4, 2023).

Section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** the following:

- The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- The factors to be applied in making the area wage adjustment for these services.

Along with other revisions discussed later in this preamble, this proposed rule would set out the required annual updates to the per diem payment rates for SNFs for FY 2025.

III. Proposed SNF PPS Rate Setting Methodology and FY 2025 Update

A. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem Federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated a Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using the SNF market basket, and then standardized for geographic variations

in wages and for the costs of facility differences in case-mix. In compiling the database used to compute the Federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA 1997 prescribed, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas and adjusted the portion of the Federal rate attributable to wage-related costs by a wage index to reflect geographic variations in wages.

B. SNF Market Basket Update

1. SNF Market Basket

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2022 (86 FR 42444 through 42463), we rebased and revised the SNF market basket, which included updating the base year from 2014 to 2018. In this proposed rule, we propose to update the base year from 2018 to 2022.

The SNF market basket is used to compute the market basket percentage increase that is used to update the SNF Federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage increase is adjusted by a forecast error adjustment, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule.

As outlined in this proposed rule, we propose a FY 2025 SNF market basket percentage increase of 2.8 percent based on IHS Global Inc.'s (IGI's) fourth quarter 2023 forecast of the proposed 2022-based SNF market basket (before application of the forecast error adjustment and productivity adjustment). We also propose that if more recent data subsequently become available (for example, a more recent estimate of the market basket and/or the productivity adjustment), we would use such data, if appropriate, to determine the FY 2025 SNF market basket percentage increase, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule.

2. Proposed Market Basket Update for FY 2025

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage increase as the percentage change in the SNF market basket from the midpoint of the previous FY to the midpoint of the current FY. For the Federal rates outlined in this proposed rule, we use the percentage change in the SNF market basket to compute the update factor for FY 2025. This factor is based on the FY 2025 percentage increase in the proposed 2022-based SNF market basket reflecting routine, ancillary, and capital-related expenses. Sections 1888(e)(4)(E)(ii)(IV) and (e)(5)(B)(i) of the Act require that the update factor used to establish the FY 2025 unadjusted Federal rates be at a level equal to the SNF market basket percentage increase. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2023 through September 30, 2024 to the average market basket level for the period of October 1, 2024 through September 30, 2025. This process yields a percentage increase in the proposed 2022-based SNF market basket of 2.8 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust the percentage increase by the forecast error adjustment from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage increase in the market basket exceeds a 0.5 percentage point threshold in absolute terms. Additionally, section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage increase by the productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity (TFP) for the period ending September 30, 2025) which is estimated to be 0.4 percentage point, as described in section III.B.4. of this proposed rule.

We also note that section 1888(e)(6)(A)(i) of the Act provides that, beginning with FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year involved, after application of section 1888(e)(5)(B)(ii) of the Act (the productivity adjustment) and section 1888(e)(5)(B)(iii) of the Act (the market basket increase). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket percentage change being less than zero for a fiscal year and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act applies only to the fiscal year involved, and that the reduction cannot be taken into account in computing the payment amount for a subsequent fiscal year.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003 final rule (68 FR 46057 through 46059), § 413.337(d)(2) provides for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004 and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058), the adjustment will reflect both upward and downward adjustments, as appropriate.

For FY 2023 (the most recently available FY for which there is final data), the forecasted or estimated increase in the SNF market basket was 3.9 percent, and the actual increase for FY 2023 was 5.6 percent, resulting in the actual increase being 1.7 percentage points higher than the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket

exceeds the 0.5 percentage point threshold, under the policy previously described (comparing the forecasted and actual market basket percentage increase), the FY 2025 market basket percentage increase of 2.8 percent would be adjusted upward to account for the forecast error adjustment of 1.7 percentage points, resulting in a SNF market basket percentage increase of 4.5 percent, which is then reduced by the productivity adjustment of 0.4 percentage point, discussed in section III.B.4. of this proposed rule. This results in a proposed SNF market basket update for FY 2025 of 4.1 percent.

Table 2 shows the forecasted and actual market basket increases for FY 2023.

TABLE 2—DIFFERENCE BETWEEN THE ACTUAL AND FORECASTED MARKET BASKET INCREASES FOR FY 2023

Index	Forecasted FY 2023 increase *	Actual FY 2023 increase **	FY 2023 difference
SNF	3.9	5.6	1.7

* Published in **Federal Register**; based on second quarter 2022 IGI forecast (2018-based SNF market basket).
** Based on the fourth quarter 2023 IGI forecast (2018-based SNF market basket), with historical data through third quarter 2023.

4. Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148, enacted March 23, 2010) requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost-reporting period, or other annual period).

The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measure of productivity for the U.S. We note that previously the productivity measure referenced at section 1886(b)(3)(B)(xi)(II) of the Act was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term MFP with TFP. BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business total factor productivity. We refer readers to the BLS website at *www.bls.gov* for the BLS historical published TFP data. A complete description of the TFP projection methodology is available on our website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 SNF final rule (86 FR 42429) we noted that, effective with FY 2022 and forward, we changed the name of this adjustment to refer to it as the ''productivity adjustment,'' rather than the ''MFP adjustment.''

Per section 1888(e)(5)(A) of the Act, the Secretary shall establish a SNF market basket that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the productivity adjustment may result in the market basket percentage being less than zero for a FY and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding fiscal year. Thus, if the application of the productivity adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in a productivity-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted Federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

Based on the data available for this FY 2025 SNF PPS proposed rule, the proposed productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business TFP for the period ending September 30, 2025) is projected to be 0.4 percentage point.

Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), and as discussed previously in section III.B.1. of this proposed rule, the proposed market basket percentage increase for FY 2025 for the SNF PPS is based on IGI's fourth quarter 2023 forecast of the SNF market basket percentage increase, which is estimated to be 2.8 percent. This market basket percentage increase is then increased by 1.7 percentage points, due to application of the forecast error adjustment discussed earlier in section III.B.3. of this proposed rule. Finally, as discussed earlier in section III.B.4. of this proposed rule, we are applying a 0.4 percentage point productivity adjustment to the FY 2025 SNF market basket percentage increase. Therefore, the resulting proposed productivity-adjusted FY 2025 SNF market basket update is equal to 4.1 percent, which reflects a market basket percentage increase of 2.8 percent, plus the 1.7 percentage points forecast error adjustment, and reduced by the 0.4 percentage point productivity adjustment. Thus, we propose to apply a net SNF market basket update factor of 4.1 percent in our determination of the FY 2025 SNF PPS unadjusted Federal per diem rates.

5. Unadjusted Federal Per Diem Rates for FY 2024

As discussed in the FY 2019 SNF PPS final rule (83 FR 39162), in FY 2020 we implemented a new case-mix classification system to classify SNF patients under the SNF PPS, the PDPM. As discussed in section V.B.1. of that final rule (83 FR 39189), under PDPM, the unadjusted Federal per diem rates are divided into six components, five of which are case-mix adjusted components (Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA)), and one of which is a non-case-mix

component, as existed under the previous RUG–IV model. We propose to use the SNF market basket, adjusted as described previously in sections III.B.1. through III.B.4. of this proposed rule, to adjust each per diem component of the Federal rates forward to reflect the change in the average prices for FY 2024 from the average prices for FY 2023. We also propose to further adjust the rates by a wage index budget neutrality factor, described in section III.D. of this proposed rule.

Further, in the past, we used the revised Office of Management and Budget (OMB) delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634), with updates as reflected in OMB Bulletin Nos. 15–01 and 17–01, to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. As discussed in the FY 2021 SNF PPS proposed and final rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) to identify a facility's urban or rural status effective beginning with FY 2021. However, as further described in section V.A of this proposed rule, the current CBSAs are based on OMB standards contained in Bulletin 20–01, which is based on data collected during the 2010 Decennial Census. In this proposed rule, we are proposing to update the SNF PPS wage index using the CBSAs defined within Bulletin 23–01.

Tables 3 and 4 reflect the proposed unadjusted Federal rates for FY 2025, prior to adjustment for case-mix.

TABLE 3—PROPOSED FY 2025 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$73.16	$68.10	$27.31	$127.52	$96.21	$114.20

TABLE 4—PROPOSED FY 2025 UNADJUSTED FEDERAL RATE PER DIEM—R

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$83.39	$76.59	$34.41	$121.83	$91.92	$116.31

C. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the Federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the FY 2019 final rule (83 FR 39162, August 8, 2018), we finalized a new case-mix classification model, the PDPM, which took effect beginning October 1, 2019. The previous RUG–IV model classified most patients into a therapy payment group and primarily used the volume of therapy services provided to the patient as the basis for payment classification, thus creating an incentive for SNFs to furnish therapy regardless of the individual patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing the administrative burden on SNFs.

The PDPM uses clinical data from the MDS to assign case-mix classifiers to each patient that are then used to calculate a per diem payment under the SNF PPS, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act. As discussed in section IV.A. of this proposed rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the timeframes for MDS completion in our Resident Assessment Instrument (RAI) Manual. As we have stated in prior rules, for an MDS to be considered valid for use in determining payment, the MDS assessment should be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.*

Under section 1888(e)(4)(H) of the Act, each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The proposed FY 2025 payment rates set forth in this proposed rule reflect the use of the PDPM case-mix classification system from October 1, 2023, through September 30, 2024. The proposed case-mix adjusted PDPM payment rates for FY 2025 are listed separately for urban and rural SNFs, in Tables A5 and A6 with corresponding case-mix values.

Given the differences between the previous RUG–IV model and PDPM in terms of patient classification and billing, it was important that the format of Tables A5 and A6 reflect these differences. More specifically, under both RUG–IV and PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim to bill for covered SNF services. Under RUG–IV, the HIPPS code included the three-character RUG–IV group into which the patient classified, as well as a two-character assessment indicator code that represented the assessment used to generate this code. Under PDPM, while providers still use a HIPPS code, the characters in that code represent different things. For example, the first character 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 5 and 6 reflect the PDPM's structure. Accordingly, Column 1 of Tables 5 and 6 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.

Tables 5 and 6 do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP Program, discussed in section VI. of this proposed rule, or other adjustments, such as the variable per diem adjustment.

TABLE 5—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

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

TABLE 6—PDPM CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

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

D. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We will continue this practice for FY 2025, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the inpatient prospective payment system (IPPS) also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we would continue to use the pre-reclassified IPPS hospital wage data, without applying the occupational mix, rural floor, or outmigration adjustment, as the basis for the SNF PPS wage index. For FY 2025, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000) gave the Secretary the discretion to establish a geographic reclassification procedure specific to SNFs, but only after collecting the data necessary to establish a SNF PPS wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of the data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors (MACs), potentially far in excess of those required under the IPPS, given that there are nearly five times as many SNFs as there are inpatient hospitals. While we do not believe this undertaking is feasible at this time, we will continue to explore implantation of a spot audit process to improve SNF cost reports, which is determined to be adequately accurate for cost development purposes, in such a manner as to permit us to establish a SNF-specific wage index in the future.

In addition, we will continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2025 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we will continue using the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2025, the only rural area without wage index data available is North Dakota. We have determined that the borders of 18 rural counties are local and contiguous with 8 urban counties. Therefore, under this methodology, the wage indexes for the counties of Burleigh/Morton/Oliver (CBSA 13900: 0.9020), Cass (CBSA 22020: 0.8763), Grand Forks (CBSA 24220: 0.7865), and McHenry/Renville/Ward (CBSA 33500: 0.7686) are averaged, resulting in an imputed rural wage index of 0.8334 for rural North Dakota for FY 2025. In past years for rural Puerto Rico, we did not apply this methodology due to the distinct economic circumstances there; due to the close proximity of almost all of Puerto Rico's various urban and non-urban areas, this methodology will produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas. However, because rural Puerto Rico now has hospital wage index data on which to base an area wage adjustment, we will not apply this policy for FY 2025. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2025, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), after the expiration of this 1-year transition on September 30, 2006, we used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided minor updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013 and were adopted under the SNF PPS in the FY 2017 SNF PPS final rule (81 FR 51983, August 5, 2016). In addition, on August 15, 2017, OMB issued Bulletin No. 17–01 which announced a new urban CBSA, Twin Falls, Idaho (CBSA 46300) which was adopted in the SNF PPS final rule for FY 2019 (83 FR 39173, August 8, 2018).

As discussed in the FY 2021 SNF PPS final rule (85 FR 47594), we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1-year transition for FY 2021 under which we applied a 5

percent cap on any decrease in a hospital's wage index compared to its wage index for the prior fiscal year (FY 2020). The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the SNF PPS.

In the FY 2023 SNF PPS final rule (87 FR 47521 through 47525), we finalized a policy to apply a permanent 5 percent cap on any decreases to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. We amended the SNF PPS regulations at 42 CFR 413.337(b)(4)(ii) to reflect this permanent cap on wage index decreases. Additionally, we finalized a policy that a new SNF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new SNF would not have a wage index in the prior FY. A full discussion of the adoption of this policy is found in the FY 2023 SNF PPS final rule.

As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, we did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01 which updates and supersedes OMB Bulletin No. 20–01 based on the decennial census. OMB Bulletin No. 23–01 revised delineations for CBSAs which are made up of counties and equivalent entities (*e.g.,* boroughs, a city and borough, and a municipality in Alaska, planning regions in Connecticut, parishes in Louisiana, municipios in Puerto Rico, and independent cities in Maryland, Missouri, Nevada, and Virginia). For FY 2025, we propose to adopt the revised OMB delineations identified in OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*). The wage index applicable to FY 2025 is set forth in Table A available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Once calculated, we will apply the wage index adjustment to the labor-related portion of the Federal rate. Each year, we calculate a labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are labor-intensive and vary with the local labor market) in the input price index. In the SNF PPS final rule for FY 2022 (86 FR 42437), we finalized a proposal to revise the labor-related share to reflect the relative importance of the 2018-based SNF market basket 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. The methodology for calculating the labor-related portion beginning in FY 2022 is discussed in detail in the FY 2022 SNF PPS final rule (86 FR 42461 through 42463). As described later in section V.A. of this proposed rule, we are proposing to rebase and revise the labor-related share to reflect the relative importance of the proposed 2022-based SNF market basket cost weights for the following 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.

We calculate the proposed labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2025. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2025 than the base year weights from the SNF market basket. We calculate the labor-related relative importance for FY 2025 in four steps. First, we compute the FY 2025 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2025 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2025 relative importance for each cost category by multiplying this ratio by the base year (2022) weight. Finally, we add the FY 2025 relative importance for each of the labor-related 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 portion of Capital-Related expenses) to produce the proposed FY 2025 labor-related relative importance.

Table 7 summarizes the labor-related share for FY 2025, based on IGI's fourth quarter 2023 forecast of the proposed 2022-based SNF market basket, compared to the labor-related share that was used for the FY 2024 SNF PPS final rule.

TABLE 7—LABOR-RELATED SHARE, FY 2024 AND FY 2025

	Final FY 2024 labor-related share based on 2023q2 forecast of the 2018-based SNF market basket [1]	Proposed FY 2025 labor-related share based on 2023q4 forecast of the proposed 2022-based SNF market basket [2]
Wages and salaries	52.5	53.2
Employee benefits	9.3	9.1
Professional fees: Labor-related	3.4	3.5
Administrative & facilities support services	0.6	0.4
Installation, maintenance & repair services	0.4	0.5

TABLE 7—LABOR-RELATED SHARE, FY 2024 AND FY 2025—Continued

	Final FY 2024 labor-related share based on 2023q2 forecast of the 2018-based SNF market basket [1]	Proposed FY 2025 labor-related share based on 2023q4 forecast of the proposed 2022-based SNF market basket [2]
All other: Labor-related services	2.0	2.0
Capital-related (.391)	2.9	3.2
Total	71.1	71.9

[1] Published in the **Federal Register**; Based on the second quarter 2023 IHS Global Inc. forecast of the 2018-based SNF market basket.
[2] Based on the fourth quarter 2023 IHS Global Inc. forecast of the proposed 2022-based SNF market basket.

To calculate the labor portion of the case-mix adjusted per diem rate, we will multiply 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 proposed FY 2025 labor-related share percentage provided in Table 7. The remaining portion of the rate would be the non-labor portion. Under the previous RUG–IV model, we included tables which provided the case-mix adjusted RUG–IV rates, by RUG–IV group, broken out by total rate, labor portion and non-labor portion, such as Table 9 of the FY 2019 SNF PPS final rule (83 FR 39175). However, as we discussed in the FY 2020 final rule (84 FR 38738), under PDPM, as the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and given the sheer volume of possible combinations of these five case-mix adjusted components, it is not feasible to provide tables similar to those that existed in the prior rulemaking.

Therefore, to aid interested parties in understanding the effect of the wage index on the calculation of the SNF per diem rate, we have included a hypothetical rate calculation in Table 9.

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage adjustment had not been made. For FY 2025 (Federal rates effective October 1, 2023), we apply an adjustment to fulfill the budget neutrality requirement. We meet 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 2025 to the weighted average wage adjustment factor for FY 2025. For this calculation, we will use the same FY 2023 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor portion of the rate component multiplied by the wage index plus the non-labor portion of the rate component. The proposed budget neutrality factor for FY 2025 is 1.0002.

We note that if more recent data become available (for example, revised wage data), we would use such data, if appropriate, to determine the wage index budget neutrality factor in the SNF PPS final rule.

E. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, section 1888(h) of the Act requires the Secretary to reduce the adjusted Federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished during a fiscal year by 2 percent, and to adjust the resulting rate for a SNF by the value-based incentive payment amount earned by the SNF based on the SNF's performance score for that fiscal year under the SNF VBP Program. To implement these requirements, we finalized in the FY 2019 SNF PPS final rule the addition of § 413.337(f) to our regulations (83 FR 39178).

Please see section VII. of this proposed rule for further discussion of the updates we are proposing for the SNF VBP Program.

F. Adjusted Rate Computation Example

Tables 8 through 10 provide examples generally illustrating payment calculations during FY 2025 under PDPM for a hypothetical 30-day SNF stay, involving the hypothetical SNF XYZ, located in Frederick, MD (Urban CBSA 23224), for a hypothetical patient who is classified into such groups that the patient's HIPPS code is NHNC1. Table 8 shows the adjustments made to the Federal per diem rates (prior to application of any adjustments under the SNF VBP Program as discussed) to compute the provider's proposed case-mix adjusted per diem rate for FY 2025, based on the patient's PDPM classification, as well as how the variable per diem (VPD) adjustment factor affects calculation of the per diem rate for a given day of the stay. Table 9 shows the adjustments made to the case-mix adjusted per diem rate from Table 8 to account for the provider's wage index. The wage index used in this example is based on the FY 2025 SNF PPS wage index that appears in Table A available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Finally, Table 10 provides the case-mix and wage index adjusted per-diem rate for this patient for each day of the 30-day stay, as well as the total payment for this stay. Table 10 also includes the VPD adjustment factors for each day of the patient's stay, to clarify why the patient's per diem rate changes for certain days of the stay. As illustrated in Table 10, SNF XYZ's total PPS payment for this particular patient's stay would equal $23,073.54.

TABLE 8—PDPM CASE-MIX ADJUSTED RATE COMPUTATION EXAMPLE

Per diem rate calculation				
Component	Component group	Component rate	VPD adjustment factor	VPD adj. rate
PT	N	$102.42	1.00	102.42
OT	N	$96.70	1.00	96.70
SLP	H	$73.74	1.00	73.74
Nursing	N	$187.45	1.00	187.45
NTA	C	$167.41	3.00	502.23
Non-Case-Mix		$114.20		114.20
Total PDPM Case-Mix Adj. Per Diem				1,076.74

TABLE 9—WAGE INDEX ADJUSTED RATE COMPUTATION EXAMPLE

PDPM wage index adjustment calculation						
HIPPS code	PDPM case-mix adjusted per diem	Labor portion	Wage index	Wage index adjusted rate	Non-labor portion	Total case mix and wage index adj. rate
NHNC1	$1,076.74	$774.18	0.9918	$767.83	$302.56	$1,070.39

TABLE 10—ADJUSTED RATE COMPUTATION EXAMPLE

Day of stay	NTA VPD adjustment factor	PT/OT VPD adjustment factor	Case mix and wage index adjusted per diem rate
1	3.0	1.0	$1,070.39
2	3.0	1.0	1,070.39
3	3.0	1.0	1,070.39
4	1.0	1.0	737.55
5	1.0	1.0	737.55
6	1.0	1.0	737.55
7	1.0	1.0	737.55
8	1.0	1.0	737.55
9	1.0	1.0	737.55
10	1.0	1.0	737.55
11	1.0	1.0	737.55
12	1.0	1.0	737.55
13	1.0	1.0	737.55
14	1.0	1.0	737.55
15	1.0	1.0	737.55
16	1.0	1.0	737.55
17	1.0	1.0	737.55
18	1.0	1.0	737.55
19	1.0	1.0	737.55
20	1.0	1.0	737.55
21	1.0	0.98	733.59
22	1.0	0.98	733.59
23	1.0	0.98	733.59
24	1.0	0.98	733.59
25	1.0	0.98	733.59
26	1.0	0.98	733.59
27	1.0	0.98	733.59
28	1.0	0.96	729.63
29	1.0	0.96	729.63
30	1.0	0.96	729.63
Total Payment			23,073.54

V. Additional Aspects of the SNF PPS

A. SNF Level of Care—Administrative Presumption

The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system discussed in section III.C. of this proposed rule. This

approach includes an administrative presumption that utilizes a beneficiary's correct assignment, at the outset of the SNF stay, of one of the case-mix classifiers designated for this purpose to assist in making certain SNF level of care determinations.

In accordance with § 413.345, we include in each update of the Federal payment rates in the **Federal Register** a discussion of the resident classification system that provides the basis for case-mix adjustment. We also designate those specific classifiers under the case-mix classification system that represent the required SNF level of care, as provided in 42 CFR 409.30. This designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial Medicare assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment.

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 on this point using the existing administrative criteria. This presumption recognizes the strong likelihood that those beneficiaries who are correctly assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html* (where such designations appear in the paragraph entitled ''Case Mix Adjustment'') and would publish such designations in rulemaking only to the extent that we actually intend to propose changes in them. Under that approach, the set of case-mix classifiers designated for this purpose under PDPM was finalized in the FY 2019 SNF PPS final rule (83 FR 39253) and is posted on the SNF PPS website (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html*), in the paragraph entitled ''Case Mix Adjustment.''

However, we note 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, including a review to confirm that any services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations 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. Moreover, we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the Assessment Reference Date (ARD) of the initial Medicare assessment.

B. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA 1997) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297). Effective with services furnished on or after January 1, 2024, section 4121(a)(4) of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117–328, enacted December 29, 2022) added marriage and family therapists and mental health counselors to the list of practitioners at section 1888(e)(2)(A)(ii) of the Act whose services are excluded from the consolidated billing provision.

Section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999) (Pub. L. 106–113, enacted November 29, 1999) amended section 1888(e)(2)(A)(iii) of the Act by further excluding a number of individual high-cost, low probability services, identified by HCPCS codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA 1999 amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *www.cms.gov/transmittals/downloads/ab001860.pdf.*

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA 1999 not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate additional, individual services for exclusion within each of these four specified service categories. In the proposed rule for FY 2001, we also noted that the BBRA 1999 Conference report (H.R. Conf. Rep. No. 106–479 at 854 (1999)) characterizes the individual services that this legislation targets for exclusion as high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA 1999 is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA 1999 do not designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

Effective with items and services furnished on or after October 1, 2021,

section 134 in Division CC of the CAA, 2021 established an additional fifth category of excluded codes in section 1888(e)(2)(A)(iii)(VI) of the Act, for certain blood clotting factors for the treatment of patients with hemophilia and other bleeding disorders along with items and services related to the furnishing of such factors under section 1842(o)(5)(C) of the Act. Like the provisions enacted in the BBRA 1999, section 1888(e)(2)(A)(iii)(VI) of the Act gives the Secretary the authority to designate additional items and services for exclusion within the category of items and services related to blood clotting factors, as described in that section.

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

As we further explained in the final rule for FY 2001 (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA 1999: they must fall within one of the five service categories specified in the BBRA 1999 and CAA, 2021; and they also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA 1999 Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791).

In this proposed rule, we specifically solicit public comments identifying HCPCS codes in any of these five service categories (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified previously. We request that commenters identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment and the CAA, 2021 identified a set of excluded items and services by means of specifying individual HCPCS codes within the designated categories that were in effect as of a particular date (in the case of the BBRA 1999, July 1, 1999, and in the case of the CAA, 2021, July 1, 2020), as subsequently modified by the Secretary. In addition, as noted in this section of the preamble, the statute (sections 1888(e)(2)(A)(iii)(II) through (VI) of the Act) gives the Secretary authority to identify additional items and services for exclusion within the five specified categories of items and services described in the statute, which are also designated by HCPCS code. Designating the excluded services in this manner makes it possible for us to utilize program issuances as the vehicle for accomplishing routine updates to the excluded codes to reflect any minor revisions that might subsequently occur in the coding system itself, such as the assignment of a different code number to a service already designated as excluded, or the creation of a new code for a type of service that falls within one of the established exclusion categories and meets our criteria for exclusion.

Accordingly, if we identify through the current rulemaking cycle any new services that meet the criteria for exclusion from SNF consolidated billing, we will identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, October 1, 2024). By making any new exclusions in this manner, we can similarly accomplish routine future updates of these additional codes through the issuance of program instructions. The latest list of excluded codes can be found on the SNF Consolidated Billing website at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling.*

C. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. As discussed in the FY 2019 SNF PPS final rule (83 FR 39235), revisions were made to the swing bed assessment to support implementation of PDPM, effective October 1, 2019. A discussion of the assessment schedule and the MDS effective beginning FY 2020 appears in the FY 2019 SNF PPS final rule (83 FR 39229 through 39237). The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

V. Other SNF PPS Issues

A. Rebasing and Revising the SNF Market Basket

Section 1888(e)(5)(A) of the Act requires the Secretary to establish a market basket that reflects the changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

The SNF market basket is used to compute the market basket percentage increase that is used to update the SNF Federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage increase is adjusted by a forecast error adjustment, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule. The SNF market basket is also used to determine the labor-related share on an annual basis.

The SNF market basket is a fixed-weight, Laspeyres-type price index. A

Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured.

The index itself is constructed in three steps. First, a base period is selected (the proposed base period is 2022) and total base period costs are estimated for a set of mutually exclusive and exhaustive spending categories and the proportion of total costs that each category represents is calculated. These proportions are called cost weights. Second, each cost category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the cost weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the cost weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

Since the inception of the SNF PPS, the market basket used to update SNF PPS payments has been periodically rebased and revised. We last rebased and revised the market basket applicable to the SNF PPS in the FY 2022 SNF PPS final rule (86 FR 42444 through 42463) where we adopted a 2018-based SNF market basket. References to the historical market baskets used to update SNF PPS payments are listed in the FY 2022 SNF PPS final rule (86 FR 42445).

Effective for FY 2025 and subsequent fiscal years, we are proposing to rebase and revise the market basket to reflect 2022 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. Medicare-allowable costs are those costs that are eligible to be paid under the SNF PPS. For example, the SNF market basket excludes home health agency (HHA) costs as these costs would be paid under the HHA PPS, and therefore, these costs are not SNF PPS Medicare-allowable costs. We propose to maintain our policy of using data from freestanding SNFs, of which about 91 percent of SNFs that submitted a Medicare cost report for 2022 are represented in our sample shown in Table 11. We believe using freestanding Medicare cost report data, as opposed to the hospital-based SNF Medicare cost report data, for the cost weight calculation is most appropriate because of the complexity of hospital-based data and the representativeness of the freestanding data. Because hospital-based SNF expenses are embedded in the hospital cost report, any attempt to incorporate data from hospital-based facilities requires more complex calculations and assumptions regarding the ancillary costs related to the hospital-based SNF unit. We believe the use of freestanding SNF cost report data is technically appropriate for reflecting the cost structures of SNFs serving Medicare beneficiaries.

We are proposing to use 2022 as the base year as we believe that the 2022 Medicare cost reports represent the most recent, complete set of Medicare cost report data available to develop cost weights for SNFs at the time of rulemaking. We believe it is important to regularly rebase and revise the SNF market basket to reflect more recent data. Historically, the cost weights change minimally from year to year as they represent percent of total costs rather than cost levels; however, given the COVID–19 Public Health Emergency (PHE), we have been monitoring the Medicare cost report data to see if a more frequent rebasing schedule is necessary than our recent historical precedent of about every 4 years. Accordingly, while it has been only three years since the last SNF rebasing, we are proposing to incorporate data that is more reflective of recent SNF expenses that have been impacted over the COVID–19 PHE period. The 2022 Medicare cost reports are for cost reporting periods beginning on and after October 1, 2021 and before October 1, 2022. While these dates appear to reflect fiscal year data, we note that a Medicare cost report that begins in this timeframe is generally classified as a ''2022 cost report''. For example, we found that of the available 2022 Medicare cost reports for SNFs, approximately 7 percent had an October 1, 2021 begin date, approximately 75 percent of the reports had a January 1, 2022 begin date, and approximately 12 percent had a July 1, 2022 begin date. For this reason, we are defining the base year of the market basket as ''2022-based'' instead of ''FY 2022-based''.

Specifically, we are proposing to develop cost category weights for the proposed 2022-based SNF market basket in two stages. The major types of costs underlying the proposed 2022-based SNF market basket are derived from the 2022 Medicare cost report data (CMS Form 2540–10, OMB NO. 0938–0463) for freestanding SNFs. Specifically, we use the Medicare cost reports for seven specific costs: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office/Related Organization Contract Labor; and Capital-related. A residual ''All Other'' category is then estimated and reflects all remaining costs that are not captured in the seven types of costs identified above. The 2018-based SNF market basket similarly used 2018 Medicare cost report data. Second, we are proposing to divide the residual ''All Other'' cost category into more detailed subcategories, using U.S. Department of Commerce Bureau of Economic Analysis' (BEA) 2017 Benchmark Input–Output (I–O) ''The Use Table (Supply-Use Framework)'' for the Nursing and Community Care Facilities industry (NAICS 623A00) aged to 2022 using applicable price proxy growth for each category of costs. Furthermore, we are proposing to continue to use the same overall methodology as was used for the 2018-based SNF market basket to develop the capital related cost weights of the proposed 2022-based SNF market basket.

1. Development of Cost Categories and Weights

a. Use of Medicare Cost Report Data To Develop Major Cost Weights

In order to create a market basket that is representative of freestanding SNF providers serving Medicare patients and to help ensure accurate major cost weights (which is the percent of total Medicare-allowable costs, as defined below), we propose to apply edits to remove reporting errors and outliers. Specifically, the SNF Medicare cost reports used to calculate the market basket cost weights exclude any providers that reported costs less than or equal to zero for the following categories: total facility costs (Worksheet B, part 1, column 18, line 100); total operating costs (Worksheet B, part 1, column 18, line 100 less Worksheet B, part 2, column 18, line 100); Medicare general inpatient routine service costs (Worksheet D, part 1, column 1, line 1); and Medicare PPS payments (Worksheet E, part 3, column 1, line 1). We also limited our sample to providers that had a Medicare cost report reporting period that was between 10 and 14 months. The final sample used included roughly 13,100

Medicare cost reports (about 90 percent of the universe of SNF Medicare cost reports for 2022). The sample of providers is representative of the national universe of providers by region (each region is represented within plus or minus 1 percentage point of universe distribution), by ownership-type (proprietary, nonprofit, and government) (within 0.8 percentage point of universe), and by urban/rural status (within 0.1 percentage point of universe). Of the providers that were excluded from our final sample, 86 percent were due to having a cost reporting period less than 10 months or greater than 14 months, 10 percent were due to total facility costs or total operating costs not being greater than zero, and 4 percent were due to Medicare general inpatient routine service costs or Medicare PPS payments not being greater than zero.

Additionally, for all of the major cost weights, except Home Office/Related Organization Contract Labor costs, the data are trimmed to remove outliers (a standard statistical process) by: (1) requiring that major expenses (such as Wages and Salaries costs) and total Medicare-allowable costs are greater than zero; and (2) excluding the top and bottom 5 percent of the major cost weight (for example, Wages and Salaries costs as a percent of total Medicare-allowable costs). We note that missing values are assumed to be zero, consistent with the methodology for how missing values are treated in the 2018-based market basket methodology.

For the Home Office/Related Organization Contract Labor cost weight, we propose to first exclude providers whose Home Office/Related Organization Contract Labor costs are greater than Medicare-allowable total costs and then apply a trim that excludes those reporters with a Home Office/Related Organization Contract Labor cost weight above the 99th percentile. This allows providers with no Home Office/Related Organization Contract Labor costs to be included in the Home Office/Related Organization Contract Labor cost weight calculation. If we were to trim the top and bottom Home Office/Related Organization Contract Labor cost weight, we would exclude providers with a cost weight of zero (84 percent of the sample) and the Medicare cost report data (Worksheet S–2 line 45) indicate that not all SNF providers have a home office. Providers without a home office would report administrative costs that might typically be associated with a home office in the Wages and Salaries and Employee Benefits cost weights, or in the residual ''All-Other'' cost weight if they purchased these types of services from external contractors. We believe the trimming methodology that excludes those who report Home Office/Related Organization Contract Labor costs above the 99th percentile is appropriate as it removes extreme outliers while also allowing providers with zero Home Office/Related Organization Contract Labor costs, which is the majority of providers, to be included in the Home Office/Related Organization Contract Labor cost weight calculation.

The trimming process is done individually for each cost category so that providers excluded from one cost weight calculation are not automatically excluded from another cost weight calculation. We note that these trimming methods are the same types of edits performed for the 2018-based SNF market basket, as well as other PPS market baskets (including but not limited to the IPPS market basket and home health market basket). We believe this trimming process improves the accuracy of the data used to compute the major cost weights by removing possible data misreporting.

The final weights of the proposed 2022-based SNF market basket are based on weighted means. For example, the aggregate Wages and Salaries cost weight, after trimming, is equal to the sum of total Medicare-allowable wages and salaries (as defined in the ''Wages and Salaries'' section that follows) of all providers divided by the sum of total Medicare-allowable costs (as defined in the next paragraph) for all providers in the sample (as defined above in this section). This methodology is consistent with the methodology used to calculate the 2018-based SNF market basket cost weights and other PPS market basket cost weights. We note that for each of the cost weights, we evaluated the distribution of providers and costs by region, by ownership-type, and by urban/rural status. For all of the cost weights, with the exception of the PLI (which is discussed in more detail later), the trimmed sample was nationally representative.

For all of the cost weights, we use Medicare-allowable total costs as the denominator (for example, Wages and Salaries cost weight = Wages and Salaries costs divided by Medicare-allowable total costs). Medicare-allowable total costs were equal to total costs (after overhead allocation) from Worksheet B part I, column 18, for lines 30, 40 through 49, 51, 52, and 71 plus estimated Medicaid drug costs, as defined below. We included estimated Medicaid drug costs in the pharmacy cost weight, as well as the denominator for total Medicare-allowable costs. This is the same methodology used for the 2018-based SNF market basket. The inclusion of Medicaid drug costs was finalized in the FY 2008 SNF PPS final rule (72 FR 43425 through 43430), and for the same reasons set forth in that final rule, we are proposing to continue to use this methodology in the proposed 2022-based SNF market basket.

We describe the detailed methodology for obtaining costs for each of the eight cost categories determined from the Medicare Cost Report below. The methodology used in the 2018-based SNF market basket can be found in the FY 2022 SNF PPS final rule (86 FR 42446 through 42452).

(1) Wages and Salaries

To derive Wages and Salaries costs for the Medicare-allowable cost centers, we are proposing first to calculate total facility wages and salaries costs as reported on Worksheet S–3, part II, column 3, line 1. We then propose to remove the wages and salaries attributable to non-Medicare-allowable cost centers (that is, excluded areas), as well as a portion of overhead wages and salaries attributable to these excluded areas. Excluded area wages and salaries are equal to wages and salaries as reported on Worksheet S–3, part II, column 3, lines 3, 4, and 7 through 11 plus nursing facility and non-reimbursable salaries from Worksheet A, column 1, lines 31, 32, 50, and 60 through 63.

Overhead wages and salaries are attributable to the entire SNF facility; therefore, we are proposing to include only the proportion attributable to the Medicare-allowable cost centers. We are proposing to estimate the proportion of overhead wages and salaries attributable to the non-Medicare-allowable costs centers in two steps. First, we propose to estimate the ratio of excluded area wages and salaries (as defined above) to non-overhead total facility wages and salaries (total facility wages and salaries (Worksheet S–3, part II, column 3, line 1) less total overhead wages and salaries (Worksheet S–3, Part III, column 3, line 14)). Next, we propose to multiply total overhead wages and salaries by the ratio computed in step 1. We excluded providers whose excluded areas wages and salaries were greater than total facility wages and salaries and/or their excluded area overhead wages and salaries were greater than total facility wages and salaries (about 50 providers). This is the same methodology used to derive Wages and Salaries costs in the 2018-based SNF market basket.

(2) Employee Benefits

Medicare-allowable employee benefits are equal to total facility benefits as reported on Worksheet S–3, part II, column 3, lines 17 through 19 minus non-Medicare-allowable (that is, excluded area) employee benefits and minus a portion of overhead benefits attributable to these excluded areas. Excluded area employee benefits are derived by multiplying total excluded area wages and salaries (as defined above in the 'Wages and Salaries' section) times the ratio of total facility benefits to total facility wages and salaries. This ratio of benefits to wages and salaries is defined as total facility benefit costs to total facility wages and salary costs (as reported on Worksheet S–3, part II, column 3, line 1). Likewise, the portion of overhead benefits attributable to the excluded areas is derived by multiplying overhead wages and salaries attributable to the excluded areas (as defined in the 'Wages and Salaries' section) times the ratio of total facility benefit costs to total facility wages and salary costs (as defined above). Similar to the Wages and Salaries costs, we excluded providers whose excluded areas benefits were greater than total facility benefits and/or their excluded area overhead benefits were greater than total facility benefits (zero providers were excluded because of this edit). This is the same methodology used to derive Employee Benefits costs in the 2018-based SNF market basket.

(3) Contract Labor

We are proposing to derive Medicare-allowable contract labor costs from Worksheet S–3, part II, column 3, line 14, which reflects costs for contracted direct patient care services (that is, nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services). This is the same methodology used to derive the Contract Labor costs in the 2018-based SNF market basket.

(4) Pharmaceuticals

We are proposing to calculate pharmaceuticals costs using the non-salary costs from the Pharmacy cost center (Worksheet B, part I, column 0, line 11 less Worksheet A, column 1, line 11) and the Drugs Charged to Patients' cost center (Worksheet B, part I, column 0, line 49 less Worksheet A, column 1, line 49). Since these drug costs were attributable to the entire SNF and not limited to Medicare-allowable services, we propose to adjust the drug costs by the ratio of Medicare-allowable pharmacy total costs (Worksheet B, part I, column 11, for lines 30, 40 through 49, 51, 52, and 71) to total pharmacy costs from Worksheet B, part I, column 11, line 11. Worksheet B, part I allocates the general service cost centers, which are often referred to as ''overhead costs'' (in which pharmacy costs are included) to the Medicare-allowable and non-Medicare-allowable cost centers. This adjustment was made for those providers who reported Pharmacy cost center expenses. Otherwise, we assumed the non-salary Drugs Charged to Patients costs were Medicare-allowable. Since drug costs for Medicare patients are included in the SNF PPS per diem rate, a provider with Medicare days should have also reported costs in the Drugs Charged to Patient cost center. We found a small number of providers (roughly 90) did not report Drugs Charged to Patients' costs despite reporting Medicare days (an average of about 2,000 Medicare days per provider), and therefore, these providers were excluded from the Pharmaceuticals cost weight calculations. This is the same methodology used for the 2018-based SNF market basket.

Second, as was done for the 2018-based SNF market basket, we propose to continue to adjust the drug expenses reported on the Medicare cost report to include an estimate of total Medicaid drug costs, which are not represented in the Medicare-allowable drug cost weight. As stated previously in this section, the proposed 2022-based SNF market basket reflects total Medicare-allowable costs (that is, total costs for all payers for those services reimbursable under the SNF PPS). For the FY 2006-based SNF market basket (72 FR 43426), commenters noted that the total pharmaceutical costs reported on the Medicare cost report did not include pharmaceutical costs for dual-eligible Medicaid patients as these were directly reimbursed by Medicaid. Since all of the other cost category weights reflect expenses associated with treating Medicaid patients (including the compensation costs for dispensing these drugs), we made an adjustment to include these Medicaid drug expenses so the market basket cost weights would be calculated consistently.

Similar to the 2018-based SNF market basket, we propose to estimate Medicaid drug costs based on data representing dual-eligible Medicaid beneficiaries. Medicaid drug costs are estimated by multiplying Medicaid dual-eligible drug costs per day times the number of Medicaid days as reported in the Medicare-allowable skilled nursing cost center (Worksheet S–3, part I, column 5, line 1) in the SNF Medicare cost report. Medicaid dual-eligible drug costs per day (where the day represents an unduplicated drug supply day) were estimated using 2022 Part D claims for those dual-eligible beneficiaries who had a Medicare SNF stay during the year. The total drug costs per unduplicated day for 2022 of $27.43 represented all drug costs (including the drug ingredient cost, the dispensing fee, vaccine administration fee and sales tax) incurred during the 2022 calendar year (CY) for those dual-eligible beneficiaries who had a SNF Medicare stay during CY 2022. Therefore, they include drug costs incurred during a Medicaid SNF stay occurring in CY 2022. By comparison, the 2018-based SNF market basket also relied on data from the Part D claims, which yielded a dual-eligible Medicaid drug cost per day of $24.48 for 2018.

We continue to believe that Medicaid dual-eligible beneficiaries are a reasonable proxy for the estimated drug costs per day incurred by Medicaid patients staying in a skilled nursing unit under a Medicaid stay. The skilled nursing unit is the Medicare-allowable unit in a SNF, which encompasses more skilled nursing and rehabilitative care compared to a nursing facility or long-term care unit. We believe that Medicaid patients receiving this skilled nursing care would on average have similar drug costs per day to dual-eligible Medicare beneficiaries who have received Medicare skilled nursing care in the skilled nursing care unit during the year. We note that our previous analysis of the Part D claims data showed that Medicare beneficiaries with a SNF stay during the year have higher drug costs than Medicare patients without a SNF stay during the year. Also, in 2022, dual-eligible beneficiaries with a SNF stay during the year had drug costs per day of $27.43, which were approximately two times higher than the drug costs per day of $15.83 for nondual-eligible beneficiaries with a SNF Part A stay during the year.

The Pharmaceuticals cost weight using only 2022 Medicare cost report data (without the inclusion of the Medicaid dual-eligible drug costs) is 2.0 percent, compared to the proposed Pharmaceuticals cost weight (including the adjustment for Medicaid dual-eligible drug costs) of 6.4 percent. The 2018-based SNF market basket had a Pharmaceuticals cost weight using only 2018 Medicare cost report data without the inclusion of the Medicaid dual-eligible drug costs of 2.6 percent and a total Pharmaceuticals cost weight of 7.5 percent. Therefore, the 1.1 percentage point decrease in the Pharmaceuticals

cost weight between 2018 and 2022 is a result of a 0.5-percentage point decrease in the Medicaid dual-eligible drug cost weight (reflecting the 12 percent increase in the Medicaid dual-eligible drug costs per day, and a 14 percent decrease in Medicaid inpatient days between 2018 and 2022) and a 0.6-percentage point decrease in the Medicare cost report drug cost weight. The decrease in the Medicare cost report drug cost weight was consistent, in aggregate, across urban and rural status SNFs, as well as across for-profit, government, and nonprofit ownership type SNFs.

(5) Professional Liability Insurance

We are proposing to calculate the professional liability insurance (PLI) costs from Worksheet S–2 of the Medicare cost reports as the sum of premiums; paid losses; and self-insurance (Worksheet S–2, Part I, columns 1 through 3, line 41). This was the same methodology used to derive the Professional Liability costs for the 2018-based SNF market basket.

About 60 percent of SNFs (about 7,700) reported professional liability costs. After trimming, about 6,900 (reflecting about 730,000 Skilled Nursing unit beds) were included in the calculation of the PLI cost weight for the proposed 2022-based SNF market basket. These providers treated roughly 750,000 Medicare beneficiaries and had a Medicare length of stay (LOS) of 58 days, a skilled nursing unit occupancy rate of 72 percent, and an average skilled nursing unit bed size of 106 beds, which are all consistent with the national averages. We also verified that this sample of providers are representative of the national distribution of providers by ownership-type, urban/rural status, and region.

We believe the Medicare cost report data continues to be the most appropriate data source to calculate the PLI cost weight for the proposed 2022-based SNF market basket as it is representative of SNFs serving Medicare beneficiaries and reflects PLI costs (premiums, paid losses, and self-insurance) incurred during the provider's cost reporting year. A fuller discussion of the Medicare cost report data on PLI costs compared to other sources is available in the FY 2022 SNF PPS final rule (86 FR 42448).

(6) Capital-Related

We are proposing to derive the Medicare-allowable capital-related costs from Worksheet B, part II, column 18 for lines 30, 40 through 49, 51, 52, and 71. This is the same methodology to derive capital-related costs used in the 2018-based SNF market basket.

(7) Home Office/Related Organization Contract Labor Costs

We are proposing to calculate Medicare-allowable Home Office/Related Organization Contract Labor costs to be equal to data reported on Worksheet S–3, part II, column 3, line 16. About 7,100 providers (about 54 percent) in 2022 reported having a home office (as reported on Worksheet S–2, part I, line 45) about the same share of providers as those in the 2018-based SNF market basket. As discussed in section V.A.1. of this proposed rule, providers without a home office can incur these expenses directly by having their own staff, for which the costs would be included in the Wages and Salaries and Employee Benefits cost weights. Alternatively, providers without a home office could also purchase related services from external contractors for which these expenses would be captured in the residual ''All-Other'' cost weight. For this reason, unlike the other major cost weights described previously, we did not exclude providers that did not report Home Office/Related Organization Contract Labor costs. This is the same methodology that was used in the 2018-based SNF market basket.

(8) All Other (Residual)

The ''All Other'' cost weight is a residual, calculated by subtracting the major cost weights (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance, Capital-Related, and Home Office/Related Organization Contract Labor) from 100.

Table 11 shows the major cost categories and their respective cost weights as derived from the 2022 Medicare cost reports.

TABLE 11—MAJOR COST CATEGORIES DERIVED FROM THE SNF MEDICARE COST REPORTS *

Major cost categories	Proposed 2022-based	2018-Based
Wages and Salaries	43.3	44.1
Employee Benefits	7.8	8.6
Contract Labor	10.1	7.5
Pharmaceuticals	6.4	7.5
Professional Liability Insurance	1.3	1.1
Capital-Related	8.3	8.2
Home Office/Related Organization Contract Labor	0.6	0.7
All other (residual)	22.2	22.3

* Total may not sum to 100 due to rounding.

As we did for the 2018-based SNF market basket (86 FR 42449), we are proposing to allocate contract labor costs to the Wages and Salaries and Employee Benefits cost weights based on their relative proportions under the assumption that contract labor costs are comprised of both wages and salaries and employee benefits. The contract labor allocation proportion for wages and salaries is equal to the Wages and Salaries cost weight as a percent of the sum of the Wages and Salaries cost weight and the Employee Benefits cost weight. Using the 2022 Medicare cost report data, this percentage is 85 percent (1 percentage point higher than the percentage in the 2018-based SNF market basket); therefore, we are proposing to allocate approximately 85 percent of the Contract Labor cost weight to the Wages and Salaries cost weight and 15 percent to the Employee Benefits cost weight.

Table 12 shows the Wages and Salaries and Employee Benefits cost weights after contract labor allocation for the proposed 2022-based SNF market basket and the 2018-based SNF market basket.

TABLE 12—WAGES AND SALARIES AND EMPLOYEE BENEFITS COST WEIGHTS AFTER CONTRACT LABOR ALLOCATION

Major cost categories	Proposed 2022-based market basket	2018-Based market basket
Compensation	61.2	60.2
Wages and Salaries	51.8	50.4
Employee Benefits	9.3	9.9

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal; therefore, the detailed compensation cost weights may not add to the total compensation cost weight due to rounding.

Compared to the 2018-based SNF market basket, the Wages and Salaries cost weight and the Employee Benefits cost weight as calculated directly from the Medicare cost reports each decreased by 0.8 percentage point. The Contract Labor cost weight increased 2.6 percentage points and so in aggregate, the Compensation cost weight increased 1.0 percentage point from 60.2 percent to 61.2 percent.

b. Derivation of the Detailed Operating Cost Weights

To further divide the ''All Other'' residual cost weight estimated from the 2022 Medicare cost report data into more detailed cost categories, we are proposing to use the 2017 Benchmark I–O ''The Use Table (Supply-Use Framework)'' for Nursing and Community Care Facilities industry (NAICS 623A00), published by the Census Bureau's, Bureau of Economic Analysis (BEA). These data are publicly available at *https://www.bea.gov/industry/input-output-accounts-data.* The BEA Benchmark I–O data are generally scheduled for publication every 5 years with 2017 being the most recent year for which data are available. The 2017 Benchmark I–O data are derived from the 2017 Economic Census and are the building blocks for BEA's economic accounts; therefore, they represent the most comprehensive and complete set of data on the economic processes or mechanisms by which output is produced and distributed.[1] BEA also produces Annual I–O estimates. However, while based on a similar methodology, these estimates are less comprehensive and provide less detail than benchmark data. Additionally, the annual I–O data are subject to revision once benchmark data become available. For these reasons, we propose to inflate the 2017 Benchmark I–O data aged forward to 2022 by applying the annual price changes from the respective price proxies to the appropriate market basket cost categories that are obtained from the 2017 Benchmark I–O data. Next, the relative shares of the cost shares that each cost category represents to the total residual I–O costs are calculated. These resulting 2022 cost shares of the I–O data are applied to the ''All Other'' residual cost weight to obtain detailed cost weights for the residual costs for the proposed 2022-based SNF market basket. For example, the cost for Food: Direct Purchases represents 12.8 percent of the sum of the ''All Other'' 2017 Benchmark I–O Expenditures inflated to 2022. Therefore, the Food: Direct Purchases cost weight is 2.8 percent of the proposed 2022-based SNF market basket (12.8 percent × 22.2 percent = 2.8 percent). For the 2018-based SNF market basket (86 FR 42449), we used a similar methodology utilizing the 2012 Benchmark I–O data (aged to 2018).

Using this methodology, we are proposing to derive 19 detailed SNF market basket cost category weights from the proposed 2022-based SNF market basket ''All Other'' residual cost weight (22.2 percent). These categories are: (1) Fuel: Oil and Gas; (2) Electricity and Other Non-Fuel Utilities; (3) Food: Direct Purchases; (4) Food: Contract Services; (5) Chemicals; (6) Medical Instruments and Supplies; (7) Rubber and Plastics; (8) Paper and Printing Products; (9) Apparel; (10) Machinery and Equipment; (11) Miscellaneous Products; (12) Professional Fees: Labor-Related; (13) Administrative and Facilities Support Services; (14) Installation, Maintenance, and Repair Services; (15) All Other: Labor-Related Services; (16) Professional Fees: Nonlabor-Related; (17) Financial Services; (18) Telephone Services; and (19) All Other: Nonlabor-Related Services. These are the same detailed cost categories as those that were used in the 2018-based SNF market basket.

We note that the machinery and equipment expenses are for equipment that is paid for in a given year and not depreciated over the asset's useful life. Depreciation expenses for movable equipment are accounted for in the capital component of the proposed 2022-based SNF market basket (described in section V.A.1.c. of this proposed rule).

c. Derivation of the Detailed Capital Cost Weights

Similar to the 2018-based SNF market basket, we further divided the Capital-related cost weight into: Depreciation, Interest, Lease and Other Capital-related cost weights.

We calculated the depreciation cost weight (that is, depreciation costs excluding leasing costs) using depreciation costs from Worksheet S–2, column 1, lines 20 and 21. Since the depreciation costs reflect the entire SNF facility (Medicare and non-Medicare-allowable units), we used total facility capital costs (Worksheet B, Part I, column 18, line 100) as the denominator. This methodology assumes that the depreciation of an asset is the same regardless of whether the asset was used for Medicare or non-Medicare patients. This methodology yielded depreciation costs as a percent of capital costs of 22.6 percent for 2022. We then apply this percentage to the proposed 2022-based SNF market basket Medicare-allowable Capital-related cost weight of 8.3 percent, yielding a proposed Medicare-allowable depreciation cost weight (excluding leasing expenses, which is described in more detail below) of 1.9 percent for 2022. To further disaggregate the Medicare-allowable depreciation cost weight into fixed and movable depreciation, we are proposing to use the 2022 SNF Medicare cost report data for end-of-the-year capital asset balances as reported on Worksheet A–7. The 2022 SNF Medicare cost report data showed a fixed/movable split of 86/14. The 2018-based SNF market basket, which utilized the same data from the 2018 Medicare cost reports, also had a fixed/movable split of 86/14.

We derived the interest expense share of capital-related expenses from 2022 SNF Medicare cost report data, specifically from Worksheet A, column 2, line 81. Similar to the depreciation cost weight, we calculated the interest cost weight using total facility capital costs. This methodology yielded interest costs as a percent of capital costs of 17.7 percent for 2022. We then apply this percentage to the proposed 2022-based

[1] *https://www.bea.gov/resources/methodologies/concepts-methods-io-accounts.*

SNF market basket Medicare-allowable Capital-related cost weight of 8.3 percent, yielding a Medicare-allowable interest cost weight (excluding leasing expenses) of 1.5 percent. As done with the last rebasing (86 FR 42450), we are proposing to determine the split of interest expense between for-profit and not-for-profit facilities based on the distribution of long-term debt outstanding by type of SNF (for-profit or not-for-profit/government) from the 2022 SNF Medicare cost report data. We estimated the split between for-profit and not-for-profit interest expense to be 30/70 percent compared to the 2018-based SNF market basket with 25/75 percent.

Because the detailed data were not available in the Medicare cost reports, we used the most recent 2021 Census Bureau Service Annual Survey (SAS) data to derive the capital-related expenses attributable to leasing and other capital-related expenses. The 2018-based SNF market basket used the 2017 SAS data.

Based on the 2021 SAS data, we determined that leasing expenses are 65 percent of total leasing and capital-related expenses costs. In the 2018-based SNF market basket, leasing costs represent 62 percent of total leasing and capital-related expenses costs. We then apply this percentage to the proposed 2022-based SNF market basket residual Medicare-allowable capital costs of 4.9 percent derived from subtracting the Medicare-allowable depreciation cost weight and Medicare-allowable interest cost weight from the proposed 2022-based SNF market basket of total Medicare-allowable capital cost weight (8.3 percent − 1.9 percent − 1.5 percent = 4.9 percent). This produces the proposed 2022-based SNF Medicare-allowable leasing cost weight of 3.2 percent and all-other capital-related cost weight of 1.7 percent.

Lease expenses are not broken out as a separate cost category in the SNF market basket, but are distributed among the cost categories of depreciation, interest, and other capital-related expenses, reflecting the assumption that the underlying cost structure and price movement of leasing expenses is similar to capital costs in general. As was done with past SNF market baskets and other PPS market baskets, we assumed 10 percent of lease expenses are overhead and assigned them to the other capital-related expenses cost category. This is based on the assumption that leasing expenses include not only depreciation, interest, and other capital-related costs but also additional costs paid to the lessor. We distributed the remaining lease expenses to the three cost categories based on the proportion of depreciation, interest, and other capital-related expenses to total capital costs, excluding lease expenses.

Table 13 shows the capital-related expense distribution (including expenses from leases) in the proposed 2022-based SNF market basket and the 2018-based SNF market basket.

TABLE 13—COMPARISON OF THE CAPITAL-RELATED EXPENSE DISTRIBUTION OF THE PROPOSED 2022-BASED SNF MARKET BASKET AND THE 2018-BASED SNF MARKET BASKET

Cost category	Proposed 2022-based SNF market basket	2018-Based SNF market basket
Capital-related Expenses	8.3	8.2
Total Depreciation	3.0	3.0
Total Interest	2.3	2.7
Other Capital-related Expenses	3.0	2.6

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal; therefore, the detailed capital cost weights may not add to the total capital-related expenses cost weight due to rounding.

Table 14 presents the proposed 2022-based SNF market basket and the 2018-based SNF market basket cost categories and cost weights.

TABLE 14—PROPOSED 2022-BASED SNF MARKET BASKET AND 2018-BASED SNF MARKET BASKET COST CATEGORIES AND COST WEIGHTS

Cost category	Proposed 2022-based SNF market basket	2018-Based SNF market basket
Total	100.0	100.0
Compensation	61.2	60.2
Wages and Salaries [1]	51.8	50.4
Employee Benefits [1]	9.3	9.9
Utilities	2.7	1.5
Electricity and Other Non-Fuel Utilities	1.8	1.0
Fuel: Oil and Gas	0.8	0.4
Professional Liability Insurance	1.3	1.1
All Other	26.5	29.0
Other Products	16.1	17.6
Pharmaceuticals	6.4	7.5
Food: Direct Purchases	2.9	2.5
Food: Contract Services	3.4	4.3
Chemicals	0.2	0.2
Medical Instruments and Supplies	0.4	0.6
Rubber and Plastics	1.0	0.7
Paper and Printing Products	0.5	0.5
Apparel	0.4	0.5
Machinery and Equipment	0.7	0.5

TABLE 14—PROPOSED 2022-BASED SNF MARKET BASKET AND 2018-BASED SNF MARKET BASKET COST CATEGORIES AND COST WEIGHTS—Continued

Cost category	Proposed 2022-based SNF market basket	2018-Based SNF market basket
Miscellaneous Products	0.2	0.3
All Other Services	10.5	11.5
Labor-Related Services	6.5	6.4
Professional Fees: Labor-Related	3.6	3.5
Installation, Maintenance, and Repair Services	0.4	0.6
Administrative and Facilities Support	0.5	0.4
All Other: Labor-Related Services	2.0	1.9
Non Labor-Related Services	4.0	5.1
Professional Fees: Nonlabor-Related	1.8	2.0
Financial Services	0.5	1.3
Telephone Services	0.4	0.3
All Other: Nonlabor-Related Services	1.3	1.5
Capital-Related Expenses	8.3	8.2
Total Depreciation	3.0	3.0
Building and Fixed Equipment	2.5	2.5
Movable Equipment	0.4	0.4
Total Interest	2.3	2.7
For-Profit SNFs	0.7	0.7
Government and Nonprofit SNFs	1.6	2.0
Other Capital-Related Expenses	3.0	2.6

Note: The cost weights are calculated using three decimal places. For presentational purposes, we are displaying one decimal, and therefore, the detailed cost weights may not add to the aggregate cost weights or to 100.0 due to rounding.

[1] Contract labor is distributed to wages and salaries and employee benefits based on the share of total compensation that each category represents.

2. Price Proxies Used To Measure Operating Cost Category Growth

After developing the 27 cost weights for the proposed 2022-based SNF market basket, we selected the most appropriate wage and price proxies currently available to represent the rate of change for each cost category. With four exceptions (three for the capital-related expenses cost categories and one for PLI), we base the wage and price proxies on Bureau of Labor Statistics (BLS) data, and group them into one of the following BLS categories:

- *Employment Cost Indexes.* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. ECIs are superior to Average Hourly Earnings (AHE) as price proxies for input price indexes because they are not affected by shifts in occupation or industry mix, and because they measure pure price change and are available by both occupational group and by industry. The industry ECIs are based on the NAICS and the occupational ECIs are based on the Standard Occupational Classification System (SOC).
- *Producer Price Indexes.* Producer Price Indexes (PPIs) measure the average change over time in the selling prices received by domestic producers for their output. The prices included in the PPI are from the first commercial transaction for many products and some services (*https://www.bls.gov/ppi/*).
- *Consumer Price Indexes.* Consumer Price Indexes (CPIs) measure the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services (*https://www.bls.gov/cpi/*). CPIs are only used when the purchases are similar to those of retail consumers rather than purchases at the producer level, or if no appropriate PPIs are available.

We evaluate the price proxies using the criteria of reliability, timeliness, availability, and relevance:

- *Reliability.* Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because only a sample was surveyed rather than the entire population.)
- *Timeliness.* Timeliness implies that the proxy is published regularly, preferably at least once a quarter. The market baskets are updated quarterly, and therefore, it is important for the underlying price proxies to be up-to-date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, whenever possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently, because we believe that this is an optimal way to stay abreast of the most current data available.
- *Availability.* Availability means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis.
- *Relevance.* Relevance means that the proxy is applicable and representative of the cost category weight to which it is applied.

We believe that the CPIs, PPIs, and ECIs that we have selected meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

Table 19 lists all price proxies for the proposed 2022-based SNF market basket. Below is a detailed explanation of the price proxies we are proposing to use for each operating cost category.

a. Wages and Salaries

We are proposing to use the ECI for Wages and Salaries for Private Industry Workers in Nursing Care Facilities

(NAICS 6231; BLS series code CIU2026231000000I) to measure price growth of this category. NAICS 623 includes facilities that provide a mix of health and social services, with many of the health services requiring some level of nursing services. Within NAICS 623 is NAICS 6231, which includes nursing care facilities primarily engaged in providing inpatient nursing and rehabilitative services. These facilities, which are most comparable to Medicare-certified SNFs, provide skilled nursing and continuous personal care services for an extended period of time, and, therefore, have a permanent core staff of registered or licensed practical nurses. This is the same index used in the 2018-based SNF market basket.

b. Employee Benefits

We are proposing to use the ECI for Benefits for Nursing Care Facilities (NAICS 6231) to measure price growth of this category. The ECI for Benefits for Nursing Care Facilities is calculated using BLS's total compensation (BLS series ID CIU2016231000000I) for nursing care facilities series and the relative importance of wages and salaries within total compensation. We believe this constructed ECI series is technically appropriate for the reason stated above in the Wages and Salaries price proxy section. This is the same index used in the 2018-based SNF market basket.

c. Electricity and Other Non-Fuel Utilities

We are proposing to use the PPI Commodity for Commercial Electric Power (BLS series code WPU0542) to measure the price growth of this cost category as Electricity costs account for 93 percent of these expenses. This is the same index used for the Electricity cost category in the 2018-based SNF market basket.

d. Fuel: Oil and Gas

We are proposing to use a blended proxy composed of the PPI Industry for Petroleum Refineries (NAICS 324110) (BLS series code PCU32411–32411), the PPI Commodity for Natural Gas (NAICS 221200)(BLS series code WPU0531), and the PPI for Other Petroleum and Coal Products manufacturing (NAICS 324190)(BLS series code PCU32419–32419).

Our analysis of 2017 Benchmark I–O data for Nursing and Community Care Facilities found that these three NAICS industries account for approximately 93 percent of SNF Fuel: Oil and Gas expenses. The remaining 7 percent of SNF Fuel: Oil and Gas expenses are for two other incidental NAICS industries including Coal Mining and Petrochemical Manufacturing. We are proposing to create a blended index based on the three NAICS Fuel: Oil and Gas expenses listed above that account for 93 percent of SNF Fuel: Oil and Gas expenses. We propose to create this blend based on each NAICS' expenses as a share of their sum. These expenses as a share of their sum are listed in Table 15.

The 2018-based SNF market basket used a blended Fuel: Oil and Gas proxy that was based on 2012 Benchmark I–O data. We believe our proposed Fuel: Oil and Gas blended index for the proposed 2022-based SNF market basket is technically appropriate as it reflects more recent data on SNFs purchasing patterns. Table 16 provides the weights for the 2022- and 2018-based blended Fuel: Oil and Gas index.

TABLE 15—FUEL: OIL AND GAS BLENDED INDEX WEIGHTS

NAICS	Price proxy	Proposed 2022-based index (%)	2018-Based index (%)
221200	PPI Commodity for Natural Gas	7	7
324110	PPI Industry for Petroleum Refineries	72	61
324190	PPI for Other Petroleum and Coal Products manufacturing	21	32
Total		100	100

e. Professional Liability Insurance

We are proposing to use the CMS Hospital Professional Liability Insurance Index to measure price growth of this category. We were unable to find a reliable data source that collects SNF-specific PLI data. Therefore, we propose to use the CMS Hospital Professional Liability Index, which tracks price changes for commercial insurance premiums for a fixed level of coverage, holding non-price factors constant (such as a change in the level of coverage). This is the same index used in the 2018-based SNF market basket. We believe this is an appropriate proxy to measure the price growth associated of SNF PLI as it captures the price inflation associated with other medical institutions that serve Medicare patients.

f. Pharmaceuticals

We are proposing to use the PPI Commodity for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

g. Food: Direct Purchases

We are proposing to use the PPI Commodity for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

h. Food: Contract Services

We are proposing to use the CPI All Urban for Food Away From Home (All Urban Consumers) (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

i. Chemicals

For measuring price change in the Chemicals cost category, we are proposing to use a blended PPI composed of the Industry PPIs for Other Basic Organic Chemical Manufacturing (NAICS 325190) (BLS series code PCU32519–32519), Soap and Cleaning Compound Manufacturing (NAICS 325610) (BLS series code PCU32561–32561), and All Other Chemical Product and Preparation Manufacturing (NAICS 3259A0) (BLS series code PCU325998325998).

Using the 2017 Benchmark I–O data, we found that these three NAICS industries accounted for approximately 95 percent of SNF chemical expenses. The remaining 5 percent of SNF chemical expenses are for three other incidental NAICS chemicals industries

such as Paint and Coating Manufacturing. We are proposing to create a blended index based on the three NAICS chemical expenses listed above that account for 95 percent of SNF chemical expenses. We propose to create this blend based on each NAICS' expenses as a share of their sum. These expenses as a share of their sum are listed in Table 16.

The 2018-based SNF market basket used a blended chemical proxy that was based on 2012 Benchmark I–O data. We believe our proposed chemical blended index for the proposed 2022-based SNF market basket is technically appropriate as it reflects more recent data on SNFs purchasing patterns. Table 16 provides the weights for the proposed 2022-based blended chemical index and the 2018-based blended chemical index.

TABLE 16—CHEMICAL BLENDED INDEX WEIGHTS

NAICS	Price proxy	Proposed 2022-based index (%)	2018-Based index (%)
325190	PPI for Other Basic Organic Chemical Manufacturing	49	34
325610	PPI for Soap and Cleaning Compound Manufacturing	9	21
325998	PPI for Other Miscellaneous Chemical Product Manufacturing	42	45
Total		100	100

j. Medical Instruments and Supplies

For measuring price change in the Medical Instruments and Supplies cost category, we are proposing to use a blended proxy. The 2017 Benchmark I–O data shows 62 percent of medical instruments and supply costs are for Surgical and medical instrument manufacturing costs (NAICS 339112) and 38 percent are for Surgical appliance and supplies manufacturing costs (NAICS 339113). To proxy the price changes associated with NAICS 339112, we propose using the PPI—Commodity—Surgical and medical instruments (BLS series code WPU1562). To proxy the price changes associated with NAICS 339113, we propose to use 50 percent for the PPI—Commodity—Medical and surgical appliances and supplies (BLS series code WPU1563) and 50 percent for the PPI Commodity data for Miscellaneous products-Personal safety equipment and clothing (BLS series code WPU1571). The latter price proxy would reflect personal protective equipment including but not limited to face shields and protective clothing. The 2017 Benchmark I–O data does not provide specific expenses for personal protective equipment (which would be reflected in the NAICS 339113 expenses); however, we recognize that this category reflects costs faced by SNFs. In absence of any specific cost data on personal protective equipment, we propose to include the PPI Commodity data for Miscellaneous products-Personal safety equipment and clothing (BLS series code WPU1571) in the blended proxy for Medical Instruments and Supplies cost category with a weight of 19 percent (that is, 50 percent of the NAICS 339113 expenses as a percent of the sum of NAICS 339113 and NAICS 339112 expenses from the I–O).

The 2018-based SNF market basket used a blended Medical Instruments and Supplies proxy that was based on 2012 Benchmark I–O data. We believe our proposed blended index for the proposed 2022-based SNF market basket is technically appropriate as it reflects more recent data on SNFs purchasing patterns. Table 17 provides the proposed Medical Instruments and Supplies cost weight blended price proxy.

TABLE 17—MEDICAL INSTRUMENTS AND SUPPLIES BLENDED INDEX WEIGHTS

NAICS	Price proxy	Proposed 2022-based index (%)	2018-Based index (%)
339112	PPI—Commodity—Surgical and medical instruments (WUI1562)	62	46
339113	PPI—Commodity—Medical and surgical appliances and supplies (WPU1563)	19	27
	PPI Commodity data for Miscellaneous products-Personal safety equipment and clothing (WPU1571).	19	27
Total		100	100

k. Rubber and Plastics

We are proposing to use the PPI Commodity for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

l. Paper and Printing Products

We are proposing to use a 86/14 blend of the PPI Commodity for Converted Paper and Paperboard Products (BLS series code WPU0915) and the PPI Commodity for Publications Printed Matter and Printing Material (BLS Series Code WPU094) to measure the price growth of this cost category. The 2017 Benchmark I–O data shows that 86 percent of paper and printing expenses are for paper manufacturing (NAICS 322) and the remaining expenses are for Printing (NAICS 323110). The 2018-based SNF market basket used the PPI Commodity for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category.

m. Apparel

We are proposing to use the PPI Commodity for Apparel (BLS series code WPU0381) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

n. Machinery and Equipment

We are proposing to use the PPI Commodity for Machinery and Equipment (BLS series code WPU11) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

o. Miscellaneous Products

For measuring price change in the Miscellaneous Products cost category, we are proposing to use the PPI Commodity for Finished Goods less Food and Energy (BLS series code WPUFD4131). Both food and energy are already adequately represented in separate cost categories and should not also be reflected in this cost category. This is the same index used in the 2018-based SNF market basket.

p. Professional Fees: Labor-Related

We are proposing to use the ECI for Total Compensation for Private Industry Workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same index used in the 2018-based SNF market basket.

q. Administrative and Facilities Support Services

We are proposing to use the ECI for Total Compensation for Private Industry Workers in Office and Administrative Support (BLS series code CIU2010000220000I) to measure the price growth of this category. This is the same index used in the 2018-based SNF market basket.

r. Installation, Maintenance and Repair Services

We are proposing to use the ECI for Total Compensation for All Civilian Workers in Installation, Maintenance, and Repair (BLS series code CIU10100004300001) to measure the price growth of this new cost category. This is the same index used in the 2018-based SNF market basket.

s. All Other: Labor-Related Services

We are proposing to use the ECI for Total Compensation for Private Industry Workers in Service Occupations (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

t. Professional Fees: Non-Labor-Related

We are proposing to use the ECI for Total Compensation for Private Industry Workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same index used in the 2018-based SNF market basket.

u. Financial Services

We are proposing to use the ECI for Total Compensation for Private Industry Workers in Financial Activities (BLS series code CIU201520A000000I) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

v. Telephone Services

We are proposing to use the CPI All Urban for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

w. All Other: Non-Labor-Related Services

We are proposing to use the CPI All Urban for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. This is the same index used in the 2018-based SNF market basket.

3. Price Proxies Used To Measure Capital Cost Category Growth

We are proposing to apply the same capital price proxies as were used in the 2018-based SNF market basket, and below is a detailed explanation of the price proxies used for each capital cost category. We are also proposing to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. This vintage weighting method is the same method that was used for the 2018-based SNF market basket and is described below.

- Depreciation—Building and Fixed Equipment: We are proposing to use the BEA Chained Price Index for Private Fixed Investment in Structures, Nonresidential, Hospitals and Special Care (BEA Table 5.4.4. Price Indexes for Private Fixed Investment in Structures by Type). This BEA index is intended to capture prices for construction of facilities such as hospitals, nursing homes, hospices, and rehabilitation centers. This is the same index used in the 2018-based SNF market basket.
- Depreciation—Movable Equipment: We are proposing to use the PPI Commodity for Machinery and Equipment (BLS series code WPU11). This price index reflects price inflation associated with a variety of machinery and equipment that would be utilized by SNFs, including but not limited to medical equipment, communication equipment, and computers. This is the same index used in the 2018-based SNF market basket.
- Nonprofit Interest: We are proposing to use the average yield on Municipal Bonds (Bond Buyer 20-bond index). This is the same index used in the 2018-based SNF market basket.
- For-Profit Interest: For the For-Profit Interest cost category, we are proposing to use the iBoxx AAA Corporate Bond Yield index. This is the same index used in the 2018-based SNF market basket.
- Other Capital: Since this category includes fees for insurances, taxes, and other capital-related costs, we are proposing to use the CPI for Rent of Primary Residence (BLS series code CUUS0000SEHA), which would reflect the price growth of these costs. This is the same index used in the 2018-based SNF market basket.

We believe that these price proxies are the most appropriate proxies for SNF capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability.

As stated above, we are proposing to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. To capture the long-term nature, the price proxies are vintage-weighted and the vintage weights are calculated using a two-step process. First, we determine the expected useful life of capital and debt instruments held by SNFs. Second, we identify the proportion of expenditures within a cost category that is attributable to each individual year over the useful life of the relevant capital assets, or the vintage weights.

We rely on Bureau of Economic Analysis (BEA) fixed asset data to derive the useful lives of both fixed and movable capital, which is the same data source used to derive the useful lives for the 2018-based SNF market basket. The specifics of the data sources used are explained below.

a. Calculating Useful Lives for Movable and Fixed Assets

Estimates of useful lives for movable and fixed assets for the proposed 2022-based SNF market basket are 9 and 27 years, respectively. These estimates are based on three data sources from the BEA: (1) current-cost average age; (2) historical-cost average age; and (3) industry-specific current cost net stocks of assets.

BEA current-cost and historical-cost average age data by asset type are not available by industry but are published at the aggregate level for all industries. The BEA does publish current-cost net capital stocks at the detailed asset level for specific industries. There are 64 detailed movable assets (including intellectual property) and there are 32 detailed fixed assets in the BEA

estimates. Since we seek aggregate useful life estimates applicable to SNFs, we developed a methodology to approximate movable and fixed asset ages for nursing and residential care services (NAICS 623) using the published BEA data. For the proposed 2022-based SNF market basket, we use the current-cost average age for each asset type from the BEA fixed assets Table 2.9 for all assets and weight them using current-cost net stock levels for each of these asset types in the nursing and residential care services industry, NAICS 6230. For example, nonelectro medical equipment current-cost net stock (accounting for about 29 percent of total movable equipment current-cost net stock in 2022 is multiplied by an average age of 4.8 years for nonelectro medical equipment for all industries. Current-cost net stock levels are available for download from the BEA website at *https://apps.bea.gov/iTable/index_FA.cfm.* We then aggregate the ''weighted'' current-cost net stock levels (average age multiplied by current-cost net stock) into movable and fixed assets for NAICS 6230. We then adjust the average ages for movable and fixed assets by the ratio of historical-cost average age (Table 2.10) to current-cost average age (Table 2.9).

This produces historical cost average age data for fixed (structures) and movable (equipment and intellectual property) assets specific to NAICS 6230 of 13.6 and 4.4 years for 2022, respectively. This reflects the average age of an asset at a given point in time, whereas we want to estimate a useful life of the asset. To do this, we multiply each of the average age estimates by two to convert to average useful lives with the assumption that the average age reflects the midpoint of useful life and is normally distributed (about half of the assets are below the average at a given point in time, and half above the average at a given point in time). This produces estimates of likely useful lives of 27.2 and 8.8 years for fixed and movable assets, which we round to 27 and 9 years, respectively. We are proposing an interest vintage weight time span of 25 years, obtained by weighting the fixed and movable vintage weights (27 years and 9 years, respectively) by the fixed and movable split (86 percent and 14 percent, respectively). This is the same methodology used for the 2018-based SNF market basket, which had useful lives of 26 years and 9 years for fixed and movable assets, respectively.

b. Constructing Vintage Weights

Given the expected useful life of capital (fixed and movable assets) and debt instruments, we must determine the proportion of capital expenditures attributable to each year of the expected useful life for each of the three asset types: building and fixed equipment, movable equipment, and interest. These proportions represent the vintage weights. We were not able to find a historical time series of capital expenditures by SNFs. Therefore, we approximated the capital expenditure patterns of SNFs over time using alternative SNF data sources. For building and fixed equipment, we used the stock of beds in nursing homes from the National Nursing Home Survey (NNHS) conducted by the National Center for Health Statistics (NCHS) for 1962 through 1999. For 2000 through 2018, we extrapolated the 1999 bed data forward using measurements of the moving average rate of growth in the number of beds as reported in SNF Medicare cost report data on Worksheet S–3, part I, column 1, line 8. A more detailed discussion of this methodology was published in the FY 2022 SNF final rule (86 FR 42457). We are proposing to continue this methodology for the proposed 2022-based SNF market basket by extrapolating the 2018 bed data forward using the average growth in the number of beds over the 2019 to 2022 time period. We then propose to use the change in the stock of beds each year to approximate building and fixed equipment purchases for that year. This procedure assumes that bed growth reflects the growth in capital-related costs in SNFs for building and fixed equipment. We believe that this assumption is reasonable because the number of beds reflects the size of a SNF, and as a SNF adds beds, it also likely adds fixed capital.

As was done for the 2018-based SNF market basket (as well as prior market baskets), we are proposing to estimate movable equipment purchases based on the ratio of ancillary costs to routine costs. The time series of the ratio of ancillary costs to routine costs for SNFs measures changes in intensity in SNF services, which are assumed to be associated with movable equipment purchase patterns. The assumption here is that as ancillary costs increase compared to routine costs, the SNF caseload becomes more complex and would require more movable equipment. The lack of movable equipment purchase data for SNFs over time required us to use alternative SNF data sources. A more detailed discussion of this methodology was published in the FY 2008 SNF final rule (72 FR 43428). We believe the resulting two time series, determined from beds and the ratio of ancillary to routine costs, reflect real capital purchases of building and fixed equipment and movable equipment over time.

To obtain nominal purchases, which are used to determine the vintage weights for interest, we converted the two real capital purchase series from 1963 through 2022 determined above to nominal capital purchase series using their respective price proxies (the BEA Chained Price Index for Nonresidential Construction for Hospitals & Special Care Facilities and the PPI for Machinery and Equipment). We then combined the two nominal series into one nominal capital purchase series for 1963 through 2022. Nominal capital purchases are needed for interest vintage weights to capture the value of debt instruments.

Once we created these capital purchase time series for 1963 through 2022, we averaged different periods to obtain an average capital purchase pattern over time: (1) for building and fixed equipment, we averaged 34, 27-year periods; (2) for movable equipment, we averaged 52, 9-year periods; and (3) for interest, we averaged 36, 25-year periods. We calculate the vintage weight for a given year by dividing the capital purchase amount in any given year by the total amount of purchases during the expected useful life of the equipment or debt instrument.

The vintage weights for the proposed 2022-based SNF market basket and the 2018-based SNF market basket are presented in Table 18.

TABLE 18—PROPOSED 2022-BASED VINTAGE WEIGHTS AND 2018-BASED VINTAGE WEIGHTS

Year [1]	Building and fixed equipment		Movable equipment		Interest	
	Proposed 2022-based 27 years	2018-based 26 years	Proposed 2022-based 9 years	2018-based 9 years	Proposed 2022-based 25 years	2018-based 24 years
1	0.049	0.049	0.106	0.135	0.026	0.027
2	0.048	0.050	0.121	0.140	0.027	0.028
3	0.048	0.049	0.119	0.128	0.028	0.029
4	0.046	0.047	0.103	0.112	0.030	0.031
5	0.045	0.045	0.117	0.119	0.031	0.032
6	0.043	0.043	0.124	0.111	0.033	0.034
7	0.042	0.041	0.101	0.084	0.035	0.036
8	0.042	0.040	0.093	0.080	0.038	0.037
9	0.039	0.037	0.115	0.091	0.041	0.038
10	0.037	0.035	.....	.....	0.043	0.040
11	0.038	0.036	.....	.....	0.045	0.043
12	0.039	0.036	.....	.....	0.045	0.047
13	0.038	0.036	.....	.....	0.044	0.049
14	0.038	0.036	.....	.....	0.044	0.051
15	0.038	0.035	.....	.....	0.045	0.050
16	0.036	0.036	.....	.....	0.045	0.048
17	0.034	0.036	.....	.....	0.045	0.048
18	0.033	0.038	.....	.....	0.045	0.048
19	0.033	0.037	.....	.....	0.043	0.048
20	0.032	0.036	.....	.....	0.042	0.048
21	0.031	0.035	.....	.....	0.042	0.047
22	0.030	0.035	.....	.....	0.043	0.047
23	0.030	0.035	.....	.....	0.044	0.047
24	0.028	0.033	.....	.....	0.045	0.049
25	0.027	0.032	.....	.....	0.051	.....
26	0.027	0.032	.....	.....	.....	.....
27	0.027	.....	.....	.....	.....	.....
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: The vintage weights are calculated using thirteen decimals. For presentation purposes, we are displaying three decimals and therefore, the detail vintage weights may not add to 1.000 due to rounding.

[1] Year 1 represents the vintage weight applied to the farthest year while the vintage weight for year 27, for example, would apply to the most recent year.

The process of creating vintage-weighted price proxies requires applying the vintage weights to the price proxy index where the last applied vintage weight in Table 18 is applied to the most recent data point. We have provided on the CMS website an example of how the vintage weighting price proxies are calculated, using example vintage weights and example price indices. The example can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html* in the zip file titled ''Weight Calculations as described in the IPPS FY 2010 Proposed Rule.''

Table 19 shows all the price proxies for the proposed 2022-based SNF market basket.

TABLE 19—PRICE PROXIES FOR THE PROPOSED 2022-BASED SNF MARKET BASKET

Cost category	Weight	Price proxy
Total	100.0	
Compensation	61.2	
Wages and Salaries [1]	51.8	ECI for Wages and Salaries for Private Industry Workers in Nursing Care Facilities.
Employee Benefits [1]	9.3	ECI for Total Benefits for Private Industry Workers in Nursing Care Facilities.
Utilities	2.7	
Electricity and Other Non-Fuel Utilities	1.8	PPI Commodity for Commercial Electric Power.
Fuel: Oil and Gas	0.8	Blend of PPIs.
Professional Liability Insurance	1.3	CMS Professional Liability Insurance Premium Index.
All Other	26.5	
Other Products	16.1	
Pharmaceuticals	6.4	PPI Commodity for Pharmaceuticals for Human Use, Prescription.
Food: Direct Purchase	2.9	PPI Commodity for Processed Foods and Feeds.
Food: Contract Purchase	3.4	CPI for Food Away From Home (All Urban Consumers).
Chemicals	0.2	Blend of PPIs.
Medical Instruments and Supplies	0.4	Blend of PPIs.

TABLE 19—PRICE PROXIES FOR THE PROPOSED 2022-BASED SNF MARKET BASKET—Continued

Cost category	Weight	Price proxy
Rubber and Plastics	1.0	PPI Commodity for Rubber and Plastic Products.
Paper and Printing Products	0.5	Blend of PPIs.
Apparel	0.4	PPI Commodity for Apparel.
Machinery and Equipment	0.7	PPI Commodity for Machinery and Equipment.
Miscellaneous Products	0.2	PPI Commodity for Finished Goods Less Food and Energy.
All Other Services	10.5	
Labor-Related Services	6.5	
Professional Fees: Labor-Related	3.6	ECI for Total Compensation for Private Industry Workers in Professional and Related.
Installation, Maintenance, and Repair Services	0.4	ECI for Total Compensation for All Civilian workers in Installation, Maintenance, and Repair.
Administrative and Facilities Support	0.5	ECI for Total Compensation for Private Industry Workers in Office and Administrative Support.
All Other: Labor-Related Services	2.0	ECI for Total Compensation for Private Industry Workers in Service Occupations.
Non Labor-Related Services	4.0	
Professional Fees: Nonlabor-Related	1.8	ECI for Total Compensation for Private Industry Workers in Professional and Related.
Financial Services	0.5	ECI for Total Compensation for Private Industry Workers in Financial Activities.
Telephone Services	0.4	CPI for Telephone Services.
All Other: Nonlabor-Related Services	1.3	CPI for All Items Less Food and Energy.
Capital-Related Expenses	8.3	
Total Depreciation	3.0	
Building and Fixed Equipment	2.5	BEA's Chained Price Index for Private Fixed Investment in Structures, Nonresidential, Hospitals and Special Care—vintage weighted 27 years.
Movable Equipment	0.4	PPI Commodity for Machinery and Equipment—vintage weighted 9 years.
Total Interest	2.3	
For-Profit SNFs	0.7	iBoxx—Average yield on Aaa bond—vintage weighted 25 years.
Government and Nonprofit SNFs	1.6	Bond Buyer—Average yield on Domestic Municipal Bonds—vintage weighted 25 years.
Other Capital-Related Expenses	3.0	CPI for Rent of Primary Residence.

Note: The cost weights are calculated using three decimal places. For presentation purposes, we are displaying one decimal, and therefore, the detailed cost weights may not add to the aggregate cost weights or to 100.0 due to rounding.

[1] Contract labor is distributed to wages and salaries and employee benefits based on the share of total compensation that each category represents.

4. Labor-Related Share

We define the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Effective for FY 2025, we are proposing to revise and update the labor-related share to reflect the relative importance of the proposed 2022-based SNF market basket cost categories that we believe are labor-intensive and vary with, or are influenced by, the local labor market. For the proposed 2022-based SNF market basket these are: (1) Wages and Salaries (including allocated contract labor costs as described above); (2) Employee Benefits (including allocated contract labor costs as described above); (3) Professional Fees: Labor-Related; (4) Administrative and Facilities Support Services; (5) Installation, Maintenance, and Repair Services; (6) All Other: Labor-Related Services; and (7) a proportion of capital-related expenses. We propose to continue to include a proportion of capital-related expenses because a portion of these expenses are deemed to be labor-intensive and vary with, or are influenced by, the local labor market. For example, a proportion of construction costs for a medical building would be attributable to local construction workers' compensation expenses.

Consistent with previous SNF market basket revisions and rebasings, the All Other: Labor-related services cost category is mostly comprised of building maintenance and security services (including, but not limited to, landscaping services, janitorial services, waste management services services) and dry cleaning and laundry services. Because these services tend to be labor-intensive and are mostly performed at the SNF facility or in the local area (and therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

These are the same cost categories we have included in the LRS for the 2018-based SNF market basket rebasing (86 FR 42461), as well as the same categories included in the LRS for the 2021-based IRF market basket (88 FR 50984), and 2021-based IPF market basket (88 FR 51078).

As discussed in the FY 2022 SNF PPS final rule (86 FR 42462), in an effort to determine more accurately the share of nonmedical professional fees (included in the proposed 2022-based SNF market basket Professional Fees cost categories) that should be included in the labor-related share, we surveyed SNFs regarding the proportion of those fees that are attributable to local firms and the proportion that are purchased from national firms. Based on these weighted results, we determined that SNFs purchase, on average, the following portions of contracted professional services inside their local labor market:

- 78 percent of legal services.
- 86 percent of accounting and auditing services.

- 89 percent of architectural, engineering services.
- 87 percent of management consulting services.

Together, these four categories represent 3.6 percentage points of the total costs for the proposed 2022-based SNF market basket. We applied the percentages from this special survey to their respective SNF market basket weights to separate them into labor-related and nonlabor-related costs. As a result, we are designating 2.8 of the 3.6 percentage points total to the labor-related share, with the remaining 0.8 percentage point categorized as nonlabor-related.

In addition to the professional services as previously listed, for the proposed 2022-based SNF market basket, we propose to allocate a proportion of the Home Office/Related Organization Contract Labor cost weight, calculated using the Medicare cost reports as previously stated, into the Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related cost categories. We propose to classify these expenses as labor-related and nonlabor-related as many facilities are not located in the same geographic area as their home office, and, therefore, do not meet our definition for the labor-related share that requires the services to be purchased in the local labor market.

Similar to the 2018-based SNF market basket, we propose for the proposed 2022-based SNF market basket to use the Medicare cost reports for SNFs to determine the home office labor-related percentages. The Medicare cost report requires a SNF to report information regarding its home office provider. Using information on the Medicare cost report, we compared the location of the SNF with the location of the SNF's home office. We propose to classify a SNF with a home office located in their respective labor market if the SNF and its home office are located in the same Metropolitan Statistical Area (MSA). Then we determine the proportion of the Home Office/Related Organization Contract Labor cost weight that should be allocated to the labor-related share based on the percent of total Home Office/Related Organization Contract Labor costs for those SNFs that had home offices located in their respective local labor markets of total Home Office/Related Organization Contract Labor costs for SNFs with a home office. We determined a SNF's and its home office's MSA using their zip code information from the Medicare cost report.

Using this methodology, we determined that 25 percent of SNFs' Home Office/Related Organization Contract Labor costs were for home offices located in their respective local labor markets. Therefore, we propose to allocate 25 percent of the Home Office/Related Organization Contract Labor cost weight (0.1 percentage point = 0.6 percent × 25 percent) to the Professional Fees: Labor-Related cost weight and 75 percent of the Home Office/Related Organization Contract Labor cost weight to the Professional Fees: Nonlabor-Related cost weight (0.4 percentage point = 0.6 percent × 75 percent). The 2018-based SNF market basket used a similar methodology for allocating the Home Office/Related Organization Contract Labor cost weight to the labor-related share.

In summary, based on the two allocations mentioned earlier, we propose to apportion 2.9 percentage points into the Professional Fees: Labor-Related cost category consisting of the Professional Fees (2.8 percentage points) and Home Office/Related Organization Contract Labor (0.1 percentage point) cost weights. This amount was added to the portion of professional fees that we already identified as labor-related using the I–O data such as contracted advertising and marketing costs (approximately 0.6 percentage point of total costs) resulting in a Professional Fees: Labor-Related cost weight of 3.6 percent.

Table 20 compares the FY 2025 labor-related share based on the proposed 2022-based SNF market basket relative importance and the FY 2024 labor-related share based on the 2018-based SNF market basket relative importance as finalized in the FY 2024 SNF final rule (88 FR 53213).

TABLE 20—FY 2024 AND FY 2025 SNF LABOR-RELATED SHARE

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

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

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

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

The proposed FY 2025 SNF labor-related share is 0.8 percentage point higher than the FY 2024 SNF labor-related share (based on the 2018-based SNF market basket). The higher labor-related share is primarily due to incorporating the 2022 Medicare cost report data, which resulted in a higher Compensation cost weight, as well as higher relative importance of the Capital cost category.

5. Market Basket Estimate for the FY 2025 SNF PPS Update

As discussed previously in this proposed rule, beginning with the FY 2025 SNF PPS update, we are proposing to adopt the proposed 2022-based SNF market basket as the appropriate market basket of goods and services for the SNF PPS. Consistent with historical practice, we estimate the market basket update for the SNF PPS based on IHS Global Inc.'s (IGI) forecast. IGI is a nationally

recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets and total factor productivity (TFP).

Based on IGI's fourth quarter 2023 forecast with historical data through the third quarter of 2023, the most recent estimate of the proposed 2022-based SNF market basket update for FY 2025 is 2.8 percent—which is 0.1 percentage point lower than the FY 2025 percent change of the 2018-based SNF market basket. We are also proposing that if more recent data subsequently become available (for example, a more recent estimate of the market basket and/or the TFP), we would use such data, if appropriate, to determine the FY 2025 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, or productivity adjustment in the SNF PPS final rule.

Table 21 compares the proposed 2022-based SNF market basket and the 2018-based SNF market basket percent changes. While there are slight differences of up to 0.2 percentage point in certain years, there is no difference in the average growth rates between the two market baskets in either the historical (FY 2020–FY 2023) or forecast period (FY 2024–FY 2026) when rounded to one decimal place.

TABLE 21—PROPOSED 2022-BASED SNF MARKET BASKET AND 2018-BASED SNF MARKET BASKET, PERCENT CHANGES: 2020–2026

Fiscal Year (FY)	Proposed 2022-based SNF market basket	2018-Based SNF market basket
Historical data:		
FY 2020	2.0	2.1
FY 2021	3.6	3.6
FY 2022	6.5	6.3
FY 2023	5.6	5.6
Average FY 2020–2023	4.4	4.4
Forecast:		
FY 2024	3.7	3.7
FY 2025	2.8	2.9
FY 2026	2.7	2.7
Average FY 2024–2026	3.1	3.1

Source: IHS Global, Inc. 4th quarter 2023 forecast with historical data through 3rd quarter 2023.

B. Proposed Changes to SNF PPS Wage Index

1. Core-Based Statistical Areas (CBSAs) for the FY 2025 SNF PPS Wage Index

a. Background

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We proposed to continue this practice for FY 2025, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the IPPS also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we would continue to use, as the basis for the SNF PPS wage index, the IPPS hospital wage data, unadjusted for occupational mix, without taking into account geographic reclassifications under section 1886(d)(8) and (d)(10) of the Act, and without applying the rural floor under section 4410 of the BBA 1997 and the outmigration adjustment under section 1886(d)(13) of the Act. For FY 2025, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data).

The applicable SNF PPS wage index value is assigned to a SNF on the basis of the labor market area in which the SNF is geographically located. In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Area (MSA) and the creation of micropolitan statistical areas and combined statistical areas. In adopting the Core-Based Statistical Areas (CBSA) geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided minor updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01

were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. In addition, on August 15, 2017, OMB issued Bulletin No. 17–01 which announced a new urban CBSA, Twin Falls, Idaho (CBSA 46300). As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), and as we note in this proposed rule, this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03 which superseded the August 15, 2017 OMB Bulletin No. 17–01. Subsequently, on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of bulletin No. 18–04, may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.* While OMB Bulletin No. 18–04 is not based on new census data, it includes some material changes to the OMB statistical area delineations, including some new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, CMS did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20 01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*) which updates and supersedes OMB Bulletin No. 20–01 based upon the 2020 Standards for Delineating Core Based Statistical Areas (''the 2020 Standards'') published by the Office of Management and Budget (OMB) on July 16, 2021 (86 FR 37770). OMB Bulletin No. 23–01 revised CBSA delineations which are comprised of counties and equivalent entities (for example, boroughs, a city and borough, and a municipality in Alaska, planning regions in Connecticut, parishes in Louisiana, municipios in Puerto Rico, and independent cities in Maryland, Missouri, Nevada, and Virginia). For FY 2025, we propose to adopt the revised OMB delineations identified in OMB Bulletin No. 23–01.

To implement these changes for the SNF PPS beginning in FY 2025, it is necessary to identify the revised labor market area delineation for each affected county and provider in the country. The revisions OMB published on July 21, 2023 contain a number of significant changes. For example, under the proposed revised OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would split apart. We discuss these changes in more detail later in this proposed rule.

b. Proposed Implementation of Revised Labor Market Area Delineations

We typically delay implementing revised OMB labor market area delineations to allow for sufficient time to assess the new changes. For example, as discussed in the FY 2014 SNF PPS proposed rule (78 FR 26448) and final rule (78 FR 47952), we delayed implementing the revised OMB statistical area delineations described in OMB Bulletin No. 13–01 to allow for sufficient time to assess the new changes. We believe it is important for the SNF PPS to use the latest labor market area delineations available as soon as is reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We further believe that using the delineations reflected in OMB Bulletin No. 23–01 would increase the integrity of the SNF PPS wage index system by creating a more accurate representation of geographic variations in wage levels. We have reviewed our findings and impacts relating to the revised OMB delineations set forth in OMB Bulletin No. 23–01 and find no compelling reason to further delay implementation. Because we believe we have broad authority under section 1888(e)(4)(G)(ii) of the Act to determine the labor market areas used for the SNF PPS wage index, and because we believe the delineations reflected in OMB Bulletin No. 23–01 better reflect the local economies and wage levels of the areas in which hospitals are currently located, we are proposing to implement the revised OMB delineations as described in the July 21, 2023 OMB Bulletin No. 23–01, for the SNF PPS wage index effective beginning in FY 2025. In addition, we will apply the permanent 5 percent cap policy in FY 2025 on decreases in a hospital's wage index compared to its wage index for the prior fiscal year (FY 2024) to assist providers in adapting to the revised OMB delineations (if we finalize the implementation of such delineations for the SNF PPS wage index beginning in FY 2025). This policy is discussed in more detail later in this proposed rule. We invite comments on these proposals.

(1) Micropolitan Statistical Areas

As discussed in the FY 2006 SNF PPS proposed rule (70 FR 29093 through 29094) and final rule (70 FR 45041), we considered how to use the Micropolitan Statistical Area definitions in the calculation of the wage index. OMB defines a ''Micropolitan Statistical Area'' as a CBSA ''associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000'' (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), we determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's SNF PPS rural wage index (see 70 FR 29094 and 70 FR 45040 through 45041)).

Thus, the SNF PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in non-MSA areas, and the statewide rural wage index is assigned to SNFs located in those areas. Because Micropolitan Areas tend to encompass smaller population centers and contain fewer hospitals than MSAs, we determined that if Micropolitan Areas were to be treated as separate labor market areas, the SNF PPS wage index would have included significantly more single-provider labor market areas. As we explained in the FY 2006 SNF PPS proposed rule (70 FR 29094), recognizing Micropolitan Areas as independent labor markets would generally increase the potential for dramatic shifts in year-to-year wage index values because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of an area. Dramatic shifts in an area's wage index from year-to-year are problematic and create instability in the payment levels from year-to-year, which could make fiscal planning for SNFs difficult if we adopted this approach. For these reasons, we adopted a policy

to include Micropolitan Areas in the state's rural wage area for purposes of the SNF PPS wage index and have continued this policy through the present.

We believe that the best course of action would be to continue the policy established in the FY 2006 SNF PPS final rule and include Micropolitan Areas in each state's rural wage index. These areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). We do not believe it would be appropriate to calculate a separate wage index for areas that typically may include only a few hospitals for the reasons discussed in the FY 2006 SNF PPS proposed rule, and as discussed earlier. Therefore, in conjunction with our proposal to implement the revised OMB labor market delineations beginning in FY 2025 and consistent with the treatment of Micropolitan Areas under the IPPS, we are proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of the state's rural wage index.

(2) Urban Counties That Would Become Rural Under the Revised OMB Delineations

As previously discussed, we are proposing to implement the new OMB statistical area delineations (based upon the 2020 decennial Census data) beginning in FY 2025 for the SNF PPS wage index. Our analysis shows that a total of 54 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural area, for SNF PPS payment beginning in FY 2025, if we adopt the new OMB delineations. Table 22 lists the 54 urban counties that would be rural if we finalize our proposal to implement the new OMB delineations.

TABLE 22—COUNTIES THAT WOULD TRANSITION FROM URBAN TO RURAL STATUS

FIPS county code	County name	State	Current CBSA	Current CBSA name
01129	Washington	AL	33660	Mobile, AL.
05025	Cleveland	AR	38220	Pine Bluff, AR.
05047	Franklin	AR	22900	Fort Smith, AR-OK.
05069	Jefferson	AR	38220	Pine Bluff, AR.
05079	Lincoln	AR	38220	Pine Bluff, AR.
09015	Windham	CT	49340	Worcester, MA-CT.
10005	Sussex	DE	41540	Salisbury, MD-DE.
13171	Lamar	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA.
16077	Power	ID	38540	Pocatello, ID.
17057	Fulton	IL	37900	Peoria, IL.
17077	Jackson	IL	16060	Carbondale-Marion, IL.
17087	Johnson	IL	16060	Carbondale-Marion, IL.
17183	Vermilion	IL	19180	Danville, IL.
17199	Williamson	IL	16060	Carbondale-Marion, IL.
18121	Parke	IN	45460	Terre Haute, IN.
18133	Putnam	IN	26900	Indianapolis-Carmel-Anderson, IN.
18161	Union	IN	17140	Cincinnati, OH-KY-IN.
21091	Hancock	KY	36980	Owensboro, KY.
21101	Henderson	KY	21780	Evansville, IN-KY.
22045	Iberia	LA	29180	Lafayette, LA.
24001	Allegany	MD	19060	Cumberland, MD-WV.
24047	Worcester	MD	41540	Salisbury, MD-DE.
25011	Franklin	MA	44140	Springfield, MA.
26155	Shiawassee	MI	29620	Lansing-East Lansing, MI.
27075	Lake	MN	20260	Duluth, MN-WI.
28031	Covington	MS	25620	Hattiesburg, MS.
31051	Dixon	NE	43580	Sioux City, IA-NE-SD.
36123	Yates	NY	40380	Rochester, NY.
37049	Craven	NC	35100	New Bern, NC.
37077	Granville	NC	20500	Durham-Chapel Hill, NC.
37085	Harnett	NC	22180	Fayetteville, NC.
37087	Haywood	NC	11700	Asheville, NC.
37103	Jones	NC	35100	New Bern, NC.
37137	Pamlico	NC	35100	New Bern, NC.
42037	Columbia	PA	14100	Bloomsburg-Berwick, PA.
42085	Mercer	PA	49660	Youngstown-Warren-Boardman, OH-PA.
42089	Monroe	PA	20700	East Stroudsburg, PA.
42093	Montour	PA	14100	Bloomsburg-Berwick, PA.
42103	Pike	PA	35084	Newark, NJ-PA.
45027	Clarendon	SC	44940	Sumter, SC.
48431	Sterling	TX	41660	San Angelo, TX.
49003	Box Elder	UT	36260	Ogden-Clearfield, UT.
51113	Madison	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
51175	Southampton	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
51620	Franklin City	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
54035	Jackson	WV	16620	Charleston, WV.
54043	Lincoln	WV	16620	Charleston, WV.
54057	Mineral	WV	19060	Cumberland, MD-WV.
55069	Lincoln	WI	48140	Wausau-Weston, WI.
72001	Adjuntas	PR	38660	Ponce, PR.
72055	Guanica	PR	49500	Yauco, PR.

TABLE 22—COUNTIES THAT WOULD TRANSITION FROM URBAN TO RURAL STATUS—Continued

FIPS county code	County name	State	Current CBSA	Current CBSA name
72081	Lares	PR	10380	Aguadilla-Isabela, PR.
72083	Las Marias	PR	32420	Mayagüez, PR.
72141	Utuado	PR	10380	Aguadilla-Isabela, PR.

We are proposing that, for purposes of determining the wage index under the SNF PPS, the wage data for all hospitals located in the counties listed in Table 22 would be considered rural when calculating their respective state's rural wage index under the SNF PPS. We recognize that rural areas typically have lower area wage index values than urban areas, and SNFs located in these counties may experience a negative impact in their SNF PPS payment due to the proposed adoption of the revised OMB delineations. Furthermore, for SNF providers currently located in an urban county that would be considered rural should this proposal be finalized, we would utilize the rural unadjusted per diem rates, found in Table 4, as the basis for determining payment rates for these facilities beginning on October 1, 2024.

(3) Rural Counties That Would Become Urban Under the Revised OMB Delineations

As previously discussed, we are proposing to implement the revised OMB statistical area delineations based upon OMB Bulletin No. 18–04 beginning in FY 2025. Analysis of these OMB statistical area delineations shows that a total of 54 counties (and county equivalents) that are currently located in rural areas would be located in urban areas if we finalize our proposal to implement the revised OMB delineations.

Table 23 lists the 54 rural counties that would be urban if we finalize this proposal.

TABLE 23—COUNTIES THAT WOULD TRANSITION FROM RURAL TO URBAN STATUS

FIPS county code	County	State	Proposed CBSA	Proposed CBSA name
01087	Macon	AL	12220	Auburn-Opelika, AL.
01127	Walker	AL	13820	Birmingham, AL.
12133	Washington	FL	37460	Panama City-Panama City Beach, FL.
13187	Lumpkin	GA	12054	Atlanta-Sandy Springs-Roswell, GA.
15005	Kalawao	HI	27980	Kahului-Wailuku, HI.
17053	Ford	IL	16580	Champaign-Urbana, IL.
17127	Massac	IL	37140	Paducah, KY-IL.
18159	Tipton	IN	26900	Indianapolis-Carmel-Greenwood, IN.
18179	Wells	IN	23060	Fort Wayne, IN.
20021	Cherokee	KS	27900	Joplin, MO-KS.
21007	Ballard	KY	37140	Paducah, KY-IL.
21039	Carlisle	KY	37140	Paducah, KY-IL.
21127	Lawrence	KY	26580	Huntington-Ashland, WV-KY-OH.
21139	Livingston	KY	37140	Paducah, KY-IL.
21145	Mc Cracken	KY	37140	Paducah, KY-IL.
21179	Nelson	KY	31140	Louisville/Jefferson County, KY-IN.
22053	Jeffrson Davis	LA	29340	Lake Charles, LA.
22083	Richland	LA	33740	Monroe, LA.
26015	Barry	MI	24340	Grand Rapids-Wyoming-Kentwood, MI.
26019	Benzie	MI	45900	Traverse City, MI.
26055	Grand Traverse	MI	45900	Traverse City, MI.
26079	Kalkaska	MI	45900	Traverse City, MI.
26089	Leelanau	MI	45900	Traverse City, MI.
27133	Rock	MN	43620	Sioux Falls, SD-MN.
28009	Benton	MS	32820	Memphis, TN-MS-AR.
28123	Scott	MS	27140	Jackson, MS.
30007	Broadwater	MT	25740	Helena, MT.
30031	Gallatin	MT	14580	Bozeman, MT.
30043	Jefferson	MT	25740	Helena, MT.
30049	Lewis And Clark	MT	25740	Helena, MT.
30061	Mineral	MT	33540	Missoula, MT.
32019	Lyon	NV	39900	Reno, NV.
37125	Moore	NC	38240	Pinehurst-Southern Pines, NC.
38049	Mchenry	ND	33500	Minot, ND.
38075	Renville	ND	33500	Minot, ND.
38101	Ward	ND	33500	Minot, ND.
39007	Ashtabula	OH	17410	Cleveland, OH.
39043	Erie	OH	41780	Sandusky, OH.
41013	Crook	OR	13460	Bend, OR.
41031	Jefferson	OR	13460	Bend, OR.
42073	Lawrence	PA	38300	Pittsburgh, PA.
45087	Union	SC	43900	Spartanburg, SC.
46033	Custer	SD	39660	Rapid City, SD.
47081	Hickman	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN.

TABLE 23—COUNTIES THAT WOULD TRANSITION FROM RURAL TO URBAN STATUS—Continued

FIPS county code	County	State	Proposed CBSA	Proposed CBSA name
48007	Aransas	TX	18580	Corpus Christi, TX.
48035	Bosque	TX	47380	Waco, TX.
48079	Cochran	TX	31180	Lubbock, TX.
48169	Garza	TX	31180	Lubbock, TX.
48219	Hockley	TX	31180	Lubbock, TX.
48323	Maverick	TX	20580	Eagle Pass, TX.
48407	San Jacinto	TX	26420	Houston-Pasadena-The Woodlands, TX.
51063	Floyd	VA	13980	Blacksburg-Christiansburg-Radford, VA.
51181	Surry	VA	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC.
55123	Vernon	WI	29100	La Crosse-Onalaska, WI-MN.

We are proposing that, for purposes of calculating the area wage index under the SNF PPS, the wage data for hospitals located in the counties listed in Table 23 would be included in their new respective urban CBSAs. Typically, SNFs located in an urban area would receive a wage index value higher than or equal to SNFs located in their state's rural area. Furthermore, for SNFs currently located in a rural county that would be considered urban should this proposal be finalized, we would utilize the urban unadjusted per diem rates found in Table 3, as the basis for determining the payment rates for these facilities beginning October 1, 2024.

(4) Urban Counties That Would Move to a Different Urban CBSA Under the Revised OMB Delineations

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs.

In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 31460 (Madera, CA) currently is a single county (Madera, CA) CBSA. Madera County would be a part of CBSA 23420 (Fresno, CA) under the new OMB delineations.

In another type of change, some CBSAs have counties that would split off to become part of, or to form, entirely new labor market areas. For example, CBSA 29404 (Lake County-Kenosha County, IL-WI) currently is comprised of two counties (Lake County, IL and Kenosha County, WI). Under the new OMB delineations, Kenosha county would split off and form the new CBSA 28450 (Kenosha, WI), while Lake county would remain in CBSA 29404.

Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Meade County, KY, would move from CBSA 21060 (Elizabethtown-Fort Knox, KY) to CBSA 31140 (Louisville/Jefferson County, KY-IN). CBSA 21060 would still exist in the new labor market delineations with fewer constituent counties. Table 24 lists the urban counties that would move from one urban CBSA to another urban CBSA under the new OMB delineations.

TABLE 24—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA

FIPS county code	County name	State	Current CBSA	Proposed CBSA
06039	Madera	CA	31460	23420
11001	The District	DC	47894	47764
12053	Hernando	FL	45300	45294
12057	Hillsborough	FL	45300	45294
12101	Pasco	FL	45300	45294
12103	Pinellas	FL	45300	41304
12119	Sumter	FL	45540	48680
13013	Barrow	GA	12060	12054
13015	Bartow	GA	12060	31924
13035	Butts	GA	12060	12054
13045	Carroll	GA	12060	12054
13057	Cherokee	GA	12060	31924
13063	Clayton	GA	12060	12054
13067	Cobb	GA	12060	31924
13077	Coweta	GA	12060	12054
13085	Dawson	GA	12060	12054
13089	De Kalb	GA	12060	12054
13097	Douglas	GA	12060	12054
13113	Fayette	GA	12060	12054
13117	Forsyth	GA	12060	12054
13121	Fulton	GA	12060	12054
13135	Gwinnett	GA	12060	12054
13143	Haralson	GA	12060	31924
13149	Heard	GA	12060	12054
13151	Henry	GA	12060	12054
13159	Jasper	GA	12060	12054
13199	Meriwether	GA	12060	12054

TABLE 24—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA—Continued

FIPS county code	County name	State	Current CBSA	Proposed CBSA
13211	Morgan	GA	12060	12054
13217	Newton	GA	12060	12054
13223	Paulding	GA	12060	31924
13227	Pickens	GA	12060	12054
13231	Pike	GA	12060	12054
13247	Rockdale	GA	12060	12054
13255	Spalding	GA	12060	12054
13297	Walton	GA	12060	12054
18073	Jasper	IN	23844	29414
18089	Lake	IN	23844	29414
18111	Newton	IN	23844	29414
18127	Porter	IN	23844	29414
21163	Meade	KY	21060	31140
22103	St. Tammany	LA	35380	43640
24009	Calvert	MD	47894	30500
24017	Charles	MD	47894	47764
24033	Prince Georges	MD	47894	47764
24037	St. Marys	MD	15680	30500
25015	Hampshire	MA	44140	11200
34009	Cape May	NJ	36140	12100
34023	Middlesex	NJ	35154	29484
34025	Monmouth	NJ	35154	29484
34029	Ocean	NJ	35154	29484
34035	Somerset	NJ	35154	29484
36027	Dutchess	NY	39100	28880
36071	Orange	NY	39100	28880
37019	Brunswick	NC	34820	48900
39035	Cuyahoga	OH	17460	17410
39055	Geauga	OH	17460	17410
39085	Lake	OH	17460	17410
39093	Lorain	OH	17460	17410
39103	Medina	OH	17460	17410
39123	Ottawa	OH	45780	41780
47057	Grainger	TN	34100	28940
51013	Arlington	VA	47894	11694
51043	Clarke	VA	47894	11694
51047	Culpeper	VA	47894	11694
51059	Fairfax	VA	47894	11694
51061	Fauquier	VA	47894	11694
51107	Loudoun	VA	47894	11694
51153	Prince William	VA	47894	11694
51157	Rappahannock	VA	47894	11694
51177	Spotsylvania	VA	47894	11694
51179	Stafford	VA	47894	11694
51187	Warren	VA	47894	11694
51510	Alexandria City	VA	47894	11694
51600	Fairfax City	VA	47894	11694
51610	Falls Church City	VA	47894	11694
51630	Fredericksburg City	VA	47894	11694
51683	Manassas City	VA	47894	11694
51685	Manassas Park City	VA	47894	11694
53061	Snohomish	WA	42644	21794
54037	Jefferson	WV	47894	11694
55059	Kenosha	WI	29404	28450
72023	Cabo Rojo	PR	41900	32420
72059	Guayanilla	PR	49500	38660
72079	Lajas	PR	41900	32420
72111	Penuelas	PR	49500	38660
72121	Sabana Grande	PR	41900	32420
72125	San German	PR	41900	32420
72153	Yauco	PR	49500	38660

If providers located in these counties move from one CBSA to another under the new OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values.

In other cases, adopting the revised OMB delineations would involve a change only in CBSA name and/or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 19430 (Dayton-Kettering, OH) would experience a change to its name and become CBSA 19430 (Dayton-Kettering-Beavercreek, OH), while all of its three constituent counties would remain the same. We consider these proposed

changes (where only the CBSA name and/or number would change) to be inconsequential changes with respect to the SNF PPS wage index. Table 25 sets forth a list of such CBSAs where there would be a change in CBSA name and/or number only if we adopt the revised OMB delineations.

TABLE 25—URBAN CBSAS WITH CHANGE TO NAME AND/OR NUMBER

Current CBSA	Current CBSA name	Proposed CBSA	Proposed CBSA name
10380	Aguadilla-Isabela, PR	10380	Aguadilla, PR.
10540	Albany-Lebanon, OR	10540	Albany, OR.
12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA.
12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA.
12420	Austin-Round Rock-Georgetown, TX	12420	Austin-Round Rock-San Marcos, TX.
12540	Bakersfield, CA	12540	Bakersfield-Delano, CA.
13820	Birmingham-Hoover, AL	13820	Birmingham, AL.
13980	Blacksburg-Christiansburg, VA	13980	Blacksburg-Christiansburg-Radford, VA.
14860	Bridgeport-Stamford-Norwalk, CT	14860	Bridgeport-Stamford-Danbury, CT.
15260	Brunswick, GA	15260	Brunswick-St. Simons, GA.
15680	California-Lexington Park, MD	30500	Lexington Park, MD.
16540	Chambersburg-Waynesboro, PA	16540	Chambersburg, PA.
16984	Chicago-Naperville-Evanston, IL	16984	Chicago-Naperville-Schaumburg, IL.
17460	Cleveland-Elyria, OH	17410	Cleveland, OH.
19430	Dayton-Kettering, OH	19430	Dayton-Kettering-Beavercreek, OH.
19740	Denver-Aurora-Lakewood, CO	19740	Denver-Aurora-Centennial, CO.
21060	Elizabethtown-Fort Knox, KY	21060	Elizabethtown, KY.
21060	Elizabethtown-Fort Knox, KY	31140	Louisville/Jefferson County, KY-IN.
21780	Evansville, IN-KY	21780	Evansville, IN.
21820	Fairbanks, AK	21820	Fairbanks-College, AK.
22660	Fort Collins, CO	22660	Fort Collins-Loveland, CO.
23224	Frederick-Gaithersburg-Rockville, MD	23224	Frederick-Gaithersburg-Bethesda, MD.
23844	Gary, IN	29414	Lake County-Porter County-Jasper County, IN.
24340	Grand Rapids-Kentwood, MI	24340	Grand Rapids-Wyoming-Kentwood, MI.
24860	Greenville-Anderson, SC	24860	Greenville-Anderson-Greer, SC.
25540	Hartford-East Hartford-Middletown, CT	25540	Hartford-West Hartford-East Hartford, CT.
25940	Hilton Head Island-Bluffton, SC	25940	Hilton Head Island-Bluffton-Port Royal, SC.
26380	Houma-Thibodaux, LA	26380	Houma-Bayou Cane-Thibodaux, LA.
26420	Houston-The Woodlands-Sugar Land, TX	26420	Houston-Pasadena-The Woodlands, TX.
26900	Indianapolis-Carmel-Anderson, IN	26900	Indianapolis-Carmel-Greenwood, IN.
27900	Joplin, MO	27900	Joplin, MO-KS.
27980	Kahului-Wailuku-Lahaina, HI	27980	Kahului-Wailuku, HI.
29404	Lake County-Kenosha County, IL-WI	28450	Kenosha, WI.
29404	Lake County-Kenosha County, IL-WI	29404	Lake County, IL.
29820	Las Vegas-Henderson-Paradise, NV	29820	Las Vegas-Henderson-North Las Vegas, NV.
31020	Longview, WA	31020	Longview-Kelso, WA.
31460	Madera, CA	23420	Fresno, CA.
34100	Morristown, TN	28940	Knoxville, TN.
34740	Muskegon, MI	34740	Muskegon-Norton Shores, MI.
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	34820	Myrtle Beach-Conway-North Myrtle Beach, SC.
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	48900	Wilmington, NC.
35084	Newark, NJ-PA	35084	Newark, NJ.
35154	New Brunswick-Lakewood, NJ	29484	Lakewood-New Brunswick, NJ.
35300	New Haven-Milford, CT	35300	New Haven, CT.
35380	New Orleans-Metairie, LA	43640	Slidell-Mandeville-Covington, LA.
35840	North Port-Sarasota-Bradenton, FL	35840	North Port-Bradenton-Sarasota, FL.
35980	Norwich-New London, CT	35980	Norwich-New London-Willimantic, CT.
36084	Oakland-Berkeley-Livermore, CA	36084	Oakland-Fremont-Berkeley, CA.
36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ.
36260	Ogden-Clearfield, UT	36260	Ogden, UT.
36540	Omaha-Council Bluffs, NE-IA	36540	Omaha, NE-IA.
37460	Panama City, FL	37460	Panama City-Panama City Beach, FL.
39100	Poughkeepsie-Newburgh-Middletown, NY	28880	Kiryas Joel-Poughkeepsie-Newburgh, NY.
39340	Provo-Orem, UT	39340	Provo-Orem-Lehi, UT.
39540	Racine, WI	39540	Racine-Mount Pleasant, WI.
41540	Salisbury, MD-DE	41540	Salisbury, MD.
41620	Salt Lake City, UT	41620	Salt Lake City-Murray, UT.
41900	San Germán, PR	32420	Mayagüez, PR.
42644	Seattle-Bellevue-Kent, WA	21794	Everett, WA.
42680	Sebastian-Vero Beach, FL	42680	Sebastian-Vero Beach-West Vero Corridor, FL.
42700	Sebring-Avon Park, FL	42700	Sebring, FL.
43620	Sioux Falls, SD	43620	Sioux Falls, SD-MN.
44140	Springfield, MA	11200	Amherst Town-Northampton, MA.
44420	Staunton, VA	44420	Staunton-Stuarts Draft, VA.
44700	Stockton, CA	44700	Stockton-Lodi, CA.
45300	Tampa-St. Petersburg-Clearwater, FL	41304	St. Petersburg-Clearwater-Largo, FL.
45300	Tampa-St. Petersburg-Clearwater, FL	45294	Tampa, FL.

TABLE 25—URBAN CBSAS WITH CHANGE TO NAME AND/OR NUMBER—Continued

Current CBSA	Current CBSA name	Proposed CBSA	Proposed CBSA name
45540	The Villages, FL	48680	Wildwood-The Villages, FL.
45780	Toledo, OH	41780	Sandusky, OH.
47220	Vineland-Bridgeton, NJ	47220	Vineland, NJ.
47260	Virginia Beach-Norfolk-Newport News, VA-NC	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC.
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV.
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD.
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD.
48140	Wausau-Weston, WI	48140	Wausau, WI.
48300	Wenatchee, WA	48300	Wenatchee-East Wenatchee, WA.
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	48424	West Palm Beach-Boca Raton-Delray Beach, FL.
49340	Worcester, MA-CT	49340	Worcester, MA.
49500	Yauco, PR	38660	Ponce, PR.
49660	Youngstown-Warren-Boardman, OH-PA	49660	Youngstown-Warren, OH.

5. Change to County-Equivalents in the State of Connecticut

The June 6, 2022 Census Bureau Notice (87 FR 34235–34240), OMB Bulletin No. 23–01 replaced the 8 counties in Connecticut with 9 new ''Planning Regions.'' Planning regions now serve as county-equivalents within the CBSA system. We are proposing to adopt the planning regions as county equivalents for wage index purposes. We believe it is necessary to adopt this migration from counties to planning region county-equivalents in order to maintain consistency with OMB updates. We are providing the following crosswalk with the current and proposed FIPS county and county-equivalent codes and CBSA assignments.

TABLE 26—CONNECTICUT COUNTIES TO PLANNING REGIONS

FIPS	Current county	Current CBSA	Proposed FIPS	Proposed planning region area (county equivalent)	Proposed CBSA
9001	Fairfield	14860	9190	Western Connecticut	14860
9001	Fairfield	14860	9120	Greater Bridgeport	14860
9003	Hartford	25540	9110	Capitol	25540
9005	Litchfield	7	9160	Northwest Hills	7
9007	Middlesex	25540	9130	Lower Connecticut River Valley	25540
9009	New Haven	35300	9170	South Central Connecticut	35300
9009	New Haven	35300	9140	Naugatuck Valley	47930
9011	New London	35980	9180	Southeastern Connecticut	35980
9013	Tolland	25540	9110	Capitol	25540
9015	Windham	49340	9150	Northeastern Connecticut	7

2. Transition Policy for FY 2025 Wage Index Changes

Overall, we believe that implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. We recognize that some SNFs (43 percent) would experience decreases in their area wage index values as a result of this proposal, though less than 1 percent of providers would experience a significant decrease (that is, greater than 5 percent) in their area wage index value. We also realize that many SNFs (57 percent) would have higher area wage index values after adopting the revised OMB delineations.

CMS recognizes that SNFs in certain areas may experience reduced payment due to the proposed adoption of the revised OMB delineations and has finalized transition policies to mitigate negative financial impacts and provide stability to year-to-year wage index variations. In FY 2023, the 5 percent cap policy was made permanent for all SNFs. This 5 percent cap on reductions policy is discussed in further detail in FY 2023 final rule at 87 FR 47521 through 47523. It is CMS's long held opinion that revised labor market delineations should be adopted as soon as is possible to maintain the integrity the wage index system. We believe the 5 percent cap policy will sufficiently mitigate significant disruptive financial impacts on SNFs negatively affected by the proposed adoption of the revised OMB delineations. We do not believe any additional transition is necessary considering that the current cap on wage index decreases, which was not in place when implementing prior decennial census updates in FY 2006 and FY 2015, ensures that a SNF's wage index would not be less than 95 percent of its final wage index for the prior year.

Furthermore, consistent with the requirement at section 1888(e)(4)(G)(ii) of the Act that wage index adjustments must be made in a budget neutral manner, the applied 5 percent cap on the decrease in an SNF's wage index would not result in any change in estimated aggregate SNF PPS payments by applying a budget neutrality factor to the unadjusted Federal per diem rates. The methodology for calculating this budget neutrality factor is discussed below in section III.D of this proposed rule.

We invite comments on our proposed implementation of revised labor market area delineations. The proposed wage index applicable to FY 2025 is set forth in Table A available on the CMS website at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Table A provides a crosswalk between the FY 2024 wage index for a provider using the current OMB delineations in effect in FY 2024 and the FY 2025 wage index using the proposed revised OMB delineations.

C. Technical Updates to the PDPM ICD–10 Mappings

1. Background

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the Patient Driven Payment Model (PDPM), effective October 1, 2019. The PDPM utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM, hereafter referred to as ICD–10) codes in several ways, including using the patient's primary diagnosis to assign patients to clinical categories under several PDPM components, specifically the PT, OT, SLP, and NTA components. While other ICD–10 codes may be reported as secondary diagnoses and designated as additional comorbidities, the PDPM does not use secondary diagnoses to assign patients to clinical categories. The PDPM ICD–10 code to clinical category mapping, ICD–10 code to SLP comorbidity mapping, and ICD–10 code to NTA comorbidity mapping (hereafter collectively referred to as the PDPM ICD–10 code mappings) are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.*

In the FY 2020 SNF PPS final rule (84 FR 38750), we outlined the process by which we maintain and update the PDPM ICD–10 code mappings, as well as the SNF Grouper software and other such products related to patient classification and billing, to ensure that they reflect the most up to date codes. Beginning with the updates for FY 2020, we apply non-substantive changes to the PDPM ICD–10 code mappings through a sub-regulatory process consisting of posting the updated PDPM ICD–10 code mappings on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.* Such nonsubstantive changes are limited to those specific changes that are necessary to maintain consistency with the most current PDPM ICD–10 code mappings.

On the other hand, substantive changes that go beyond the intention of maintaining consistency with the most current PDPM ICD–10 code mappings, such as changes to the assignment of a code to a clinical category or comorbidity list, would be through notice and comment rulemaking because they are changes that affect policy. We note that, in the case of any diagnoses that are either currently mapped to Return to Provider or that we are finalizing to classify into this category, this is not intended to reflect any judgment on the importance of recognizing and treating these conditions. Rather, we believe that there are more specific or appropriate diagnoses that would better serve as the primary diagnosis for a Part-A covered SNF stay.

2. Clinical Category Changes for New ICD–10 Codes for FY 2025

Each year, we review the clinical category assigned to new ICD–10 diagnosis codes and propose changing the assignment to another clinical category if warranted. This year, we are proposing changing the clinical category assignment for the following four new codes that were effective on October 1, 2023.

- E88.10 *Metabolic Syndrome* was initially mapped to the clinical category of Medical Management. The National Institutes of Health (NIH) as the presence of at least three of the following traits: Large waist, elevated triglyceride levels, reduced high-density lipoprotein (HDL) cholesterol, increased blood pressure, and/or elevated fasting blood glucose. Metabolic syndrome is a cluster of metabolic risk factors for cardiovascular diseases and type 2 diabetes mellitus. The root causes of metabolic syndrome are overweight/obesity, physical inactivity, and genetic factors. Given this, treatment for Metabolic Syndrome typically occurs outside of a Part A SNF stay and we do not believe it would serve appropriately as the primary diagnosis for a Part A-covered SNF stay. For this reason, we propose to change the mapping of this code from Medical Management to the clinical category of Return to Provider.
- E88.811 *Insulin Resistance Syndrome, Type A* was initially mapped to the clinical category of Medical Management. Type A insulin resistance syndrome (TAIRS) is a rare disorder characterized by severe insulin resistance due to defects in insulin receptor signaling and treatment typically occurs outside of a Part A SNF stay. For this reason, we propose to change the mapping of this code from Medical Management to the clinical category of Return to Provider.
- E88.818 *Other Insulin Resistance* was initially mapped to the clinical category of Medical Management. Other Insulin Resistance is used to specify a medical diagnosis of other insulin resistance such as Insulin resistance, Type B. Treatment typically occurs outside of a Part A SNF stay. For this reason, we propose to change the mapping of this code from Medical Management to the clinical category of Return to Provider.
- E88.819 *Insulin Resistance, Unspecified* was initially mapped to the clinical category of Medical Management and is utilized to indicate when a specific type of insulin resistance has not been specifically identified. Treatment typically occurs outside of a Part A SNF stay. For this reason, we propose to change the mapping of this code from Medical Management to the clinical category of Return to Provider.

We solicit comments on the proposed substantive changes to the PDPM ICD–10 code mappings discussed in this section, as well as comments on additional substantive and non-substantive changes that commenters believe are necessary.

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

1. Background

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the PDPM, effective October 1, 2019. Under the PDPM, payment is determined through the combination of six payment components. Five of the components (PT, OT, SLP, NTA, and nursing) are case-mix adjusted. Additionally, there is a non-case-mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics.

The NTA component utilizes a comorbidity score to assign the patient to an NTA component case-mix group, which is determined by the presence of conditions or the use of extensive services (henceforth also referred to as comorbidities) that were found to be correlated with increases in NTA costs for SNF patients. The presence of these conditions and extensive services is reported by providers on certain items of the Minimum Data Set (MDS) resident assessment, with some conditions and extensive services being identified by ICD–10–CM codes (hereafter referred to as ICD–10 codes) that are coded in Item I8000 of the MDS. MDS Item I8000 is an open-ended item on the MDS assessment where the provider can fill in additional active diagnoses for the patient that are either not explicitly on the MDS, or are more severe or specific diagnoses, in the form of ICD–10 codes. For conditions and extensive services where the source is indicated as MDS item I8000, CMS posts an NTA Comorbidity to ICD–10 Mapping, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model,* that provides a crosswalk between the listed condition and the ICD–10 codes that may be coded to

qualify that condition to serve as part of the patient's NTA classification.

During the development of PDPM, CMS identified a list of 50 conditions and extensive services that were associated with increases in NTA costs. Each of the 50 comorbidities used under PDPM for NTA classification is assigned a certain number of points based on its relative costliness. To determine the patient's NTA comorbidity score, a provider would identify all the comorbidities for which a patient would qualify and then add the points for each comorbidity together. The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA component classification group. More information about the creation of the NTA component scoring method can be found in Section 3.7 of the SNF PDPM Technical Report, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research*.

In response to stakeholder comments, CMS stated in the FY 2019 SNF PPS final rule that we would consider revisiting both the list of included NTA comorbidities and the points assigned to each condition or extensive service based on changes in the patient population and care practices over time (83 FR 39224). This request for information (RFI) solicits comment on the methodology CMS is currently considering for updating the NTA component.

2. Updates to the Study Population and Methodology

We are considering several changes to the NTA study population as a foundation upon which to update the NTA component. First, we are considering updating the years used for data corresponding to Medicare Part A SNF stays, including claims, assessments, and cost reports. To develop PDPM, CMS used a study population of Medicare Part A SNF stays with admissions from FY 2014 through FY 2017 (see FY 2019 SNF PPS final rule, 83 FR 39220). This methodology is described in more detail in Section 3.2.1 of the SNF PDPM technical report, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research*. The updated study population will instead use Medicare Part A SNF stays with admissions from FY 2019 through FY 2022. However, as discussed in the FY 2023 SNF PPS final rule (87 FR 47526 through 47528), data from much of this time period was affected by the national COVID–19 PHE with significant impacts on nursing homes. We are therefore considering using the same subset population used for the PDPM parity adjustment recalibration by excluding stays with either a COVID–19 diagnosis or stays using a COVID–19 PHE-related modification under section 1812(f) of the Act.

Next, we are considering making certain methodological changes to reflect more accurate and reliable coding of NTA conditions and extensive services on SNF Part A claims and the MDS after PDPM implementation. We had taken a broad approach when creating the initial PDPM NTA list to predict what NTA coding practices would be after PDPM implementation, given the absence of analogous data in the previous Resource Utilization Groups, Version IV (RUG–IV) payment model. The NTA list was therefore created using data from a variety of different sources, including using Medicare inpatient, outpatient, and Part B claims to identify the presence of condition categories from the Medicare Parts C and D risk adjustment models (hereafter referred to as CCs and RxCCs, respectively). More information about this methodology can be found in Section 3.7 of the SNF PDPM Technical Report, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research*. Given that we now have several years of post-PDPM implementation data, we believe it would more accurately reflect the coding of conditions and extensive services under PDPM to rely exclusively upon SNF PPS Part A claims and the MDS. We are therefore considering updating the methodology to only utilize SNF Part A claims and the MDS, and not claim types from other Medicare settings.

Additionally, we are considering modifying the overlap methodology to rely more upon the MDS items that use a checkbox to record the presence of conditions and extensive services whenever possible, while allowing for potentially more severe or specific diagnoses to be indicated on MDS item I8000 when it would be useful for more accurate patient classification under PDPM. During the development of the NTA component, CMS included both MDS items and ICD–10 diagnoses from the Medicare Part C CCs and Part D RxCCs. Because the CCs were developed to predict utilization of Medicare Part C services, while the RxCCs were developed to predict Medicare Part D drug costs, the largest component of NTA costs, we stated in the FY 2019 SNF PPS final rule that we believed using both sources allowed us to define the conditions and extensive services potentially associated with NTA utilization more comprehensively (83 FR 39220). In cases where there was considerable overlap between an MDS item and its CC or RxCC definition, to ensure accurate estimation of statistically significant regression results, we chose the CC or RxCC definition if it had higher average NTA cost per day than the MDS item before running the final regression analysis. More information about this methodology can be found in Section 3.7 of the SNF PDPM Technical Report, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research*.

Since the implementation of PDPM, we believe patient conditions and extensive services are now more accurately and reliably reported by providers using MDS items. We are therefore considering prioritizing the reporting of conditions on the MDS by raising the cost threshold for selecting the overlapping CC or RxCC definitions from any additional cost to 5 dollars in average NTA cost per day, which is the amount that we observe to be generally associated with a 1-point NTA increase. Specifically, since any dollar amount less than 5 dollars would render the two options indistinguishable from each other in the point assignment when comparing relative costliness, choosing MDS items over CC/RxCCs will not lead to any loss of the most expensive representations of the conditions and services in the regression model.

3. Updates to Conditions and Extensive Services Used for NTA Classification

Table 27 provides the list of conditions and extensive services that would be used for NTA classification following the various changes we are considering to the methodology outlined above. For each condition or extensive service, we have also included the frequency of stays, the average NTA cost per day, the ordinary least squares (OLS) estimate of its impact on NTA costs per day, and the assigned number of points based on its relative impact on a patient's NTA costs. Conditions and extensive services with a greater impact on NTA costs were assigned more points, while those with less of an impact were assigned fewer points. More information about this methodology can be found in Section 3.7 of the SNF PDPM Technical Report, available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research*.

TABLE 27—CONDITIONS AND EXTENSIVE SERVICES USED FOR NTA CLASSIFICATION

NTA comorbidity	% of stays	Avg NTA costs	OLS estimate	PDPM points
DGN: HIV/AIDS	0.3	$128	$71.01	7
RxCC: Lung Transplant Status	0.0	117	49.29	5
O0100H2: Special Treatments/Programs: Intravenous Medication Post-admit Code	8.6	105	46.99	5
MDS: Parenteral IV feeding: Level high	0.3	120	46.27	5
RxCC: Cystic Fibrosis	0.0	99	31.10	3
RxCC: Major Organ Transplant Status, Except Lung	0.5	85	21.66	2
CC: Cirrhosis of Liver	2.0	77	18.92	2
RxCC: Chronic Myeloid Leukemia	0.1	75	17.81	2
DGN: Endocarditis	0.5	97	17.46	2
RxCC: Opportunistic Infections	0.3	85	16.91	2
I2900: Active Diagnoses: Diabetes Mellitus (DM) Code	38.2	66	15.67	2
O0100I2: Special Treatments/Programs: Transfusion Post-admit Code	0.2	80	14.65	1
MDS: Parenteral IV feeding: Level Low	0.0	82	14.26	1
CC: Bone/Joint/Muscle Infections/Necrosis—Except: RxCC: Aseptic Necrosis of Bone	2.9	97	14.23	1
I6200: Active Diagnoses: Asthma COPD Chronic Lung Disease Code	29.2	66	13.72	1
O0100D2: Special Treatments/Programs: Suctioning Post-admit Code	0.8	86	13.11	1
RxCC: Psoriatic Arthropathy and Systemic Sclerosis	0.2	72	12.87	1
RxCC: Chronic Pancreatitis	0.3	75	12.64	1
RxCC: Specified Hereditary Metabolic/Immune Disorders	0.0	74	10.36	1
I5200: Active Diagnoses: Multiple Sclerosis Code	0.9	63	9.84	1
O0100F2: Special Treatments/Programs: Ventilator Post-admit Code	0.3	99	9.79	1
RxCC: Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.6	65	9.16	1
M1040B: Other Foot Skin Problems: Diabetic Foot Ulcer Code	1.6	87	9.07	1
RxCC: Narcolepsy and Cataplexy	0.1	68	9.01	1
RxCC: Venous Thromboembolism	4.4	64	8.86	1
B0100: Comatose	0.0	87	8.64	1
M0300X1: Highest Stage of Unhealed Pressure Ulcer—Stage 4	1.6	80	8.48	1
I1300: Active Diagnoses: Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease	2.3	63	7.77	1
RxCC: Atrial Arrhythmias	26.4	60	7.35	1
RxCC: Sickle Cell Anemia	0.0	65	7.27	1
RxCC: Myelodysplastic Syndromes and Myelofibrosis	0.4	65	7.11	1
I2500: Wound Infection Code	2.1	84	6.96	1
RxCC: Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	2.5	62	6.94	1
RxCC: Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease—Except: CC: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.3	64	6.60	1
CC: Complications of Specified Implanted Device or Graft	0.3	75	6.39	1
I6100: Active Diagnoses: Post Traumatic Stress Disorder	0.6	67	5.94	1
RxCC: Aplastic Anemia and Other Significant Blood Disorders	0.4	64	5.90	1
O0100M2: Special Treatments/Programs: Isolation Post-admit Code	2.0	68	5.77	1
I0600: Active Diagnoses: Heart Failure	29.5	63	5.72	1
H0100D: Bladder and Bowel Appliances: Intermittent catheterization	0.8	59	5.39	1
I6300: Active Diagnoses: Respiratory Failure	12.5	67	5.10	1
RxCC: Morbid Obesity	6.7	69	5.02	1
I5700: Active Diagnoses: Anxiety Disorder	22.4	59	4.89	1
CC: Disorders of Immunity—Except: RxCC: Immune Disorders	0.9	65	4.76	1
G0600D: Mobility Devices: Limb prosthesis	0.4	68	4.65	1
RxCC: Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	2.4	61	4.62	1
I1700: Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	2.7	84	4.57	1
M1040E: Other Skin Problems: Surgical Wound(s) Code	25.7	57	4.05	1
I5900: Active Diagnoses: Bipolar Disorder	3.5	61	4.02	1
RxCC: Chronic Viral Hepatitis, Except Hepatitis C	0.1	71	3.90	1

We invite comments on the updates that we are considering for the NTA component of PDPM.

VI. Skilled Nursing Facility Quality Reporting Program (SNF QRP)

A. Background and Statutory Authority

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Act, and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospital (CAH) swing-bed rural hospitals. Section 1888(e)(6)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual market basket percentage increase described in section 1888(e)(5)(B)(i) of the Act applicable to a SNF for a fiscal year (FY), after application of section 1888(e)(5)(B)(ii) of the Act (the productivity adjustment) and section 1888(e)(5)(B)(iii) of the Act, in the case of a SNF that does not submit data in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for that FY. Section 1890A of the Act requires that the Secretary establish and

follow a pre-rulemaking process, in coordination with the consensus-based entity (CBE) with a contract under section 1890(a) of the Act, to solicit input from certain groups regarding the selection of quality and efficiency measures for the SNF QRP. We have codified our program requirements in our regulations at § 413.360.

We are proposing to require SNFs to collect and submit through the Minimum Data Set (MDS) four new items and modify one item on the MDS as described in section VI.C. of this proposed rule. In section VI.E.3. of this proposed rule, we are proposing to adopt a similar validation process for the SNF QRP that we adopted for the SNF VBP, and to amend regulation text at § 413.360 to implement the validation process we propose. We are also seeking information on future measure concepts for the SNF QRP in section VI.D. of this proposed rule.

B. General Considerations Used for the Selection of Measures for the SNF QRP

For a detailed discussion of the considerations we use for the selection of SNF QRP quality, resource use, or other measures, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431).

1. Quality Measures Currently Adopted for the SNF QRP

The SNF QRP currently has 15 adopted measures, which are listed in Table 28. For a discussion of the factors used to evaluate whether a measure should be removed from the SNF QRP, we refer readers to § 413.360(b)(2).

TABLE 28—QUALITY MEASURES CURRENTLY ADOPTED FOR THE SNF QRP

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

We are not proposing to adopt any new measures for the SNF QRP.

C. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements and To Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning With the FY 2027 SNF QRP

In this proposed rule, we are proposing to require SNFs to report the following four new items [2] as standardized patient assessment data elements under the social determinants of health (SDOH) category: one item for Living Situation; two items for Food; and one item for Utilities. We are also proposing to modify one of the current items collected as a standardized patient assessment data element under the SDOH category (the Transportation item), as described in section VI.C.5. of this proposed rule.[3]

1. Definition of Standardized Patient Assessment Data

Section 1888(e)(6)(B)(i)(III) of the Act requires SNFs to submit standardized patient assessment data required under section 1899B(b)(1) of the Act. Section 1899B(b)(1)(A) of the Act requires post-acute care (PAC) providers to submit standardized patient assessment data under applicable reporting provisions (which, for SNFs, is the SNF QRP) with respect to the admission and discharge of an individual (and more frequently as the Secretary deems appropriate) using a standardized patient assessment instrument. Section 1899B(a)(1)(C) of the Act requires, in part, the Secretary to modify the PAC assessment instruments in order for PAC providers, including SNFs, to submit standardized patient assessment data under the Medicare program. SNFs are currently required to report standardized patient assessment data through the patient

[2] Items may also be referred to as ''data elements.''

[3] As noted in section VI.C.3, hospitals are required to report whether they have screened patients for five standardized SDOH categories: housing instability, food insecurity, utility difficulties, transportation needs, and interpersonal safety.

assessment instrument, referred to as the MDS. Section 1899B(b)(1)(B) of the Act describes standardized patient assessment data as data required for at least the quality measures described in section 1899B(c)(1) of the Act and that is with respect to the following categories: (1) functional status, such as mobility and self-care at admission to a PAC provider and before discharge from a PAC provider; (2) cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia; (3) special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition; (4) medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers; (5) impairments, such as incontinence and an impaired ability to hear, see, or swallow, and (6) other categories deemed necessary and appropriate by the Secretary.

2. Social Determinants of Health Collected as Standardized Patient Assessment Data Elements

Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect standardized patient assessment data elements with respect to other categories deemed necessary and appropriate. Accordingly, we finalized the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 SNF PPS final rule (84 FR 38805 through 38817), and defined SDOH as the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health.[4] According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30 to 55 percent of health outcomes.[5] This is part of a growing body of research that highlights the importance of SDOH on health outcomes. Subsequent to the FY 2020 SNF PPS final rule, we expanded our definition of SDOH: SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[6] [7] [8] This expanded definition aligns our definition of SDOH with the definition used by HHS agencies, including OASH, the Centers for Disease Control and Prevention (CDC) and the White House Office of Science and Technology Policy.[9] [10] We currently collect seven items in this SDOH category of standardized patient assessment data elements: ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation (84 FR 38805 through 38817).[11]

In accordance with our authority under section 1899B(b)(1)(B)(vi) of the Act, we similarly finalized the creation of the SDOH category of standardized patient assessment data elements for Inpatient Rehabilitation Facilities (IRFs) in the FY 2020 IRF PPS final rule (84 FR 39149 through 39161), for Long-Term Care Hospitals (LTCHs) in the FY 2020 Inpatient Prospective Payment System (IPPS)/LTCH PPS final rule (84 FR 42577 through 84 FR 42588), and for Home Health Agencies (HHAs) in the Calendar Year (CY) 2020 HH PPS final rule (84 60597 through 60608). We also collect the same seven SDOH items in these PAC providers' respective patient assessment instruments (84 FR 39161, 84 FR 42590, and 84 FR 60610, respectively).

Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjustors or in future quality measures. Our ability to perform these analyses relies on existing data collection of SDOH items from PAC settings. We adopted these SDOH items using common standards and definitions across the four PAC providers to promote interoperable exchange of longitudinal information among these PAC providers, including SNFs, and other providers. We believe this information may facilitate coordinated care, continuity in care planning, and the discharge planning process from PAC settings.

We noted in our FY 2020 SNF PPS final rule that each of the items we were adopting at that time was identified in the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) report as impacting care use, cost and outcomes for Medicare beneficiaries (84 FR 38806). At that time, we acknowledged that other items may also be useful to understand. The SDOH items we are now proposing to adopt as standardized patient assessment data elements under the SDOH category in this proposed rule were also identified in the 2016 NASEM report [12] or the 2020 NASEM report [13] as impacting care use, cost and outcomes for Medicare beneficiaries. The items have the capacity to take into account treatment preferences and care goals of residents and their caregivers, to inform our understanding of resident complexity and SDOH that may affect care outcomes, and ensure that SNFs are in a position to impact them through the provision of services and supports, such as connecting residents and their caregivers with identified needs with social support programs.

Health-related social needs (HRSNs) are individual-level, adverse social conditions that negatively impact a person's health or health care,[14] and are the resulting effects of SDOH. Examples of HRSNs include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.[15] Certain HRSNs can directly influence an individual's physical, psychosocial, and functional status. This is particularly true for food

[4] FY 2020 SNF PPS final rule (84 FR 38805).

[5] World Health Organization. Social determinants of health. Available at *https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1*.

[6] Using Z Codes: The Social Determinants of Health (SDOH). Data Journey to Better Outcomes.

[7] Improving the Collection of Social Determinants of Health (SDOH) Data with ICD–10–CM Z Codes. *https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf*.

[8] *CMS.gov*. Measures Management System (MMS). CMS Focus on Health Equity. Health Equity Terminology and Quality Measures. *https://mmshub.cms.gov/about-quality/quality-at-CMS/goals/cms-focus-on-health-equity/health-equity-terminology*.

[9] Centers for Disease Control and Prevention. Social Determinants of Health (SDOH) and PLACES Data.

[10] ''U.S. Playbook To Address Social Determinants Of Health'' from the White House Office Of Science And Technology Policy (November 2023).

[11] These SDOH data are also collected for purposes outlined in section 2(d)(2)(B) of the Improving Medicare Post-Acute Care Transitions Act (IMPACT Act). For a detailed discussion on SDOH data collection under section 2(d)(2)(B) of the IMPACT Act, see the FY 2020 SNF PPS final rule (84 FR 38805 through 38817).

[12] National Academies of Sciences, Engineering, and Medicine. 2016. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: The National Academies Press. *https://doi.org/10.17226/21858*.

[13] National Academies of Sciences, Engineering, and Medicine. 2020. Leading Health Indicators 2030: Advancing Health, Equity, and Well-Being. Washington, DC: The National Academies Press. *https://doi.org/10.17226/25682*.

[14] Centers for Medicare & Medicaid Services. ''A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights.'' August 2022. Available at *https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion*.

[15] Berkowitz, S.A., T.P. Baggett, and S.T. Edwards, ''Addressing Health-Related Social Needs: Value-Based Care or Values-Based Care?'' Journal of General Internal Medicine, vol. 34, no. 9, 2019, pp. 1916–1918, *https://doi.org/10.1007/s11606-019-05087-3*.

security, housing stability, utilities security, and access to transportation.[16]

We are proposing to require SNFs to collect and submit four new items in the MDS as standardized patient assessment data elements under the SDOH category because these items would collect information not already captured by the current SDOH items. Specifically, we believe the ongoing identification of SDOH would have three significant benefits. First, promoting screening for these SDOH could serve as evidence-based building blocks for supporting healthcare providers in actualizing their commitment to address disparities that disproportionately impact underserved communities. Second, screening for SDOH improves health equity through identifying potential social needs so the SNF may address those with the resident, their caregivers, and community partners during the discharge planning process, if indicated.[17] Third, these SDOH items could support our ongoing SNF QRP initiatives by providing data with which to stratify SNF's performance on measures and or in future quality measures.

Additional collection of SDOH items would permit us to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries. For example, we recently developed and released the Health Equity Confidential Feedback Reports, which provided data to SNFs on whether differences in quality measure outcomes are present for their residents by dual-enrollment status and race and ethnicity.[18] We note that advancing health equity by addressing the health disparities that underlie the country's health system is one of our strategic pillars [19] and a Biden-Harris Administration priority.[20]

3. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements Beginning With the FY 2027 SNF QRP

We are proposing to require SNFs to collect and submit four new items as standardized patient assessment data elements under the SDOH category using the MDS: one item for Living Situation, as described in section VI.C.3.(a) of this proposed rule; two items for Food, as described in section VI.C.3.(b) of this proposed rule; and one item for Utilities, as described in section VI.C.3.(c) of this proposed rule.

We selected the proposed SDOH items from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC Model. The AHC HRSN Screening Tool is a universal, comprehensive screening for HRSNs that addresses five core domains as follows: (1) housing instability (for example, homelessness, poor housing quality); (2) food insecurity; (3) transportation difficulties; (4) utility assistance needs; and (5) interpersonal safety concerns (for example, intimate-partner violence, elder abuse, child maltreatment).[21]

We believe that requiring SNFs to report the Living Situation, Food, Utilities, and Transportation items that are currently included in the AHC HRSN Screening Tool would further standardize the screening of SDOH across quality programs. For example, our proposal would align, in part, with the requirements of the Hospital Inpatient Quality Reporting (IQR) Program and the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. As of January 2024, hospitals are required to report whether they have screened patients for the standardized SDOH categories of housing instability, food insecurity, utility difficulties, transportation needs, and interpersonal safety to meet the Hospital IQR Program requirements.[22] Additionally, beginning January 2025, IPFs will also be required to report whether they have screened patients for the same set of SDOH categories.[23] As we continue to standardize data collection across PAC settings, we believe using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between SNFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process.

Below we describe each of the four proposed items in more detail.

(a) Living Situation

Healthy People 2030 prioritizes economic stability as a key SDOH, of which housing stability is a component.[24] [25] Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.[26] These experiences may negatively affect one's physical health and access to health care. Housing instability can also lead to homelessness, which is housing deprivation in its most severe form.[27] On a single night in 2023, roughly 653,100 people, or 20 out of every 10,000 people in the United States, were experiencing homelessness.[28] Studies also found that people who are homeless have an increased risk of

[16] Hugh Alderwick and Laura M. Gottlieb, ''Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems: Milbank Quarterly,'' Milbank Memorial Fund, November 18, 2019, *https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/*.

[17] American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. December 2020. Accessed: January 18, 2022. Available at *https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf*.

[18] In October 2023, we released two new annual Health Equity Confidential Feedback Reports to SNFs: The Discharge to Community (DTC) Health Equity Confidential Feedback Report and the Medicare Spending Per Beneficiary (MSPB) Health Equity Confidential Feedback Report. The PAC Health Equity Confidential Feedback Reports stratified the DTC and MSPB measures by dual-enrollment status and race/ethnicity. For more information on the Health Equity Confidential Feedback Reports, please refer to the Education and Outreach materials available on the SNF QRP Training web page at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training*.

[19] Brooks-LaSure, C. (2021). My First 100 Days and Where We Go from Here: A Strategic Vision for CMS. Centers for Medicare & Medicaid. Available at *https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms*.

[20] The Biden-Harris Administration's strategic approach to addressing health related social needs can be found in The U.S. Playbook to Address Social Determinants of Health (SDOH) (2023): *https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf*.

[21] More information about the AHC HRSN Screening Tool is available on the website at *https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf*.

[22] Centers for Medicare & Medicaid Services, FY2023 IPPS/LTCH PPS final rule (87 FR 49202 through 49215).

[23] Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121).

[24] Office of Disease Prevention and Health Promotion. (n.d.). Healthy People 2030 | Priority Areas: Social Determinants of Health. Retrieved from U.S. Department of Health and Human Services: *https://health.gov/healthypeople/priority-areas/social-determinants-health*.

[25] Healthy People 2030 is a long-term, evidence-based effort led by the U.S. Department of Health and Human Services (HHS) that aims to identify nationwide health improvement priorities and improve the health of all Americans.

[26] Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine, 21*(1), 71–77. doi: *10.1111/j.1525-1497.2005.00278.x*.

[27] Homelessness is defined as ''lacking a regular nighttime residence or having a primary nighttime residence that is a temporary shelter or other place not designed for sleeping.'' Crowley, S. (2003). The affordable housing crisis: Residential mobility of poor families and school mobility of poor children. Journal of Negro Education, 72(1), 22–38. *https://doi.org/10.2307/3211288*.

[28] The 2023 Annual Homeless Assessment Report (AHAR) to Congress. The U.S. Department of Housing and Urban Development 2023. *https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf*.

premature death and experience chronic disease more often than among the general population.[29] We believe that SNFs can use information obtained from the Living Situation item during a resident's discharge planning. For example, SNFs could work in partnership with community care hubs and community-based organizations to establish new care transition workflows, including referral pathways, contracting mechanisms, data sharing strategies, and implementation training that can track HRSNs to ensure unmet needs, such as housing, are successfully addressed through closed loop referrals and follow-up.[30] SNFs could also take action to help alleviate a resident's other related costs of living, like food, by referring the resident to community-based organizations that would allow the resident's additional resources to be allocated towards housing without sacrificing other needs.[31] Finally, SNFs could use the information obtained from the Living Situation item to better coordinate with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a resident's housing stability are not lost during vulnerable transition periods.

Due to the potential negative impacts housing instability can have on a resident's health, we are proposing to adopt the Living Situation item as a new standardized patient assessment data element under the SDOH category. The proposed Living Situation item is based on the Living Situation item currently collected in the AHC HRSN Screening Tool,[32] [33] and was adapted from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.[34] The proposed Living Situation item asks, ''What is your living situation today?'' The proposed response options are: (0) I have a steady place to live; (1) I have a place to live today, but I am worried about losing it in the future; (2) I do not have a steady place to live; (7) Resident declines to respond; and (8) Resident unable to respond. A draft of the Living Situation item proposed as a standardized patient assessment data element under the SDOH category can be found in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information*.

(b) Food

The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.[35] Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities. For example, a study found that food-insecure adults may be at an increased risk for obesity.[36] Another study found that food-insecure adults have a significantly higher probability of death from any cause or cardiovascular disease in long-term follow-up care, in comparison to adults that are food secure.[37]

While having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.[38] The United States Department of Agriculture (USDA) defines nutrition security as ''consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being.'' [36] Nutrition security builds on and complements long standing efforts to advance food security. Studies have shown that older adults struggling with food insecurity consume fewer calories and nutrients and have lower overall dietary quality than those who are food secure, which can put them at nutritional risk.[39] Older adults are also at a higher risk of developing malnutrition, which is considered a state of deficit, excess, or imbalance in protein, energy, or other nutrients that adversely impacts an individual's own body form, function, and clinical outcomes.[40] About 50 percent of older adults are affected by malnutrition, which is further aggravated by a lack of food security and poverty.[41] These facts highlight why the Biden-Harris Administration launched the White House Challenge to End Hunger and Build Health Communities.[42]

We believe that adopting items to collect and analyze information about a resident's food security at home could provide additional insight to their health complexity and help facilitate coordination with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a resident's food security are not lost during vulnerable transition periods. For example, a SNF's dietitian or other clinically qualified nutrition professional could work with the

[29] Baggett, T.P., Hwang, S.W., O'Connell, J.J., Porneala, B.C., Stringfellow, E.J., Orav, E.J., Singer, D.E., & Rigotti, N.A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. JAMA Internal Medicine, 173(3), 189–195. *https://doi.org/10.1001/jamainternmed.2013.1604*. Schanzer, B., Dominguez, B., Shrout, P.E., & Caton, C.L. (2007). Homelessness, health status, and health care use. American Journal of Public Health, 97(3), 464–469. doi: *https://doi.org/10.2105/ajph.2005.076190*.

[30] U.S. Department of Health & Human Services (HHS), Call to Action, ''Addressing Health Related Social Needs in Communities Across the Nation.'' November 2023. *https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf*.

[31] Henderson, K.A., Manian, N., Rog, D.J., Robison, E., Jorge, E., AlAbdulmunem, M. ''Addressing Homelessness Among Older Adults'' (Final Report). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 26, 2023.

[32] More information about the AHC HRSN Screening Tool is available on the website at *https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf*.

[33] The AHC HRSN Screening Tool Living Situation item includes two questions. In an effort to limit SNF burden, we are only proposing the first question.

[34] National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. ''PRAPARE.'' 2017. *https://prapare.org/the-prapare-screening-tool/*.

[35] U.S. Department of Agriculture, Economic Research Service. (n.d.). *Definitions of food security*. Retrieved March 10, 2022, from *https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/*.

[36] Hernandez, D.C., Reesor, L.M., & Murillo, R. (2017). Food insecurity and adult overweight/obesity: Gender and race/ethnic disparities. *Appetite, 117,* 373–378.

[37] Banerjee, S., Radak, T., Khubchandani, J., & Dunn, P. (2021). Food Insecurity and Mortality in American Adults: Results From the NHANES-Linked Mortality Study. Health promotion practice, 22(2), 204–214. *https://doi.org/10.1177/1524839920945927*.

[38] National Center for Health Statistics. (2022, September 6). Exercise or Physical Activity. Retrieved from Centers for Disease Control and Prevention: *https://www.cdc.gov/nchs/fastats/exercise.htm*.

[39] Ziliak, J.P., & Gundersen, C. (2019). The State of Senior Hunger in America 2017: An Annual Report. Prepared for Feeding America. Available at *https://www.feedingamerica.org/research/senior-hunger-research/senior*.

[40] The Malnutrition Quality Collaborative. (2020). National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Washington, DC: Avalere Health and Defeat Malnutrition Today. Available at *https://defeatmalnutrition.today/advocacy/blueprint/*.

[41] Food Research & Action Center (FRAC). ''Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs.'' December 2019. *https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf*.

[42] The White House Challenge to End Hunger and Build Health Communities (Challenge) was a nationwide call-to-action released on March 24, 2023 to stakeholders across all of society to make commitments to advance President Biden's goal to end hunger and reduce diet-related diseases by 2030—all while reducing disparities. More information on the White House Challenge to End Hunger and Build Health Communities can be found: *https://www.whitehouse.gov/briefing-room/statements-releases/2023/03/24/fact-sheet-biden-harris-administration-launches-the-white-house-challenge-to-end-hunger-and-build-healthy-communities-announces-new-public-private-sector-actions-to-continue-momentum-from-hist/*.

resident and their caregiver to plan healthy, affordable food choices prior to discharge.[43] SNFs could also refer a resident that indicates lack of food security to government initiatives such as the Supplemental Nutrition Assistance Program (SNAP) and food pharmacies (programs to increase access to healthful foods by making them affordable), two initiatives that have been associated with lower health care costs and reduced hospitalization and emergency department visits.[44]

We are proposing to adopt two Food items as new standardized patient assessment data elements under the SDOH category. These proposed items are based on the Food items currently collected in the AHC HRSN Screening Tool and were adapted from the USDA 18-item Household Food Security Survey (HFSS).[45] The first proposed Food item states, ''Within the past 12 months, you worried that your food would run out before you got money to buy more.'' The second proposed Food item States, ''Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.'' We propose the same response options for both items: (0) Often true; (1) Sometimes true; (2) Never True; (7) Resident to declines to respond; and (8) Resident unable to respond. A draft of the Food items proposed to be adopted as standardized patient assessment data elements under the SDOH category can be found in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

(c) Utilities

A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.[46] According to the United States Department of Energy, one in three households in the U.S. are unable to adequately meet basic household energy needs.[47] The consequences associated with a lack of utility security are represented by three primary dimensions: economic; physical; and behavioral. Residents with low incomes are disproportionately affected by high energy costs, and they may be forced to prioritize paying for housing and food over utilities.[48] Some residents may face limited housing options, and therefore, are at increased risk of living in lower-quality physical conditions with malfunctioning heating and cooling systems, poor lighting, and outdated plumbing and electrical systems.[49] Residents with a lack of utility security may use negative behavioral approaches to cope, such as using stoves and space heaters for heat.[50] In addition, data from the Department of Energy's U.S. Energy Information Administration confirm that a lack of energy security disproportionately affects certain populations, such as low-income and African American households.[51] The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have a direct impact on a person's health.[52] For example, research has shown associations between a lack of energy security and respiratory conditions as well as mental health–related disparities and poor sleep quality in vulnerable populations such as the elderly, children, the socioeconomically disadvantaged, and the medically vulnerable.[53]

We believe adopting an item to collect information about a resident's utility security would facilitate the identification of residents who may not have utility security and who may benefit from engagement efforts. For example, SNFs may be able to use the information on utility security to help connect some residents in need to programs that can help older adults pay for their home energy (heating/cooling) costs, like the Low-Income Home Energy Assistance Program (LIHEAP).[54] SNFs may also be able to partner with community care hubs and community-based organizations to assist the resident in applying for these and other local utility assistance programs, as well as helping them navigate the enrollment process.[55]

We are proposing to adopt a new item, Utilities, as a new standardized patient assessment data element under the SDOH category. This proposed item is based on the Utilities item currently collected in the AHC HRSN Screening Tool, and was adapted from the Children's Sentinel Nutrition Assessment Program (C–SNAP) survey.[56] The proposed Utilities item asks, ''In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?'' The proposed response options are: (0) Yes; (1) No; (2) Already shut off; (7) Resident declines to respond; and (8) Resident unable to respond. A draft of the Utilities item proposed as a standardized patient assessment data element under the SDOH category can be found in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

4. Interested Parties Input

We developed our proposal to add these items after considering feedback we received in response to our request

[43] Schroeder K., Smaldone A. Food Insecurity: A Concept Analysis. Nurse Forum. 2015 Oct–Dec;50(4):274–84. doi: 10.1111/nuf.12118. Epub 2015 Jan 21. PMID: 25612146; PMCID: PMC4510041.

[44] Tsega M., Lewis C., McCarthy D., Shah T., Coutts K. Review of Evidence for Health-Related Social Needs Interventions. July 2019. The Commonwealth Fund. *https://www.commwealthfund.org/sites/default/files/2019-07/ROI-evidence-review-final-version.pdf.*

[45] More information about the HFSS tool can be found at *https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/survey-tools/.*

[46] Hernández D. Understanding 'energy insecurity' and why it matters to health. Soc Sci Med. 2016 Oct; 167:1–10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

[47] US Energy Information Administration. ''One in Three U.S. Households Faced Challenges in Paying Energy Bills in 2015.'' 2017 Oct 13. *https://www.eia.gov/consumption/residential/reports/2015/energybills/.*

[48] Hernández D. ''Understanding 'energy insecurity' and why it matters to health.'' Soc Sci Med. 2016; 167:1–10.

[49] Hernández D. Understanding 'energy insecurity' and why it matters to health. Soc Sci Med. 2016 Oct;167:1–10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

[50] Hernández D. ''What 'Merle' Taught Me About Energy Insecurity and Health.'' Health Affairs, VOL.37, NO.3: Advancing Health Equity Narrative Matters. March 2018. *https://doi.org/10.1377/hlthaff.2017.1413.*

[51] US Energy Information Administration. ''One in Three U.S. Households Faced Challenges in Paying Energy Bills in 2015.'' 2017 Oct 13. *https://www.eia.gov/consumption/residential/reports/2015/energybills/.*

[52] Hernández D. Understanding 'energy insecurity' and why it matters to health. Soc Sci Med. 2016 Oct;167:1–10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

[53] Hernández D, Siegel E. Energy insecurity and its ill health effects: A community perspective on the energy-health nexus in New York City. Energy Res Soc Sci. 2019 Jan;47:78–83. *doi: 10.1016/j.erss.2018.08.011.* Epub 2018 Sep 8. PMID: 32280598; PMCID: PMC7147484.

[54] U.S. Department of Health & Human Services. Office of Community Services. Low Income Home Energy Assistance Program (LIHEAP). *https://www.acf.hhs.gov/ocs/programs/liheap.*

[55] National Council on Aging (NCOA). ''How to Make It Easier for Older Adults to Get Energy and Utility Assistance.'' Promising Practices Clearinghouse for Professionals. Jan 13, 2022. *https://www.ncoa.org/article/how-to-make-it-easier-for-older-adults-to-get-energy-and-utility-assistance.*

[56] This validated survey was developed as a clinical indicator of household energy security among pediatric caregivers. Cook, J.T., D.A. Frank., P.H. Casey, R. Rose-Jacobs, M.M. Black, M. Chilton, S. Ettinger de Cuba, et al. ''A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers.'' Pediatrics, vol. 122, no. 4, 2008, pp. e874–e875. *https://doi.org/10.1542/peds.2008-0286.*

for information (RFI) on Principles for Selecting and Prioritizing SNF QRP Quality Measures and Concepts Under Consideration for Future Years in the FY 2024 SNF PPS final rule (88 FR 53265 through 53267). This RFI sought to obtain input on a set of principles to identify SNF QRP measures, as well as additional thoughts about measurement gaps, and suitable measures for filling these gaps. In response to this solicitation, commenters stated that the inclusion of a malnutrition screening and intervention measures would promote both quality and health equity. Other measures and measurement concepts included health equity, psychosocial issues, and caregiver status. The FY 2024 SNF PPS final rule includes a summary of the public comments that we received in response to the RFI and our responses to those comments (88 FR 53265 through 53267).

We also considered comments received in response to our Health Equity Update in the FY 2024 SNF PPS final rule. Comments were generally supportive of CMS' efforts to develop ways to measure and mitigate health inequities. One commenter referenced their belief that collection of SDOH would enhance holistic care, call attention to impairments that might be mitigated or resolved, and facilitate clear communication between residents and SNFs. While there were commenters who urged CMS to balance reporting requirements so as not to create undue administrative burden, another commenter suggested CMS incentivize collection of data on SDOH such as housing stability and food security. The FY 2024 SNF PPS final rule (88 FR 53268 through 53269) includes a summary of the public comments that we received in response to the Health Equity Update and our responses to those comments.

Additionally, we considered feedback we received when we proposed the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 SNF PPS proposed rule (84 FR 17671 through 17679). Commenters were generally in favor of the concept of collecting SDOH items and stated that, if implemented appropriately, the data could be useful in identifying and addressing health care disparities, as well as refining the risk adjustment of outcome measures. The FY 2020 SNF PPS final rule (84 FR 38805 through 38818) includes a summary of the public comments that we received and our responses to those comments. We incorporated this input into the development of this proposal.

We invite comment on the proposal to adopt four new items as standardized patient assessment data elements under the SDOH category beginning with the FY 2027 SNF QRP: one Living Situation item; two Food items; and one Utilities item.

5. Proposal To Modify the Transportation Item Beginning With the FY 2027 SNF QRP

Beginning October 1, 2023, SNFs began collecting seven items adopted as standardized patient assessment data elements under the SDOH category on the MDS.[57] One of these items, A1250. Transportation, collects data on whether a lack of transportation has kept a resident from getting to and from medical appointments, meetings, work, or from getting things they need for daily living. This item was adopted as a standardized patient assessment data element under the SDOH category in the FY 2020 SNF PPS final rule (84 FR 38805 through 38809). As we discussed in the FY 2020 SNF PPS final rule (84 FR 38814 through 42588), we continue to believe that access to transportation for ongoing health care and medication access needs, particularly for those with chronic diseases, is essential to successful chronic disease management and that the collection of a Transportation item would facilitate the connection to programs that can address identified needs (84 FR 38815 through 42588).

As part of our routine item and measure monitoring work, we continually assess the implementation of the new SDOH items. We have identified an opportunity to improve the data collection for A1250. Transportation in the MDS by aligning it with the Transportation category collected in our other programs.[58] Specifically, we are proposing to modify the current Transportation item in the MDS so that it aligns with a Transportation item collected on the AHC HRSN Screening Tool, one of the potential tools the IPFQR and Hospital IQR Programs may select for data collection.

A1250. Transportation currently collected in the MDS asks: ''Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?'' The response options are: (A) Yes, it has kept me from medical appointments or from getting my medications; (B) Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need; (C) No; (X) Resident unable to respond; and (Y) Resident declines to respond. The Transportation item collected in the AHC HRSN Screening Tool asks, ''In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?'' The two response options are: Yes; and No. Consistent with the AHC HRSN Screening Tool and adapted from the PRAPARE tool, we are proposing to modify the A1250. Transportation item currently collected in the SNF MDS in two ways: (1) revise the look-back period for when the resident experienced lack of reliable transportation; and (2) simplify the response options.

First, the proposed modification of the Transportation item would use a defined 12-month look back period, while the current Transportation item uses a look back period of six to 12 months. We believe the distinction of a 12-month look back period would reduce ambiguity for both residents and clinicians, and therefore, improve the validity of the data collected. Second, we are proposing to simplify the response options. Currently, SNFs separately collect information on whether a lack of transportation has kept the patient from medical appointments or from getting medications, and whether a lack of transportation has kept the resident from non-medical meetings, appointments, work, or from getting things they need. Although transportation barriers can directly affect a person's ability to attend medical appointments and obtain medications, a lack of transportation can also affect a person's health in other ways, including accessing goods and services, obtaining adequate food and clothing, and social activities.[59] The proposed modified Transportation item would collect information on whether a lack of reliable transportation has kept the resident from medical appointments, meetings, work or from getting things needed for daily living, rather than collecting the information separately. As discussed previously, we believe reliable transportation services are fundamental to a person's overall

[57] The seven SDOH items are ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation (84 FR 38805 through 38818).

[58] Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121).

[54] Centers for Medicare & Medicaid Services, FY2023 IPPS/LTCH PPS final rule (87 FR 49202 through 49215).

[59] Victoria Transport Policy Institute. (2016, August 25). Basic access and basic mobility: Meeting society's most important transportation needs. Retrieved from *http://www.vtpi.org/tdm/tdm103.htm*.

health, and as a result, the burden of collecting this information separately outweighs its potential benefit.

For the reasons stated previously, we are proposing to modify A1250. Transportation based on the Transportation item adopted for use in the AHC HRSN Screening Tool and adapted from the PRAPARE tool. The proposed Transportation item asks, ''In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?'' The proposed response options are: (0) Yes; (1) No; (7) Resident declines to respond; and (8) Resident unable to respond. A draft of the proposed modified Transportation item can be found in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

We invite comment on the proposal to modify the current Transportation item previously adopted as a standardized patient assessment data element under the SDOH category beginning with the FY 2027 SNF QRP.

D. SNF QRP Quality Measure Concepts Under Consideration for Future Years—Request for Information (RFI)

We are seeking input on the importance, relevance, appropriateness, and applicability of each of the concepts under consideration listed in Table 29 for future years in the SNF QRP. In the FY 2024 SNF PPS proposed rule (88 FR 21353 through 21355), we published a request for information (RFI) on a set of principles for selecting and prioritizing SNF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps. Within this proposed rule, we also sought input on data available to develop measures, approaches for data collection, perceived challenges or barriers, and approaches for addressing identified challenges. We refer readers to the FY 2024 SNF PPS final rule (88 FR 53265 through 53267) for a summary of the public comments we received in response to the RFI.

Subsequently, our measure development contractor convened a Technical Expert Panel (TEP) on December 15, 2023 to obtain expert input on the future measure concepts that could fill the measurement gaps identified in our FY 2024 RFI.[60] The TEP also discussed the alignment of PAC and Hospice measures with CMS' ''Universal Foundation'' of quality measures.[61] The Universal Foundation aims to focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for comparisons across programs, and help identify measurement gaps.

In consideration of the feedback we have received through these activities, we are seeking input on four concepts for the SNF QRP. One is a composite of vaccinations,[62] which could represent overall immunization status of residents such as the Adult Immunization Status measure[63] in the Universal Foundation. A second concept on which we are seeking feedback is the concept of depression for the SNF QRP, which may be similar to the Clinical Screening for Depression and Follow-up measure[64] in the Universal Foundation. Finally, we are seeking feedback on the concepts of pain management and patient experience of care/patient satisfaction for the SNF QRP.

TABLE 29—FUTURE MEASURE CONCEPTS UNDER CONSIDERATION FOR THE SNF QRP

Quality measure concepts
Vaccination Composite.
Pain Management.
Depression.
Patient Experience of Care/Patient Satisfaction.

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

E. Form, Manner, and Timing of Data Submission Under the SNF QRP

1. Background

We refer readers to the current regulatory text at § 413.360(b) for information regarding the policies for reporting specified data for the SNF QRP.

2. Proposed Reporting Schedule for the Proposed New Standardized Patient Assessment Data Elements, and the Modified Transportation Data Element, Beginning October 1, 2025 for the FY 2027 SNF QRP

As discussed in section VI.C.3. and VI.C.5. of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category (one Living Situation item, two Food items, and one Utilities item) and to modify the Transportation standardized patient assessment data element previously adopted under the SDOH category beginning with the FY 2027 SNF QRP.

We are proposing that SNFs would be required to report these new items and the modified Transportation item using the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP. Starting in CY 2026, SNFs would be required to submit data for the entire calendar year for each program year.

We are also proposing that SNFs that submit the Living Situation, Food, and Utilities items proposed for adoption as standardized patient assessment data elements under the SDOH category with respect to admission only would be deemed to have submitted those items with respect to both admission and discharge. We propose that SNFs would be required to submit these items at admission only (and not at discharge) because it is unlikely that the assessment of those items at admission would differ from the assessment of the same item at discharge. This would align the data collection for these proposed items with other SDOH items (that is, Race, Ethnicity, Preferred Language, and Interpreter Services) which are only collected at admission.[65] A draft of the proposed items is available in the Downloads section of the SNF QRP Measures and Technical Information web page at *https://www.cms.gov/medicare/quality/snf-quality-reporting-program/measures-and-technical-information.*

As we noted in section VI.C.5 of this proposed rule, we continually assess the

[60] The Post-Acute Care (PAC) and Hospice Quality Reporting Program Cross-Setting TEP summary report will be published in early summer or as soon as technically feasible. SNFs can monitor the Partnership for Quality Measurement website at *https://mmshub.cms.gov/get-involved/technical-expert-panel/updates* for updates.

[61] Centers for Medicare & Medicaid Services. Aligning Quality Measures Across CMS—the Universal Foundation. November 17, 2023. *https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.*

[62] A composite measure can summarize multiple measures through the use of one value or piece of information. More information can be found at *https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/downloads/composite-measures.pdf.*

[63] CMS Measures Inventory Tool. Adult immunization status measure found at *https://cmit.cms.gov/cmit/#/FamilyView?familyId=26.*

[64] CMS Measures Inventory Tool. Clinical Depression Screening and Follow-Up measure found at *https://cmit.cms.gov/cmit/#/FamilyView?familyId=672.*

[65] FY 2020 SNF PPS final rule (84 FR 38817 through 38818).

implementation of the new SDOH items, including A1250. Transportation, as part of our routine item and measure monitoring work. We received feedback from interested parties in response to the FY 2020 SNF PPS proposed rule (84 FR 17676 through 17678) noting their concern with the burden of collecting the Transportation item at admission and discharge. Specifically, commenters stated that a resident's access to transportation is unlikely to change between admission and discharge. We analyzed the data SNFs reported from October 1, 2023 through December 31, 2023 (Quarter 4 of CY 2023) and found that residents' responses do not significantly change from admission to discharge.[66] Specifically, the proportion of residents [67] who responded ''Yes'' to the Transportation item at admission versus at discharge differed by only 0.60 percentage points during this period. We find these results convincing, and therefore are proposing to require SNFs to collect and submit the proposed modified standardized patient assessment data element, Transportation, at admission only.

We invite public comment on our proposal to collect data on the following items proposed as standardized patient assessment data elements under the SDOH category at admission only beginning with October 1, 2025 SNF admissions: (1) Living Situation as described in section VI.C.3(a) of this proposed rule; (2) Food as described in section VI.C.3(b) of this proposed rule; and (3) Utilities as described in section VI.C.3(c) of this proposed rule. We also invite comment on our proposal to collect the proposed modified standardized patient assessment data element, Transportation, at admission only beginning with October 1, 2025 SNF admissions as described in section VI.C.5 of this proposed rule.

3. Proposal To Participate in a Validation Process Beginning With the FY 2027 SNF QRP

Section 1888(h)(12)(A) of the Act (as added by section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260)) requires the Secretary to apply a process to validate data submitted under the SNF QRP. Accordingly, we are proposing to require SNFs to participate in a validation process that would apply to data submitted using the MDS and SNF Medicare fee-for-service claims as a SNF QRP requirement beginning with the FY 2027 SNF QRP. We are also proposing to amend the regulation text at § 413.360.

We are also considering additional validation methods that may be appropriate to include in the future for the current measures submitted through the National Healthcare Safety Network (NHSN), as well as for other new measures we may consider for the program. Any updates to specific program requirements related to the validation process would be addressed through separate and future notice-and-comment rulemaking, as necessary.

(a) Proposal To Participate in a Validation Process for Assessment-Based Measures

The MDS is a resident assessment instrument that SNFs must complete for all residents in a Medicare or Medicaid certified nursing facility, and for residents whose stay is covered under SNF PPS in a non-critical access hospital swing bed facility. The MDS includes the resident in the assessment process, and uses standard protocols used in other settings to improve clinical assessment and support the credibility of programs that rely on MDS, like the SNF QRP.[68]

We are proposing to adopt a similar validation process for the SNF QRP that we have adopted for the SNF Value-Based Purchasing (VBP) program in the FY 2024 SNF PPS final rule (88 FR 53323 through 53325) beginning with the FY 2027 SNF QRP. This method would closely align with the validation process we have adopted for the SNF VBP program and would have the following elements:

- We propose that our validation contractor would select, on an annual basis, up to 1,500 SNFs that submit at least one MDS record in the calendar year (CY) 3 years prior to the applicable FY SNF QRP. For example, for the FY 2027 SNF QRP, we would choose up to 1,500 SNFs that submitted at least one MDS record in CY 2024. We are also proposing that the SNFs that are selected to participate in the SNF QRP validation for a program year would be the same SNFs that are randomly selected to participate in the SNF VBP validation process for the corresponding SNF VBP program year.
- We propose that our validation contractor would request up to 10 medical records from each of the selected SNFs. Each SNF selected would only be required to submit records once in a fiscal year, for a maximum of 10 records for each SNF selected. To decrease the burden for the selected SNF, we are proposing that the validation contractor would request that the SNFs submit the same medical records, at the same time, that are required from the same SNFs for purposes of the SNF VBP validation.
- We propose that the selected SNFs would have the option to submit digital or paper copies of the requested medical records to the validation contractor and would be required to submit the medical records within 45 days of the date of the request (as documented on the request). If the validation contractor has not received the medical records within 30 days of the date of the request, the validation contractor would send the SNF a reminder in writing to inform the SNF that it must submit the requested medical records within 45 days of the date of the initial request.

We propose that if a SNF does not submit the requested number of medical records within 45 days of the initial request, we would, under section 1888(e)(6)(A) of the Act, reduce the SNF's otherwise applicable annual market basket percentage update by 2 percent. The reduction would be applied to the payment update 2 fiscal years after the fiscal year for which the validation contractor requested records. For example, if the validation contractor requested records for FY 2027, and the SNF did not send them, we would reduce the SNF's otherwise applicable annual market basket percentage update by 2 percent for the FY 2029 SNF QRP.

We also intend to propose in future rulemaking the process by which we would evaluate the submitted medical records against the MDS to determine the accuracy of the MDS data that the SNF reported and that CMS used to calculate the measure results. We invite public comment on what that process could include.

We solicit public comments on our proposal to require SNFs who participate in the SNF QRP to participate in a validation process for assessment-based measures beginning with the FY 2027 SNF QRP.

(b) Proposal To Apply the Existing Validation Process for Claims-Based Measures Reported in the SNF QRP

Beginning with the FY 2027 SNF QRP, we are proposing to apply the process we currently use to ensure the accuracy of the Medicare fee-for-service claims to validate claims-based measures under the SNF QRP. Specifically, information reported

[66] Due to data availability of SNF SDOH standardized patient assessment data elements, this is based on one quarter of Transportation data.

[67] The analysis is limited to residents who responded to the Transportation item at both admission and discharge.

[68] Centers for Medicare and Medicaid Services (CMS). (2023, March 29). Minimum Data Set (MDS) 3.0 for Nursing Homes and Swing Bed Providers. *https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqimds30.*

through Medicare Part A fee-for-service claims are validated for accuracy by Medicare Administrative Contractors (MACs) to ensure accurate Medicare payments. MACs use software to determine whether billed services are medically necessary and should be covered by Medicare, review claims to identify any ambiguities or irregularities, and use a quality assurance process to help ensure quality and consistency in claim review and processing. They conduct prepayment and post-payment audits of Medicare claims, using both random selection and targeted reviews based on analyses of claims data.

We use data to calculate claims-based measures for the SNF QRP. We believe that adopting the MAC's existing process of validating claims for medical necessity through targeted and random audits would satisfy the statutory requirement to adopt a validation process for data submitted under the SNF QRP for claims-based measures at section 1888(h)(12)(A) of the Act (as added by section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260)).

We solicit public comment on our proposal to apply the MAC's existing validation process for the SNF QRP claims-based measures beginning with the FY 2027 program year.

(c) Proposal To Amend the Regulation Text at § 413.360

We propose to amend our regulation at § 413.360 to reflect these proposed policies. Specifically, we propose to add (g) to our regulation at § 413.360, which will incorporate the procedural requirements we are proposing for these validation processes for SNF QRP under these sections VI.E.3(a) and VI.E.3(b). We also propose to add paragraph (f)(1)(iv) to our regulation at § 413.360 to establish that, if the SNF is selected for the validation process, the SNF must submit up to 10 medical records requested, in their entirety. Finally, we propose minor technical amendments for our regulation at § 413.360(f)(3) to apply to all data completion thresholds implemented in § 413.360(f)(1).

We solicit public comments on our proposal to amend our regulation at § 413.360.

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

We are not proposing any new policies regarding the public display of measure data at this time. For a discussion about our policies regarding public display of SNF QRP measure data and procedures for the SNF's opportunity to review and correct data and information, we refer readers to the FY 2017 SNF PPS final rule (81 FR 52045 through 52048).

VII. Proposed Updates to the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

A. Statutory Background

Through the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, we award incentive payments to SNFs to encourage improvements in the quality of care provided to Medicare beneficiaries. The SNF VBP Program is authorized by section 1888(h) of the Act, and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing bed rural hospitals. We believe the SNF VBP Program has helped to transform how Medicare payment is made for SNF care, moving increasingly towards rewarding better value and outcomes instead of merely rewarding volume. Our codified policies for the SNF VBP Program can be found in our regulations at 42 CFR 413.337(f) and 413.338.

1. Spotlight on the CMS National Quality Strategy

As part of the CMS National Quality Strategy,[69] we are committed to aligning measures across our quality programs and ensuring we measure quality across the entire care continuum in a way that promotes the best, safest, and most equitable care for all individuals.

We believe that improving alignment of measures across the CMS quality programs will reduce provider burden while also improving the effectiveness of quality programs. However, we also recognize that a one-size-fits-all approach would fail to capture important aspects of quality in our healthcare system across populations and care settings.

To move towards a more streamlined approach that does not lose sight of important aspects of quality, we are implementing a building-block approach: a ''Universal Foundation'' of quality measures across as many of our quality reporting and value-based care programs as possible, with additional measures added on depending on the population or setting (''add-on sets'').[70]

Our goal with the Universal Foundation is to focus provider attention on measures that are the most meaningful for patients and patient outcomes, reduce provider burden by streamlining and aligning measures, allow for consistent stratification of measures to identify disparities in care between and among populations, accelerate the transition to interoperable, digital quality measures, and allow for comparisons across quality and value-based care programs to better understand what drives quality improvement and what does not.

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

We believe that the creation of this Universal Foundation will result in higher quality care for the more than 150 million Americans covered by our programs and will serve as an alignment standard for the rest of the healthcare system. We continue to collect feedback from interested parties through listening sessions, requests for information and proposed rulemaking, and other interactions to refine our approach as we work to implement the Universal Foundation across our quality programs. As we continue building the SNF VBP measure set, we intend to align with the measures in the Universal Foundation, as well as the post-acute care add-on measure set, to the extent feasible.

B. Proposed Regulation Text Technical Updates

We are proposing to make several technical updates to our regulation text. First, we are proposing to update § 413.337(f) to correct the cross-references in that section to § 413.338(a). Second, we are proposing to update the definition of ''SNF readmission measure'' in § 413.338(a) by replacing the references to the Skilled Nursing Facility Potentially Preventable Readmissions (SNFPPR) measure with a reference to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure, by clarifying that we specified both measures under section 1888(g) of the Act, and by clarifying that the SNF readmission measure will be the SNF WS PPR beginning October 1, 2027.

This change would align the definition of ''SNF readmission measure'' with policies we have previously finalized for SNF VBP, including that we will not use the SNFPPR and that we will replace the SNFRM with the SNF WS PPR beginning October 1, 2027. In addition,

[69] *https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy.*

[70] *https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.*

we are proposing to redesignate the term ''performance score'' at § 413.338(a) with the term ''SNF performance score'' for consistency with the terminology we are now using in the Program, and to make conforming edits to the last sentence of § 413.337(f). We are also proposing to replace the references to ''program year'' with ''fiscal year'' in the definitions of ''health equity adjustment (HEA) bonus points,'' ''measure performance scaler'', ''top tier performing SNF'', and ''underserved multiplier'' to align the terminology with that used in the remainder of that section.

We are also proposing to update § 413.338(f) to redesignate paragraphs (f)(1) through (4) as paragraphs (f)(2) through (5), respectively. We are also proposing to add a new paragraph (f)(1) and to revise the newly redesignated paragraphs (f)(2) and (3).

In addition, we are proposing to update § 413.338(j)(3) to include additional components of the MDS validation process that we finalized in the FY 2024 SNF PPS final rule (88 FR 53324). In particular, we are proposing to include the SNF selection, medical record request, and medical record submission processes for MDS validation.

Further, we are proposing to remove § 413.338(d)(5) from the regulation text because the only measure that will be in the SNF VBP Program until the FY 2026 program year is the SNFRM, and to add new paragraph (l)(1) which would state that the SNF VBP measure set for each year includes the statutorily-required SNF readmission measure, and beginning with the FY 2026 program year, up to nine additional measures specified by CMS.

We welcome public comment on these proposed technical updates to our regulation text.

C. SNF VBP Program Measures

1. Background

We refer readers to the FY 2024 SNF PPS final rule for background on the measures we have adopted for the SNF VBP Program (88 FR 53276 through 53297).

Table 30 lists the measures that have been adopted for the SNF VBP Program, along with their timeline for inclusion.

TABLE 30—SNF VBP PROGRAM MEASURES AND TIMELINE FOR INCLUSION IN THE PROGRAM

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

2. Proposal To Adopt a Measure Selection, Retention, and Removal Policy Beginning With the FY 2026 SNF VBP Program Year

Section 1888(h)(2) of the Act requires the Secretary to apply the measure specified under subsection (g)(1) (currently the SNFRM) and replace that measure, as soon as practicable, with the measure specified under subsection (g)(2) (currently the SNF WS PPR measure). That section also allows the Secretary to apply, as appropriate, up to nine additional measures to the SNF VBP Program, in addition to the statutorily required SNF Readmission Measure. We have now adopted seven additional measures for the Program (see the FY 2023 SNF PPS final rule (87 FR 47564 through 47580) and the FY 2024 SNF PPS final rule (88 FR 53280 through 53296)).

Now that the SNF VBP Program includes measures in addition to the SNFRM (which will be replaced with the SNF WS PPR measure beginning with the FY 2028 program year), we believe it is appropriate to adopt a policy that governs the retention of measures in the Program, as well as criteria we would use to consider whether a measure should be removed from the Program. These policies would help ensure that the Program's measure set remains focused on the best and most appropriate metrics for assessing care quality in the SNF setting. We also believe that the measure removal policy, as described later in this section, would streamline the rulemaking process by providing a sub-regulatory process that we could utilize to remove measures from the Program that raise safety concerns while also providing sufficient opportunities for the public to consider, and provide input on, future proposals to remove a measure.

Other CMS quality reporting programs, including the SNF QRP and Hospital Inpatient Quality Reporting (IQR) Program, have adopted similar policies. For example, in the FY 2016 SNF PPS final rule (80 FR 46431 through 46432), the SNF QRP adopted 7 removal factors and, in the FY 2019 SNF PPS final rule (83 FR 39267 through 39269), the SNF QRP adopted an additional measure removal factor, such that a total of eight measure removal factors are now used to determine whether a measure should be removed. The SNF QRP also codified those factors at § 413.360(b)(2).

For the purposes of the SNF VBP Program, we are proposing to adopt the following measure selection, retention, and removal policy beginning with the FY 2026 SNF VBP program year. This proposed policy would apply to all SNF VBP measures except for the SNF readmission measure because we are statutorily required to retain that measure in the measure set.

First, we are proposing that when we adopt a measure for the SNF VBP Program for a particular program year, that measure would be automatically retained for all subsequent program years unless we propose to remove or replace the measure. We believe that this policy would make clear that when we adopt a measure for the SNF VBP Program, we intend to include that measure in all subsequent program

years. This policy would also avoid the need to continuously propose a measure for subsequent program years.

Second, we are proposing that we would use notice and comment rulemaking to remove or replace a measure in the SNF VBP Program to allow for public comment. We are also proposing that we would use the following measure removal factors to determine whether a measure should be considered for removal or replacement:

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

(2) Performance and improvement on a measure do not result in better resident outcomes;

(3) A measure no longer aligns with current clinical guidelines or practices;

(4) A more broadly applicable measure for the particular topic is available;

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

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

(7) The collection or public reporting of a measure leads to negative unintended consequences other than resident harm; and

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

Each of these measure removal factors represent instances where the continued use of a measure in the Program would not support the Program's objective, which is to incentivize improvements in quality of care by linking SNF payments to performance on quality measures. Therefore, we believe that these are appropriate criteria for determining whether a measure should be removed or replaced.

Third, upon a determination by CMS that the continued requirement for SNFs to submit data on a measure raises specific resident safety concerns, we are proposing that we may elect to immediately remove the measure from the SNF VBP measure set. Upon removal of the measure, we would provide notice to SNFs and the public, along with a statement of the specific patient safety concerns that would be raised if SNFs continued to submit data on the measure. We would also provide notice of the removal in the **Federal Register**.

We are proposing to codify this policy at § 413.338(l)(2) and (l)(3) of our regulations.

We invite public comment on the proposed measure selection, retention, and removal policy. We also invite public comment on our proposal to codify this policy at § 413.338(l)(2) and (3).

3. Future Measure Considerations

Section 1888(h)(2) of the Act allows the Secretary to apply, as appropriate, up to nine additional measures to the SNF VBP Program, in addition to the statutorily required SNF Readmission Measure. These measures may include measures of functional status, patient safety, care coordination, or patient experience.

In the FY 2022 SNF PPS proposed rule (86 FR 20009 through 20011), we requested public comment on potential future measures to include in the expanded SNF VBP Program. After considering the public input we received, we adopted three new measures in the FY 2023 SNF PPS final rule (87 FR 47564 through 47580). Two of those measures will be scored beginning with the FY 2026 program year: SNF HAI and Total Nurse Staffing measures; and the third measure will be scored beginning with the FY 2027 program year: DTC PAC SNF measure. In the FY 2024 SNF PPS final rule (88 FR 53280 through 53296), we adopted four additional measures. One of those measures, the Nursing Staff Turnover measure, will be scored beginning with the FY 2026 program year, while the other three measures will be scored beginning with the FY 2027 program year: Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalizations measures.

With the adoption of those seven measures, in addition to the statutorily-required SNF Readmission Measure, the SNF VBP Program will include eight measures that cover a range of quality measure topics important for assessing the quality of care in the SNF setting. Therefore, as permitted under section 1888(h)(2)(A)(ii) of the Act, we can add up to two additional measures in the Program.

As part of our efforts to build a robust measure set for the SNF VBP Program, we are considering several options related to new measures and other measure set adjustments. First, we recognize that gaps remain in the current measure set and therefore, we are considering which measures are best suited to fill those gaps. Specifically, we are assessing several resident experience measures to determine their appropriateness and feasibility for inclusion in the Program. We are also testing the appropriateness of measures that address other CMS priorities, such as interoperability and health equity/social determinants of health.

Beyond the adoption of new measures, we are also considering other measure set adjustments. For example, we are assessing the feasibility of a staffing composite measure that would combine the two previously adopted staffing measures. We are also considering whether measure domains and domain weighting are appropriate for the SNF VBP Program.

While we are not proposing any new measures or measure set adjustments in this proposed rule, we will continue to assess and determine which, if any, of these options would help us maximize the impact of the SNF VBP Program measure set and further incentivize quality of care improvements in the SNF setting. We welcome commenters' continuing feedback on potential new measure topics and other measure set adjustments.

D. SNF VBP Performance Standards

1. Background

We refer readers to the FY 2024 SNF PPS final rule (88 FR 53299 through 53300) for a detailed history of our performance standards policies.

In the FY 2024 SNF PPS final rule (88 FR 53300), we adopted the final numerical values for the FY 2026 performance standards and the final numerical values for the FY 2027 performance standards for the DTC PAC SNF measure.

2. Estimated Performance Standards for the FY 2027 Program Year

In the FY 2024 SNF PPS final rule (88 FR 53300), we adopted the final numerical values for the FY 2027 performance standards for the DTC PAC SNF measure.

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated numerical performance standards for the remaining measures applicable for the FY 2027 program year: SNFRM, SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury (Long-Stay), Long Stay Hospitalization, and DC Function measures. In accordance with our previously finalized methodology for calculating performance standards (81 FR 51996 through 51998), the estimated numerical values for the FY 2027 program year performance standards are shown in Table 31.

TABLE 31—ESTIMATED FY 2027 SNF VBP PROGRAM PERFORMANCE STANDARDS

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

3. Estimated Performance Standards for the FY 2028 Program Year

In the FY 2024 SNF PPS final rule (88 FR 53280 through 53281), we finalized that the SNF WS PPR measure will replace the SNFRM beginning with the FY 2028 program year. In that final rule (88 FR 53299 through 53300), we also finalized that the baseline and performance periods for the SNF WS PPR measure would each be 2 consecutive years, and that FY 2025 and FY 2026 would be the performance period for the SNF WS PPR measure for the FY 2028 program year.

To meet the requirements at section 1888(h)(3)(C) of the Act, we are providing estimated numerical performance standards for the FY 2028 program year for the SNF WS PPR measure as well as the DTC PAC SNF measure. In accordance with our previously finalized methodology for calculating performance standards (81 FR 51996 through 51998), the estimated numerical values for the FY 2028 program year performance standards for the DTC PAC SNF and SNF WS PPR measures are shown in Table 32.

We note that we will provide the estimated numerical performance standards values for the remaining measures applicable in the FY 2028 program year in the FY 2026 SNF PPS proposed rule.

TABLE 32—ESTIMATED FY 2028 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure short name	Achievement threshold	Benchmark
DTC PAC SNF Measure	0.42946	0.66370
SNF WS PPR Measure	0.86756	0.92527

4. Proposed Policy for Incorporating Technical Measure Updates Into Measure Specifications and for Subsequent Updates to SNF VBP Performance Standards Beginning With the FY 2025 Program Year

We are required under section 1888(h)(3) of the Act to establish performance standards for SNF VBP measures for a performance period for a fiscal year. Under that section, we are also required to establish performance standards that include levels of achievement and improvement, the higher of which is used to calculate the SNF performance score, and to announce those performance standards no later than 60 days prior to the beginning of the performance period for the applicable fiscal year. We refer readers to the FY 2017 SNF PPS final rule (81 FR 51995 through 51998) for details on our previously finalized performance standards methodology.

In the FY 2019 SNF PPS final rule (83 FR 39276 through 39277), we finalized a policy that allows us to update the numerical values of the performance standards for a fiscal year if we discover an error in the performance standards calculations. Under this policy, if we discover additional errors with respect to that fiscal year, we will not further update the numerical values for that fiscal year.

In this proposed rule, we are proposing to adopt a policy that would allow us to update previously finalized SNF VBP measure specifications using subregulatory processes to incorporate technical measure updates. We are also proposing to use sub-regulatory processes to update the numerical values of the performance standards for a measure if that measure's specifications have been technically updated.

We currently calculate performance standards for SNF VBP measures using baseline period data, which are then used, in conjunction with performance period data, to calculate performance scores for SNFs on each measure for the applicable program year. However, during the long interval between the time we finalize the performance standards for the measures and the time that we calculate the achievement and improvement scores for those measures based on actual SNF performance, one or more of the measures may have been technically updated in a way that inhibits our ability to ensure that we are making appropriate comparisons between the baseline and performance period. We believe that to calculate the most accurate achievement and improvement scores for a measure, we should calculate the performance standards, baseline period measure results, and performance period measure results using the same measure specifications.

Therefore, we are proposing to incorporate technical measure updates into the measure specifications we have adopted for the SNF VBP Program so that these measures remain up-to-date and ensure that we can make fair comparisons between the baseline and performance periods that we adopt under the Program. Further, we are proposing that we would incorporate these technical measure updates in a sub-regulatory manner and that we would inform SNFs of any technical measure updates for any measure through postings on our SNF VBP website, listservs, and through other educational outreach efforts to SNFs. These types of technical measure updates do not substantively affect the measure rate calculation methodology. We also recognize that some updates to measures are substantive in nature and may not be appropriate to adopt without further rulemaking. In those instances, we would continue to use rulemaking to adopt substantive updates to SNF VBP measures.

With respect to what constitutes substantive versus non-substantive (technical) measure changes, we would make this determination on a case-by-case basis. Examples of technical measure changes may include, but are not limited to, updates to the case-mix or risk adjustment methodology, changes in exclusion criteria, or updates required to accommodate changes in the content and availability of assessment data. Examples of changes that we might consider to be substantive would be those in which the changes are so significant that the measure is no longer the same measure.

We are also proposing to expand our performance standards correction policy beginning with the FY 2025 program year such that we would be able to update the numerical values for the performance standards for a measure for a program year if a measure's specifications were technically updated between the time that we published the performance standards for a measure and the time that we calculate SNF performance on that measure at the conclusion of the applicable performance period. Any update we would make to the numerical values would be announced via the SNF VBP website, listservs, and through other educational outreach efforts to SNFs. In addition, this proposal would have the effect of superseding the performance standards that we establish prior to the start of the performance period for the affected measures, but we believe them to be necessary to ensure that the performance standards in the SNF VBP Program's scoring calculations enable the fairest comparison of measure performance between the baseline and performance period.

We note that these proposals align with the Technical Updates Policy for Performance Standards that we adopted for the Hospital VBP Program in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50077 through 50079).

Further, we are proposing to codify these proposals in our regulations. Specifically, we are proposing to codify our proposed policy to incorporate technical measure updates into previously finalized SNF VBP measure specifications in a subregulatory manner by adding a new paragraph (l)(4) to our regulations at § 413.338. Our current performance standards policies are codified at § 413.338(d)(6) of our regulations. However, we are proposing to redesignate that paragraph as new § 413.338(n) of our regulations and to include in paragraph (n) both the existing performance standards policies and this newly proposed expansion of our performance standards correction policy.

We invite public comment on these proposals.

E. SNF VBP Performance Scoring Methodology

1. Background

We refer readers to the FY 2024 SNF PPS final rule (88 FR 53300 through 53304) for a detailed history of our performance scoring methodology. Our performance scoring methodology is codified at §§ 413.338(d) and (e) of our regulations. We have also codified the Health Equity Adjustment (HEA) at § 413.338(k) of our regulations.

2. Proposed Measure Minimum Policies

a. Background

We refer readers to the FY 2024 SNF PPS final rule (88 FR 53301 through 53303) for details on our previously adopted case minimums and measure minimums. Our case minimum and measure minimum policies are also codified at § 413.338(b) of our regulations. In this proposed rule, we are proposing to apply the previously finalized FY 2027 measure minimum to the FY 2028 program year and subsequent years. We are not proposing any changes to our previously finalized case minimums.

b. Proposal To Apply the FY 2027 Measure Minimum to the FY 2028 SNF VBP Program Year and Subsequent Years

In the FY 2024 SNF PPS final rule (88 FR 53301 through 53303), we adopted an updated measure minimum for the FY 2027 program year. Specifically, we finalized that for a SNF to receive a SNF performance score and value-based incentive payment for the FY 2027 program year, SNFs must report the minimum number of cases for four of the eight measures during the applicable performance period. As discussed below, we are proposing to apply this measure minimum to the FY 2028 program year and subsequent years, such that SNFs must report the minimum number of cases for at least four measures during the applicable performance period. SNFs that do not meet this measure minimum requirement would be excluded from the applicable program year and would receive their adjusted Federal per diem rate for that fiscal year.

Based on our analyses for the FY 2028 program year, which are also applicable to subsequent program years for which we use the same measure set, we estimate that, under the proposed measure minimum, approximately 6 percent of SNFs would be excluded from the Program compared to the approximately 8 percent of SNFs that we estimate would be excluded from the Program in FY 2027. This represents fewer SNFs being excluded from the FY 2028 program year than our estimated number of SNFs that would be excluded from the FY 2027 program year, due to the SNF WS PPR measure replacing the SNFRM beginning in FY 2028. We also assessed the consistency of incentive payment multipliers (IPMs), or value-based incentive payment adjustment factors, between FY 2027 and FY 2028 as a proxy for SNF performance score reliability. We found that applying the FY 2027 measure minimum to the FY 2028 program year would have minimal impact on the percentage of SNFs that would receive a net-positive IPM between those two fiscal years, which indicates that the reliability of the SNF performance score would be minimally impacted if we applied the FY 2027 measure minimum to the FY 2028 program year. Based on these testing results for FY 2028, we believe that applying the FY 2027 measure minimum to the FY 2028 program year and subsequent years best balances SNF performance score reliability with our desire to ensure that as many SNFs as possible can receive a SNF performance score. We note that if we propose in future years to revise the total number of measures in the Program, we would reassess this measure minimum policy to ensure it continues to meet our previously stated goals. If needed, we would propose updates in future rulemaking.

We invite public comment on our proposal to apply the FY 2027 measure minimum in which SNFs must report the minimum number of cases for at least four measures during the performance period to the FY 2028 SNF VBP program year and subsequent years.

3. Potential Next Steps for Health Equity in the SNF VBP Program

In the FY 2024 SNF PPS final rule (88 FR 53304 through 53318), we adopted a Health Equity Adjustment (HEA) that allows SNFs that provide high quality care and care for high proportions of SNF residents who are underserved to earn bonus points. We refer readers to that final rule for an overview of our definition of health equity, current disparities in quality of care in the SNF setting, our commitment to advancing health equity, and the details of the HEA.

In the FY 2024 SNF PPS proposed rule (88 FR 21393 through 21396), we also included a request for information

(RFI) entitled ''Health Equity Approaches Under Consideration for Future Program Years,'' where we noted that significant disparities in quality of care persist in the SNF setting. We stated that the goal of explicitly incorporating health equity-focused components into the Program was to both measure and incentivize equitable care in SNFs. Although the HEA rewards high performing SNFs that care for high proportions of SNF residents with underserved populations, it does not explicitly measure or reward high provider performance among the disadvantaged or underserved population. We remain committed to achieving equity in health outcomes for residents by promoting SNF accountability for addressing health disparities, supporting SNFs' quality improvement activities to reduce these disparities, and incentivizing better care for all residents. Through the RFI, we solicited public comment on possible health equity advancement approaches to incorporate into the Program in future program years that could supplement or replace the HEA. We refer readers to the FY 2024 SNF PPS final rule (88 FR 53322) for a summary of the public comments we received in response to the health equity RFI. We are considering these comments as we continue to develop policies, quality measures, and measurement strategies on this important topic.

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

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

We are testing these various measure concepts to determine where current across- and within-provider disparities exist in performance, how we can best incentivize SNFs to improve their quality of care for all residents, including those who may be underserved, and the feasibility of incorporating a health equity-focused measure into the Program.

As we explore these and other options, we are focusing on approaches that:

- Include as many SNFs as possible and are feasible to implement;
- Integrate feedback from interested parties;
- Encourage high quality performance for all SNFs among all residents and discourage low quality performance;
- Are simple enough for SNFs to understand and can be used to guide SNFs in improvement; and
- Meet the goal of incentivizing equitable care to ensure all residents in all SNFs receive high quality care.

We are also exploring how constraints, such as sample size limitations, may impact our ability to effectively incorporate certain approaches into the Program. Lastly, we continue to explore opportunities to align with other CMS programs to minimize provider burden.

F. Proposed Updates to the SNF VBP Review and Correction Process

1. Background

We refer readers to the FY 2024 SNF PPS final rule (88 FR 53325 through 53326) and to § 413.338(f) of our regulations for details on the SNF VBP Program's public reporting requirements and the two-phase review and correction process that we have adopted for the Program. We also refer readers to the SNF VBP website (*https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/confidential-feedback-reporting-review-and-corrections*) for additional details on our review and correction process. In Phase One of the review and correction process, we accept corrections for 30 days after distributing the following quarterly confidential feedback reports to SNFs: the two Full-Year Workbooks (one each for the baseline period and performance period), generally released in December and June, respectively. Corrections are limited to errors made by CMS or its contractors when calculating a measure rate. In the FY 2022 SNF PPS final rule (86 FR 42516 through 42517), we finalized that SNFs are not able to correct any of the underlying administrative claims data used to calculate a SNF's readmission measure rate during Phase One of the review and correction process. For corrections to the underlying administrative claims data to be reflected in the SNF VBP Program's quarterly confidential feedback reports, the SNF must submit the claims correction request to their MAC and the MAC must process the correction before the ''snapshot date.'' For the SNFRM, the quarterly confidential feedback reports will not reflect any claims corrections processed after the date of the claims snapshot, which is 3 months following the last index SNF admission in the applicable baseline period or performance period.

In Phase Two of the review and correction process, SNFs may submit corrections to SNF performance scores and rankings only. We accept Phase Two corrections for 30 days after distributing the Performance Score Report that we generally release in August of each year.

Under our current review and correction policy, the SNF must identify the error for which it is requesting correction, explain its reason for requesting the correction, and submit documentation or other evidence, if available, supporting the request. SNFs must submit correction requests to the SNF VBP Program Help Desk, which is currently available at *SNFVBP@rti.org,* and the requests must contain:

- The SNF's CMS Certification Number (CCN),
- The SNF's name,
- The correction requested, and
- The reason for requesting the correction, including any available evidence to support the request.

For all review and correction requests, we will review the requests and notify the requesting SNF of the final decision. We will also implement any approved corrections before the affected data becomes publicly available.

We are proposing to apply our existing Phase One of the review and correction process to all measures

adopted in the Program regardless of the data source for a particular measure. We are also proposing ''snapshot dates'' for the new SNF VBP measures and to codify those snapshot dates in revised § 413.338(f)(1). We are also proposing to redesignate current § 413.338(f)(1) as 413.338(f)(2) and to revise that paragraph to state that the underlying data used to calculate measure rates cannot be corrected by SNFs during the SNF VBP review and correction process.

2. Proposal To Apply the Existing Phase One Review and Correction Policy to All Claims-based Measures Beginning With the FY 2026 Program Year and Proposed ''Snapshot Dates'' for Recently Adopted SNF VBP Claims-based Measures

In the FY 2023 SNF PPS final rule, we adopted the SNF HAI measure beginning with the FY 2026 SNF VBP program year (87 FR 47564 through 47570), and the DTC PAC SNF measure beginning with the FY 2027 SNF VBP program year (87 FR 47576 through 47580). In the FY 2024 SNF PPS final rule, we adopted the Long-Stay Hospitalization measure beginning with the FY 2027 SNF VBP program year (88 FR 53293 through 53296), as well as the SNF WS PPR measure beginning with the FY 2028 SNF VBP program year (88 FR 53277 through 53280). Each of these measures is calculated using claims data.

We are proposing to apply our existing Phase One review and correction process to all SNF VBP Program measures calculated using claims data. That is, Phase One corrections for claims-based measures would be limited to errors made by CMS or its contractors when calculating the measure rates. For corrections to the underlying administrative claims data to be reflected in the SNF VBP Program's quarterly confidential feedback reports, the SNF must submit any claims correction requests to their MAC before the ''snapshot date'' to ensure that those corrections are reflected fully in measure calculations.

For the SNF HAI, DTC PAC SNF, and SNF WS PPR measures, we propose to define the ''snapshot date'' as 3 months following the last SNF discharge in the applicable baseline period or performance period to align with the ''snapshot date'' we previously adopted for the Program's Phase One review and correction process. We refer readers to the FY 2022 SNF PPS final rule (86 FR 42516 through 42517) where we explain our rationale for selecting 3 months as the ''snapshot date.'' Any corrections made to claims following the ''snapshot date'' would not be reflected in our subsequent scoring calculations.

For the Long Stay Hospitalization measure, we propose to define the ''snapshot date'' as 3 months following the final quarter of the applicable baseline period or performance period. For example, for the FY 2027 SNF VBP program year, the performance period is FY 2025. The final quarter of the performance period is July 1 through September 30, 2025. The ''snapshot date'' for this performance period would be December 31, 2025. Any corrections made to claims following the ''snapshot date'' would not be reflected in our subsequent scoring calculations.

We welcome public comment on this proposal.

3. Proposal To Apply the Existing Phase One Review and Correction Policy to PBJ-based Measures Beginning With the FY 2026 Program Year and Proposed ''Snapshot Dates'' for PBJ-Based Measures

In the FY 2023 SNF PPS final rule (87 FR 47570 through 47576), we adopted the Total Nurse Staffing measure beginning with the FY 2026 SNF VBP program year. Additionally, in the FY 2024 SNF PPS final rule (88 FR 53281 through 53286), we adopted the Nursing Staff Turnover measure beginning with the FY 2026 SNF VBP program year. Each of these measures is calculated using electronic staffing data submitted by each SNF for each quarter through the PBJ system, along with daily resident census information derived from MDS 3.0 standardized patient assessments in the case of the Total Nurse Staffing measure.

We are proposing to apply our existing Phase One review and correction process to SNF VBP Program measures calculated using PBJ data. That is, Phase One corrections would be limited to errors made by CMS or its contractors when calculating the measure rates for the PBJ-based measures applicable in the SNF VBP Program. For corrections to the underlying PBJ data to be reflected in the SNF VBP Program's quarterly confidential feedback reports, the SNF must make any corrections to the underlying data within the PBJ system before the ''snapshot date.'' Any corrections made to PBJ data following the ''snapshot date'' would not be reflected in our subsequent scoring calculations.

For measures calculated using PBJ data, we propose to define the ''snapshot date'' as 45 calendar days after the last day in each fiscal quarter. This deadline is consistent with the CMS Nursing Home Quality Improvement deadline, which requires that PBJ data submissions must be received by the end of the 45th calendar day (11:59 p.m. Eastern Time) after the last day in each fiscal quarter to be considered timely. We aim to align quality programs to the extent possible to reduce confusion and burden on providers. For more information about submitting PBJ data, we refer readers to the CMS Staffing Data Submission web page at *https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission.*

We welcome public comment on this proposal.

4. Proposal To Apply the Existing Phase One Review and Correction Policy to MDS-Based Measures Beginning With the FY 2027 Program Year and Proposed ''Snapshot Dates'' for the Recently Adopted SNF VBP MDS-Based Measures

In the FY 2024 SNF PPS final rule (88 FR 53286 through 53293), we adopted the Falls with Major Injury (Long-Stay) and DC Function measures, both beginning with the FY 2027 SNF VBP program year. These two measures are calculated using data reported by SNFs on the MDS 3.0.

We are proposing to apply our existing Phase One review and correction process to SNF VBP Program measures calculated using MDS data. That is, Phase One corrections would be limited to errors made by CMS or its contractors when calculating the measure rates for the MDS-based measures applicable in the SNF VBP Program. For corrections to the underlying MDS data to be reflected in the SNF VBP Program's quarterly confidential feedback reports, the SNF must make any corrections to the underlying data via the internet Quality Improvement Evaluation System (iQIES) before the ''snapshot date.''

For the DC Function and Falls with Major Injury (Long-Stay) measures, we propose that the ''snapshot date'' is the February 15th that is 4.5 months after the last day of the applicable baseline or performance period. However, if February 15th falls on a Friday, weekend, or Federal holiday, the data submission deadline is delayed until 11:59 p.m. ET on the next business day. For example, for the FY 2027 SNF VBP program year, the performance period is FY 2025 (October 1, 2024 through September 30, 2025). The ''snapshot date'' for this performance period would normally be February 15, 2026. However, since February 15, 2026 falls on a Sunday, the snapshot date would be extended until the next business day, which is Tuesday, February 17, 2026,

due to Monday, February 16, 2026 being a Federal holiday. This is consistent with the SNF QRP QM User's Manual available at *https://www.cms.gov/files/document/snf-qm-calculations-and-reporting-users-manual-v50.pdf-0.* Any corrections made to the MDS data following the ''snapshot date'' would not be reflected in our subsequent scoring calculations.

We welcome public comment on this proposal.

G. Proposed Updates to the SNF VBP Extraordinary Circumstances Exception Policy

1. Background

Our Extraordinary Circumstances Exception (ECE) policy, which allows SNFs to request an exception to the SNF VBP requirements for one or more calendar months when there are certain extraordinary circumstances beyond the control of the SNF, is currently codified at § 413.338(d)(4) of our regulations. We are proposing to redesignate that paragraph as new § 413.338(m) of our regulations to ensure the policy remains effective beyond FY 2025. We are also proposing to amend our existing ECE policy to include the proposed changes discussed later in this section, as well as to make other technical updates to enhance the clarity of the ECE policy in our regulations.

2. Proposal To Expand the Reasons a SNF May Submit an Extraordinary Circumstance Exception Request Beginning With the FY 2025 Program Year

Paragraph (d)(4)(ii) of our regulations currently states that a SNF may request an ECE if the SNF is able to demonstrate that an extraordinary circumstance affected the care provided to its residents and subsequent measure performance. We are proposing to expand this policy to also allow a SNF to request an ECE if the SNF can demonstrate that, as a result of the extraordinary circumstance, it cannot report SNF VBP data on one or more measures by the specified deadline. This expanded policy would avoid penalizing SNFs due to circumstances out of their control, and would also align the SNF VBP ECE policy with the ECE policies we have adopted for the SNF QRP and Home Health QRP.

If we grant an ECE to a SNF under the SNF VBP, we would, as previously finalized, calculate a SNF performance score that does not include the SNF's performance on the measure or measures during the months the SNF was affected by the extraordinary circumstance.

We welcome public comment on this proposal.

3. Proposed Updates to the Instructions for Requesting an Extraordinary Circumstance Exception Beginning With the FY 2025 Program Year

Under our current ECE policy, when a SNF requests an ECE, the SNF must complete an Extraordinary Circumstances Request form (available on *https://qualitynet.cms.gov*) and send the form, along with supporting documentation, to the SNF VBP Program Help Desk within 90 days of the date that the extraordinary circumstance occurred.

The most recent version of the ECE Request Form no longer includes information related to the SNF VBP Program. Although the previous form is still available, once it is no longer available, SNFs will no longer able to use this new version of the form when submitting an ECE request for the SNF VBP Program. Accordingly, we are proposing to update our policy to align with the current SNF QRP ECE request submission process, which does not require the completion of a form and instead requires SNFs to submit specific information via email to a Help Desk. Under our proposal, beginning with the FY 2025 program year, a SNF may request an ECE 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:

- The SNF's CMS Certification Number (CCN);
- The SNF's business name and business address;
- Contact information for the SNF's CEO or CEO-designated personnel, including all applicable names, email addresses, telephone numbers, and the SNF's physical mailing address (not a PO Box);
- A description of the event, including the dates and duration of the extraordinary circumstance;
- 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 SNF VBP measure data, including, but not limited to, photographs, media articles, and any other materials that would aid CMS in determining whether to grant the ECE;
- A date when the SNF believes it will again be able to fully comply with the SNF VBP Program's requirements and a justification for the proposed date.

We welcome public comment on these proposed updates to the SNF VBP ECE policy.

VIII. Nursing Home Enforcement

A. Background

The Biden-Harris Administration is committed to ensuring that all residents living in nursing homes receive safe, high-quality care. This includes making certain that all Americans, including older Americans and people with disabilities, live in a society that is accessible, inclusive, and equitable. To ensure that residents are receiving high quality, and safe care, long-term care facilities that participate in the Medicare or Medicaid program, or both must be certified as meeting Federal participation requirements. Long-term care facilities are certified as a skilled nursing facility in Medicare and nursing facility in Medicaid, or dually-certified in both programs, as specified in sections 1819 and 1919 of the Act, respectively, and in regulations at 42 CFR part 483, subpart B.

Section 1864(a) of the Act authorizes the Secretary to enter into agreements with State survey agencies to conduct surveys (that is, inspections) to determine whether skilled nursing facilities meet the Federal participation requirements for Medicare. Section 1902(a)(33)(B) of the Act provides for state survey agencies to perform the same survey tasks for facilities participating or seeking to participate in the Medicaid program. The results of these surveys are used by CMS and the State Medicaid agency, respectively, as the basis for a decision to enter into, deny, or terminate a provider agreement with the facility. They are also used to determine whether one or more enforcement remedies should be imposed when noncompliance with requirements is identified. Surveyors observe the provision of care and services to residents, conduct interviews, and review facility and residents' documentation to determine compliance with federal requirements and ensure the residents' health and safety are adequately protected.

Under sections 1819(f)(1) and 1919(f)(1) of the Act, the Secretary must ensure that the enforcement of compliance with the participation requirements is adequate to protect the health, safety, welfare, and rights of the residents and to promote the effective use of public money. Additionally, criteria must be specified as to when and how enforcement remedies are applied, the amounts of any fines, and the severity of each remedy imposed. Criteria must also be designed to minimize the time between the identification of violations and the final imposition of the remedies. Sections 1819(h)(2)(B) and 1919(h)(3)(C) of the

Act. One of the Federal statutory enforcement remedies available to the Secretary and the States to address facility noncompliance with the requirements is a civil money penalty (CMP). Under sections 1819(h)(2)(B)(ii)(I) and 1919(h)(3)(C)(ii)(I) of the Act, CMPs may be imposed to remedy noncompliance at amounts not to exceed $10,000 for each day of noncompliance (as annually adjusted by inflation by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015). The statute additionally permits the Secretary and the States to impose a CMP for each day of noncompliance, even if a facility has since returned to substantial compliance as documented by an intervening standard survey (sections 1819(h)(2)(A) and 1919(h)(1) and (3) of the Act providing that if a facility is found to be in compliance with the requirements, ''. . . but, as of a previous period, did not meet such requirements, [the Secretary provide for] a civil money penalty . . . for the days in which he finds that the facility was not in compliance with such requirements''). The Secretary must follow the procedures set out in section 1128A of the Act in processing these CMP remedies.

The regulations that govern the imposition of CMPs and other remedies authorized by the statute were published on November 10, 1994 (59 FR 56116) and subsequently revised on September 28, 1995 (60 FR 50118), March 18, 1999 (64 FR 13354 through 13360), March 18, 2011 (76 FR 15106), and September 6, 2016 (81 FR 61538). The nursing home enforcement rules are set forth in 42 CFR part 488, subpart F, and the provisions directly affecting CMPs imposed for noncompliance with the requirements are set forth in §§ 488.430 to 488.444. In general, the severity of an enforcement action is based on the extent and/or severity of harm or potential for more than minimal harm to residents that results from the cited noncompliance. This is intended to ensure prompt compliance, incentivizing the facility to take appropriate actions to permanently correct their noncompliance and protect residents' health and safety in the future. For example, if residents experienced serious harm due to noncompliance (including death), a less impactful enforcement remedy may not compel the facility to take the appropriate actions to prevent a similar event from occurring in the future, leaving residents at risk for serious harm, injury, or death.

Under 42 CFR 488.438, the amount of CMPs increases based on the severity and/or extent of the harm, or potential for more than minimal harm that might result from noncompliance. Current regulations at § 488.408 allow for penalties to be assessed in the upper range for $3,050 to $10,000 per day (PD) or $1,000 to $10,000 per instance (PI), as annually adjusted for inflation, for noncompliance that constitutes immediate jeopardy (IJ) to resident health and safety, while penalties in the lower range of $50 to $3,000 PD or $1,000 to $10,000 PI of noncompliance, as annually adjusted for inflation, may be imposed where immediate jeopardy does not exist.

Under the current regulations, the State and/or CMS must decide whether to select either a PD or PI CMP when considering whether a CMP will be used as a remedy. A PD CMP is an amount that may be imposed for each day a facility is not in compliance until the facility corrects the noncompliance and achieves substantial compliance. A PI CMP is an amount that is imposed for each instance that a facility is not in substantial compliance. The current enforcement regulations at 42 CFR part 488, subpart F do not authorize the use of both types of CMPs during the same survey, nor do they allow for multiple PI CMPs to be imposed for multiple instances within the same noncompliance deficiency that occurred on different days during a survey.

While there is no statutory limitation of both a PI and PD being imposed on the same survey, we specified in the rulemaking that revised § 488.430(a) (published on March 18, 1999 (64 FR 13360)), that we would not impose both PD and PI CMPs during a survey. Instead, the 1999 rule required that, ''a concomitant decision must be made whether the civil money penalty will be based on a determination of per instance or per day'' (64 FR at 13356). Additionally, we noted that an ''instance'' means a singular event of noncompliance or single deficiency under a distinct regulatory area identified by an administrative ''F tag'' number used as reference on the CMS–2567, Statement of Deficiencies. (*Id.*) We are proposing revisions to this limitation to enable more types of CMPs to be imposed during a survey once a CMP remedy is selected, allowing for penalties to be better aligned with the noncompliance identified during the survey and for more consistency of CMP amount across the nation. PI CMPs are often imposed in certain circumstances, such as when noncompliance existed but was corrected prior to the survey, and for isolated instances of noncompliance unrelated to resident abuse. PI CMPs may also be imposed in cases where a deficiency is found, but the facility has not had any citations of actual or serious harm on any survey in the past three years. A PI CMP has typically not been imposed for findings of abuse or neglect, when there is continued noncompliance, or when the facility has a past history of the same type of noncompliance causing actual harm to residents. PD CMPs, however, are generally imposed when these scenarios do not exist and the facility has a history of similar noncompliance. For example, if a facility was found to be out of compliance with the requirements to prevent accidents where a resident was injured during a transfer from a wheelchair to the bed, and this was cited as an isolated instance of noncompliance that caused actual harm to a resident, a PI CMP may be imposed. We developed a Civil Money Penalty Analytic Tool to help determine CMP amounts when a CMP is one of the selected remedies, per section 1819(h)(2)(B)(ii) of the Act; 42 CFR 488.404 and 488.438.

The Biden-Harris Administration is committed to ensuring that all residents living in Medicare and Medicaid nursing homes receive safe, high-quality care. Specifically, In February 2022, alongside a suite of other reforms, CMS committed to expanding financial penalties and other enforcement sanctions to improve the safety and quality of care in the Nation's nursing homes.[68] As part of this effort, CMS examined the use of PD and PI CMPs and CMP impositions across states from January 1, 2022, to December 31, 2022. We found national variations in the length of time PD CMPs are imposed based on when the noncompliance occurred, when the survey was performed, and when the facility was found to have corrected the noncompliance. For example, from January 1, 2022–December 31, 2022, the State with the shortest average number of average days for PD CMP imposition was 1 day, and the longest average number of days in a State was 43 days. This results in vastly differing PD CMP amounts across the States based on the number of days of noncompliance, as well as the date the survey was conducted, rather than being more focused on the potential or actual harm that a deficiency may cause to residents. In other words, the same type of noncompliance may exist in two facilities, yet the PD CMP amounts would be different simply due to the number of days between the identification of noncompliance by the Surveyor and the date of correction by the facility. We believe that this results

in at least two problems. First, it could create a perception of inequity in the total amount calculated for a CMP. Second, it prevents us from holding some facilities responsible for failing to adequately protect the health, safety, and well-being of residents. Take, for example, a survey that finds noncompliance with the requirements of participation that increases the likelihood of serious injury, harm, impairment, or death to residents—such as when residents are susceptible to falls while not being monitored (even when no resident actually fell as a result of the failure to monitor). If this is identified to have started 100 days prior to the survey, a PD CMP would accrue for each of the 100 days and each additional day until the facility corrected its noncompliance, resulting in a very high CMP. Conversely, another facility's similar noncompliance might result in serious harm to a resident, when two residents fall due to failures to monitor, resulting in serious injury. But, If these falls are identified to have occurred one and two days prior to the survey, a PD CMP would only accrue for 2 days and each additional day until the noncompliance was corrected, resulting in a relatively low CMP that may not encourage prompt or lasting compliance.

These scenarios show how the timing of a survey can potentially result in a higher CMP for similar noncompliance that resulted in less harm to residents. As such, we want to ensure that CMS retains the authority to impose CMPs related to the nature of the harm that is caused by—or could be caused by—a facility's noncompliance and the length of such noncompliance, rather than the date that a standard survey was conducted or a finding of noncompliance was identified, even if the administration of imposing the CMP occurs after another survey has been conducted.

Therefore, as discussed later in this section, we propose to expand and strengthen our enforcement process by revising the regulations to increase CMS's flexibility when a CMP is the selected remedy and allow for multiple PI CMPs to be imposed for the same type of noncompliance, allow for both PD and PI CMPs to be imposed for noncompliance findings in the same survey, as well as ensure that the amount of a CMP does not depend solely on the date that the most recent standard survey is conducted or the date that a finding of noncompliance was identified by surveyors. With these proposed revisions, in certain circumstances, CMS or the State may use the survey start date when imposing a PD CMP instead of the beginning date of the noncompliance, which maintains the benefit of fines accruing to incentivize swift correction to protect existing residents' safety, and as a deterrent for future noncompliance to protect future residents' safety. In other words, by creating the ability to impose a PI CMP and PD CMP on the same survey, CMS or the State could impose a PI CMP to address the noncompliance that occurred in the past or prior to the survey, and a PD CMP beginning at the start of the survey and continuing until the facility has corrected its noncompliance. Additionally, if multiple instances of noncompliance occurred prior to the survey, CMS or the State could impose multiple PI CMPs, as well as a PD CMP. This helps ensure that similar types of noncompliance receive similar CMPs regardless of how many days prior to the survey it occurred, and ensures facilities are motivated to correct their noncompliance as soon as possible after the surveyors identify it.

These proposed revisions are not intended to expand the type of deficiencies that are subject to PD and PI CMPs. The States and CMS would continue to follow the existing criteria for imposing a PD CMP or PI CMP, including imposing a PD or PI CMP for noncompliance that occurred prior to the start of a survey. Rather, these proposed revisions would allow for more consistent CMP amounts imposed across the nation and expand the current enforcement to allow for additional CMPs that more closely align with the noncompliance that occurred. These actions will help to better ensure that compliance is quickly achieved and is lasting.

B. Provisions of the Proposed Regulations

1. Imposing Multiple per Instance Civil Money Penalties for the Same Type of Noncompliance

Sections 1819(h)(2)(B)(ii) and 1919 (h)(3)(C)(ii) of the Act authorize the Secretary to impose a CMP for each day of noncompliance. Section 1128A(d) of the Act further states that the Secretary shall consider (1) the nature of claims and the circumstances under which they were presented, (2) the degree of culpability, history of prior offenses and financial condition of the person presenting the claims, and (3) such other matters as justice may require when determining the amount or scope of any penalty. The regulations at § 488.454(d) state that, in the case of a CMP imposed for an instance of noncompliance, the remedy is the specific amount of the CMP imposed for the particular noncompliance deficiency. The meaning of an ''instance,'' therefore, focuses on a single deficiency citation of the applicable requirements of part 483, subpart B referenced on the facility's statement of deficiencies (Form CMS–2567)) and, under the current regulations, only one type of CMP can be imposed per F tag deficiency.

The statute grants the Secretary broad discretion to determine how appropriate CMPs should be enforced and only limits the imposition to a maximum daily amount. We propose to expand the circumstances in which a PI CMP can be imposed to allow for more than one PI CMP to be imposed when multiple occurrences, or ''instances'' of a specific noncompliance are identified during a survey, regardless of whether they are cited at the same regulatory deficiency tag number in the statement of deficiencies. For example, if a surveyor identifies during a survey several instances of noncompliance within a particular regulatory requirement (such as § 483.25, identified as tag F684—quality of care,) that occurred on different days, CMS or the State survey agency would be able to impose a PI CMP for each occurrence of that noncompliance for those days, as long as the total facility CMP liability did not exceed the statutory and regulatory maximum amount on any given day.

As previously mentioned, CMS imposes CMPs based on sections 1819(h)(2)(B)(ii) and 1919 (h)(3)(C)(ii) of the Act, §§ 488.404, and 488.438 which provides the amount of penalty, the ranges, basis for penalty amount, increase/decrease of penalty amounts, and factors affecting the amount. While we may impose various enforcement remedies, CMPs are frequently imposed for deficiencies that result in serious injury, harm, impairment, or death to nursing home residents. Currently, we can only impose PI CMPs for different types of noncompliance identified on a survey, while other instances of the same noncompliance would not receive a CMP due to current regulatory limitations. Since the PI CMP is limited to one broad regulatory occurrence, the amount of the PI CMP often is not sufficient to encourage sustained compliance and deter future noncompliance with the requirements of participation.

To strengthen our enforcement policies, we propose to revise § 488.401 to define ''instance'' or ''instance of noncompliance'' as a separate factual and temporal occurrence when a facility fails to meet a participation requirement. We further propose that

each instance of noncompliance would be sufficient to constitute a deficiency and that a deficiency may be comprised of multiple instances of noncompliance. This proposed revision will allow us and the States to impose multiple PI CMPs for the same type of noncompliance in a survey, thereby incentivizing facilities to take meaningful steps to permanently resolve their deficiencies. This proposed regulatory change would also provide more opportunities to impose CMPs in a manner that is consistent with the Congressional mandate to ensure that residents are protected from harm that often result in facilities with multiple occurrences of noncompliance. Because these changes focus more directly on the severity of noncompliance itself, we anticipate that, not only will they better protect nursing home residents and encourage lasting compliance, they will also create more consistency in the amount of imposed CMPs.

2. Imposing per Instance and per Day Civil Money Penalties on the Same Survey

As we noted earlier, the Act does not limit the imposition of both a PD and a PI on the same survey but only limits the total amount a penalty may be imposed for any individual day. Section 488.408(d)(2)(iii)–(iv) and § 488.408(e)(1)(iii)–(iv) outline the type of remedies that may be imposed based on the severity of the noncompliance, however these regulations do not state the manner in which the remedies may be imposed.

Because CMPs are designed to spur permanent resolution of deficiencies, We believe CMS and the States need flexibility to determine the range of CMPs that can be imposed on facilities that fail to meet the conditions of participation. For example, if a survey identifies isolated noncompliance that occurred prior to the start of the survey and also identifies separate noncompliance that began and continued to occur during the survey, we are currently unable to impose both a PI CMP and a PD CMP to address these two separate occurrences of noncompliance identified during the same survey. In other words, if a survey identified numerous instances of medication administration errors as well as systemic noncompliance with infection control policies, we believe imposing a PI CMP for the medication errors and a PD CMP for the infection control deficiencies, in this general example, could be a more effective enforcement response. Due to the additional instances of noncompliance identified, a PD CMP that covers the noncompliance with infection control requirements alone may not encourage the facility to sustain compliance. Without this type of flexibility, CMS cannot impose penalties that are sufficient to ensure that any systemic issues that caused the noncompliance are permanently corrected. Moreover, we have found that the failure of nursing homes to take the necessary steps to permanently resolve systemic problems increases the probability that deficiencies will continue, progressing to a higher scope and severity that ultimately results in harm or increased harm to residents.

For the previously stated reasons, we propose to revise §§ 488.408(e)(2)(ii) and 488.430(a) to expand our authority to impose both a PI CMP and a PD CMP, not to exceed the statutory and regulatory maximum amount on any given day even when combined, when surveyors identify noncompliance. Specifically, in § 488.408(e)(2)(ii), we propose that for each instance of noncompliance, CMS and the State may impose a PD CMP of $3,050 to $10,000 (as adjusted under 45 CFR part 102), a PI CMP of $1,000 to $10,000 (as adjusted under 45 CFR part 102), or both, in addition to the remedies specified in § 488.408(e)(2)(i). Additionally, we propose that when a survey contains multiple instances of noncompliance, CMS and the State may impose any combination of per instance or per day CMP for each instance of noncompliance within the same survey. Additionally, we propose to revise § 488.430(a) to allow for each instance of noncompliance, a PD CMP, PI CMP, ''or both'' may be imposed, regardless of whether or not the deficiencies constitute immediate jeopardy. We also propose to add that when a survey contains multiple instances of noncompliance, a combination of per instance and per day CMPs for each instance of noncompliance may be imposed within the same survey. These proposed revisions will enable PI CMPs to be imposed for noncompliance that was previously not able to be addressed once a PD CMP was selected. This would also allow CMS or a State survey agency to impose multiple PI CMPs for noncompliance that occurred prior to the start of a survey and use the survey start date to begin the PD CMP, thereby enabling more consistent CMP amounts to be imposed while still incentivizing a swift return to compliance.

Additionally, we propose to make conforming changes by revising § 488.434(a)(2)(iii) to clarify that both PD and PI CMPs can be imposed on the same survey and thus is included in the penalty notice to the facility. Furthermore, we propose to revise § 488.434(a)(2)(v) to indicate that the date and instance of noncompliance is not a singular event, but rather can be multiple ''date(s) of the instance(s) of noncompliance.'' Lastly, we propose to revise § 488.440(a)(2) to remove the phrase, ''for that particular deficiency,'' and replace with, ''per instance,'' which will allow for more than one PI CMP to be imposed on the same type of noncompliance or ''F tag'' citation. We seek public comment on these proposed revisions.

3. Timing of Enforcement

Sections 1819(h)(2)(A) and 1919(h)(1) and (3) of the Act state that when a facility is found to be in compliance with the requirements but ''. . . as of a previous period, did not meet such requirements,'' the Secretary and the State may impose a CMP for the days that the facility is found out of compliance with the requirements. The regulation at § 488.430(b) states that ''CMS or the State may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.''

Due to an increase in the number of complaint surveys being conducted, the current regulation may result in an unanticipated limit on CMS's authority to impose remedies to the noncompliance deficiencies identified when the last standard survey was performed. For example, since 2015, the percent of complaint surveys increased from 80 to 87 percent of the total number of surveys conducted, resulting in more than 10,000 additional surveys. This increase in complaint survey activity has resulted in an increase in enforcement actions taken by the States and CMS. The increase in complaint surveys has resulted in more surveys being conducted within short timeframes of each other, which can create administrative difficulties. For example, one survey may be conducted shortly after another, not leaving enough time to impose a CMP for the first survey before the second survey is concluded. But, despite the fact that there are more surveys that identify additional deficiencies, the current regulations limit how far back CMS or the State may go when calculating a CMP amount: to the last standard survey.

We propose to revise § 488.430(b) by changing ''since the last standard survey'' to ''since the last three standard surveys.'' We believe this proposed revision aligns with the statutory mandate that the Secretary ensure that enforcement remedies adequately

protect the health and safety of nursing home residents in facilities where the Medicare and/or Medicaid programs pay for services. These proposed revisions are designed to enable CMS or State survey agencies to impose a variety of CMPs for noncompliance, particularly when surveyors have identified deficiencies that cannot be addressed because, for example, a subsequent survey has taken place. In these situations, it is important for CMS and the State to be able to impose a CMP (per day, per instance, or both), as warranted, to help ensure that the facility's compliance is permanent. Additionally, limiting review of past noncompliance to the last three standard surveys is more reflective of a facility's current compliance performance.

A proposed three-standard survey lookback period is also consistent with current agency practices. For example, CMS posts the survey results for each facility for the last three standard surveys and last 3 years of complaint surveys on the *Medicare.gov* Care Compare website to provide the public with information on the facility's compliance performance. This same timeframe is also used to calculate each facility's health inspection rating for the Five-Star Quality Rating System. We seek public comments on this proposal and also seek comments on an alternative look-back period that would also ensure CMPs are imposed in a manner that is not dependent on when the next standard survey is conducted.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

Using the following format describe the information collection requirements that are in each section].

A. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding the Skilled Nursing Facility Value-Based Purchasing Program

We are not removing or adding any new or revised SNF VBP measure-related requirements or burden in this rule. Consequently, this final rule does not set out any new SNF VBP-related collections of information that would be subject to OMB approval under the authority of the PRA.

2. ICRs Regarding the Skilled Nursing Facility Quality Reporting Program (SNF QRP)

In accordance with section 1888(e)(6)(A)(i) of the Act, the Secretary must reduce by 2-percentage points the otherwise applicable annual payment update to a SNF for a fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

In section VI.C.3. of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category and modify one item collected as a standardized patient assessment data element under the SDOH category beginning with the FY 2027 SNF QRP. In section VI.E.3. of this proposed rule, we are also proposing that SNFs participating in the SNF QRP, be required to participate in a validation process. Specifically, we are proposing to adopt a similar validation process for the SNF QRP that we have adopted for the SNF VBP beginning with the FY 2027 SNF QRP.

As stated in section VII.C.3. of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category and modify one item collected as a standardized patient assessment data element under the SDOH category beginning with the FY 2027 SNF QRP. The proposed new and modified items would be collected using the MDS. The MDS, in its current form, has been approved under OMB control number 0938–1140. Four items would need to be added to the MDS at admission to allow for collection of these data, and one would be modified. Additionally, as stated in section VI.E.2. of this proposed rule, we are proposing SNFs would submit the four proposed new items and one modified item at admission only. The net result of collecting four new items at admission, modifying one item currently collected at admission, and removing the collection of one item at discharge is an increase of 0.9 minutes or 0.015 hour of clinical staff time at admission [(4 items × 0.005 hour) minus (1 item × 0.005 hour)]. We identified the staff type based on past SNF burden calculations, and our assumptions are based on the categories generally necessary to perform an assessment. We believe that the proposed new and modified items would be completed equally by a Registered Nurse (RN) and Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, individual SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates.[71] To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 33. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $65.31/hr was calculated by weighting each hourly wage equally [($78.10/hr × 0.5) plus ($52.52/hr × 0.5) = $65.31].

[71] U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

TABLE 33—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2022 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	39.05	39.05	78.10
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29–2061	26.26	26.26	52.52

We estimate that the burden and cost for SNFs for complying with requirements of the FY 2027 SNF QRP would increase under this proposal. Using FY 2023 data, we estimate a total of 1,966,662 admissions to and 754,287 planned discharges from 15,393 SNFs annually for an increase of 35,561.81 hours in burden for all SNFs [(1,966,662 admissions × 0.02 hour) minus (754,287 planned discharges × 0.005 hour)]. Given 0.02 hour at $65.31 per hour to complete an average of 128 5-day PPS assessments per provider per year minus 0.005 at $65.31 per hour to complete an average of 49 Planned Discharge assessments, we estimate the total cost would be increased by $150.88 per SNF annually, or $2,322,541.48 for all SNFs annually. The proposed increase in burden would be accounted for in a revised information collection request under OMB control number (0938–1140). The required 60-day and 30-day notices would publish in the **Federal Register** and the comment periods would be separate from those associated with this rulemaking.

In summary, under OMB control number (0938–1140), if the proposed policies in this proposed rule are finalized, we estimate the SNF QRP would result in an overall increase of 35,561.81 hours annually for 15,393 SNFs. The total cost increase related to this information collection is approximately $2,322,541.48 and is summarized in Table 34.

TABLE 34—PROPOSED ESTIMATED BURDEN ASSOCIATED WITH OMB CONTROL NUMBER 0938–1140 (CMS–10387) RELATED TO THE SNF QRP

Proposal	Per SNF		All SNFs	
	Change in annual burden hours	Change in annual cost	Change in annual burden hours	Change in annual cost
Estimated Change in Burden associated with Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element beginning with the FY 2027 SNF QRP	+2.31	+$150.88	+35,561.81	+$2,322,541.48

3. ICRs Regarding the Minimum Data Set (MDS) Beginning October 1, 2025

The MDS is used for meeting the SNF Requirements of Participation, requirements under the SNF QRP, and for payment purposes under the SNF PPS. As outlined in the FY 2019 SNF PPS final rule (83 FR 39165 through 39265), several MDS items are not needed in case-mix adjusting the per diem payment for PDPM. However, they were not accounted for in the FY 2019 SNF PPS final rule. Therefore, we are removing these items from the 5-day Medicare-required assessment beginning October 1, 2025. We have provided an estimate of the reduction in burden here and in Table 35. The items to be removed are:

- O0400.A.1. Speech-Language Pathology and Audiology Services; Individual minutes.
- O0400.A.2. Speech-Language Pathology and Audiology Services; Concurrent minutes.
- O0400.A.3. Speech-Language Pathology and Audiology Services; Group minutes.
- O0400.A.3A. Speech-Language Pathology and Audiology Services; Co-treatment minutes.
- O0400.A.4. Speech-Language Pathology and Audiology Services; Days.
- O0400.A.5. Speech-Language Pathology and Audiology Services; Therapy start date.
- O0400.A.6. Speech-Language Pathology and Audiology Services; Therapy end date.
- O0400.B.1. Occupational Therapy; Individual minutes.
- O0400.B.2. Occupational Therapy; Concurrent minutes.
- O0400.B.3. Occupational Therapy; Group minutes.
- O0400.B.3A. Occupational Therapy; Co-treatment minutes.
- O0400.B.4. Occupational Therapy; Days.
- O0400.B.5. Occupational Therapy; Therapy start date.
- O0400.B.6. Occupational Therapy; Therapy end date.
- O0400.C.1. Physical Therapy; Individual minutes.
- O0400.C.2. Physical Therapy; Concurrent minutes.
- O0400.C.3. Physical Therapy; Group minutes.
- O0400.C.3A. Physical Therapy; Co-treatment minutes.
- O0400.C.4. Physical Therapy; Days.
- O0400.C.5. Physical Therapy; Therapy start date.
- O0400.C.6. Physical Therapy; Therapy end date.
- O0400.E.2. Psychological Therapy; Days.

The net result of removing the collection of these items is a decrease of 6.6 minutes of clinical staff time at admission. We believe that these items are completed equally by a RN and LPN/LVN. Individual SNFs determine the staffing resources necessary.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the BLS May 2022 National Occupational Employment and Wage Estimates.[72] To account for other

[72] U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

indirect costs and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 35. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $65.31/hr was calculated by weighting each hourly wage equally [($78.10/hr × 0.5) plus ($52.52/hr × 0.5) = $65.31].

Using FY 2023 data, we estimate a total of 1,966,662 admissions to 15,393 SNFs annually. This equates to a decrease of 216,332.82 hours in burden for all SNFs. Given 0.11 hour at $65.31 per hour to complete an average of 128 5-day PPS assessments per provider per year, we estimate the total cost would be decreased by $917.87 per SNF annually, or $14,128,696.47 for all SNFs annually.

TABLE 35—PROPOSED ESTIMATED SNF REDUCTION IN BURDEN ASSOCIATED WITH ASSOCIATED WITH OMB CONTROL NUMBER 0938–1140 (CMS–10387) RELATED TO THE MINIMUM DATA SET COLLECTION AND SUBMISSION

	Per SNF		All SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden associated with Removal of MDS items O0400.A, O0400.B, O0400.C, and O0400.E effective October 1, 2025	−14.05	−$917.87	−216,332.82	−$14,128,696.47

4. ICRs Regarding the Proposal for SNFs To Participate in a Validation Process

In section VI.E.3 of this proposed rule, we are proposing to require SNFs to participate in a validation process beginning with the FY 2027 SNF QRP. We have provided an estimate of burden here, and in Table 36, and note that the increase in burden would be accounted for in a new information collection request.

In section VI.E.3(a). of this proposed rule, we propose to require SNFs to participate in a validation process for assessment-based measures beginning with the FY 2027 SNF QRP. We identified the staff type based on past SNF burden calculations, and our assumptions are based on the categories generally necessary to perform an assessment. We believe that the medical records would be collected and submitted by a Medical Records and Health Information Technologist and Medical Registrar (HIT/MR). However, individual SNFs determine the staffing resources necessary. For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the BLS May 2022 National Occupational Employment and Wage Estimates.[73] To account for other indirect costs and fringe benefits, we have doubled the hourly wage to establish an adjusted wage estimate of $56.02/hr. These amounts are detailed in Table 36.

TABLE 36—U.S. BUREAU OF LABOR AND STATISTICS' MAY 2022 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Other indirect costs and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Medical Records and Health Information Technologists and Medical Registrars (HIT/MR)	29–9021	28.01	28.01	56.02

We are proposing that our validation contractor would select, on an annual basis, up to 1,500 SNFs and up to 10 medical records from each of the selected SNFs. We are proposing that the selected SNFs would have the option to submit digital or paper copies of the requested medical records to the validation contractor.

For the purposes of burden estimation, we assume all of the activities associated with the validation process would be completed by a HIT/MR. For selected SNFs utilizing electronic health records (EHR), we anticipate an increase of 3 hours up to 7.5 hours of HIT/MR time per SNF to submit a sample of up to 10 records. For selected SNFs who do not utilize EHRs, we anticipate an increase of 5 hours up to 12.5 hours of HIT/MR time per SNF to submit a sample of up to 10 records. Additionally, SNFs who do not utilize EHRs may incur printing and shipping costs if they are unable to submit the records via an electronic portal, and for these SNFs, we estimate the cost to print and ship a sample of up to 10 records would range from $842.67 up to $4,114.35.

We also anticipate that a sample of up to 10 medical records would consist of SNF stays that vary in length of stay. We estimate the length of stay for each of the selected medical records could range from 20 days (or less) up to or exceeding 366 days. For purposes of our burden estimate, we anticipate the average sample of up to 10 medical records would be distributed among the possible lengths of stay (that is, approximately 40 percent of stays or 4 stays would be 1 to 30 days, 40 percent of stays or 4 stays would be 31 to 100 days, and 20 percent of stays or 2 stays would last 101 to 366 or more consecutive days). We also estimate that approximately 85 percent of nursing homes utilize some form of EHRs.[74] Therefore, we estimate the total cost to submit up to 10 medical records would range between $335,699.85 and $477,368.10 for all 1,500 SNFs selected, depending on the length of stay of the

[73] *https://www.bls.gov/oes/current/oes_nat.htm.*

[74] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6591108/#:~:text=In%20a%20nationwide%20sample%2C%20we,EHR%20adoption%20by%20nursing%20facilities.*

sample medical records and whether the SNFs use an EHR. We also estimate that total cost to submit up to 10 medical records would range between $263.29 [$335,699.85/(1,500 × 0.85 SNFs)] and $2,121.64 [$477,368.10/(1,500 × 0.15 SNFs)] per SNF selected depending on the length of stay of the sample of medical records and whether the SNF uses an EHR. On average we estimate the total cost would be increased by $813,067.95 for all 1,500 selected SNFs [[($263.29 × (1,500 × 0.85)] plus [$2,121.64 × (1,500 × 0.15)]] and $542.05 per selected SNF ($813,067.95/1,500 SNFs) annually.

In section VI.E.3(b). of this proposed rule, we propose to require SNFs to participate in a validation process for Medicare fee-for-service claims-based measures beginning with the FY 2027 SNF QRP. All Medicare fee-for-service claims-based measures are already reported to the Medicare program for payment purposes, and therefore there is no additional burden for providers.

TABLE 37—PROPOSED SNF BURDEN FOR A VALIDATION PROCESS

[OMB 0938–TBD, CMS–#####]

Proposal	Per selected SNF		All selected SNFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden associated with Proposed Participation in a Validation Process	+5.12	+$542.05	+7,680	+$813,067.95

Comments must be received on/by June 3, 2024.

If you comment on these information collection, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received on/by June 3, 2024.

X. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XI. Economic Analyses

A. Regulatory Impact Analysis

1. Statement of Need

a. Statutory Provisions

This rule updates the FY 2025 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted Federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. These are statutory provisions that prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, and we do not have the discretion to adopt an alternative approach on these issues.

With respect to the SNF QRP, this proposed rule proposes updates beginning with the FY 2027 SNF QRP. Specifically, we propose to collect four new items as standardized patient assessment data elements under the SDOH category and modify one item collected as a standardized patient assessment data element under the SDOH category in the MDS beginning with the FY 2027 SNF QRP. We believe these proposals would advance the CMS National Quality Strategy Goals of equity and engagement by encouraging meaningful collaboration between healthcare providers, caregivers, and community-based organizations to address SDOH prior to discharge from the SNF. We propose to adopt a validation process for the SNF QRP beginning with the FY 2027 SNF QRP to satisfy section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260) which requires that the measures and data submitted under the SNF QRP Program (section 1888(e)(6) of the Act) be subject to a validation process. To implement this proposed validation process for SNF QRP, we are also proposing conforming amendments to our regulation at § 413.360.

With respect to the SNF VBP Program, this rule proposes updates to the SNF VBP Program requirements for FY 2025 and subsequent years. Section 1888(h)(3) of the Act requires the Secretary to establish and announce performance standards for SNF VBP Program measures no later than 60 days before the performance period, and this proposed rule estimates numerical values of the performance standards for the FY 2027 program year for the SNFRM, SNF HAI, Total Nurse Staffing, Nursing Staff Turnover, Falls with Major Injury (Long-Stay), DC Function, and Long Stay Hospitalization measures; and numerical values of the performance standards for the FY 2028 program year for the DTC PAC SNF and SNF WS PPR measures. We are also required under section 1888(h)(1)(C) of the Act to establish a minimum number of measures that apply to a facility for the applicable performance period. Therefore, we are proposing to apply the same measure minimum we previously finalized for the FY 2027 program year (88 FR 53303) to the FY 2028 program year and subsequent program years.

b. Discretionary Provisions

In addition, this proposed rule includes the following discretionary provisions:

(1) SNF Market Basket Adjustment

We are proposing to rebase and revise the SNF market basket to reflect a 2022 base year. Since the inception of the SNF PPS, the market basket used to update SNF PPS payments has been periodically rebased and revised to reflect more recent data. We last rebased and revised the market basket applicable to the SNF PPS in the FY 2022 SNF PPS final rule (86 FR 42444 through 42463) where we adopted a 2018-based SNF market basket.

Given changes to the industry in recent years and public comments about the timeliness of the weights, we have been monitoring the Medicare cost report data to determine if a more frequent rebasing schedule than our standard schedule (which has generally been about every 4 years). In light of this analysis, we are proposing to

incorporate data that is more reflective of recent SNF expenses.

(2) SNF Forecast Error Adjustment

Each year, we evaluate the SNF market basket forecast error for the most recent year for which historical data is available. The forecast error is determined by comparing the projected SNF market basket increase each year with the actual SNF market basket increase in that year. In evaluating the data for FY 2023, we found that the forecast error for that year was 1.7 percentage points, exceeding the 0.5 percentage point threshold we established in regulation for proposing adjustments to correct for forecast error. Given that the forecast error exceeds the 0.5 percentage point threshold, current regulations require that the SNF market basket percentage increase for FY 2025 be adjusted upward by 1.7 percentage points to account for forecasting error in the FY 2023 SNF market basket update.

(3) Technical Updates to ICD–10 Mappings

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the PDPM, effective October 1, 2019. The PDPM utilizes ICD–10 codes in several ways, including using the patient's primary diagnosis to assign patients to clinical categories under several PDPM components, specifically the PT, OT, SLP and NTA components. In this rule, we finalize several substantive changes to the PDPM ICD–10 code mapping.

2. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled ''Modernizing Regulatory Review'' (April 6, 2023), the Regulatory Flexibility Act (RFA, September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094 entitled ''Modernizing Regulatory Review'' (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the Administrator of OIRA for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) ($200 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) as measured by the $200 million or more in any 1 year, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed these proposed regulations, and the Departments have provided the following assessment of their impact.

3. Overall Impacts

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2024 (88 FR 53200). We estimate that the aggregate impact will be an increase of approximately $1.3 billion (4.1 percent) in Part A payments to SNFs in FY 2025. This reflects a $1.3 billion (4.1 percent) increase from the update to the payment rates. We note in this proposed rule that these impact numbers do not incorporate the SNF VBP Program reductions that we estimate would total $187.69 million in FY 2025. We note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, very susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and (e)(5) of the Act and implementing regulations at § 413.337(d), we are updating the FY 2024 payment rates by a factor equal to the market basket percentage increase adjusted for the forecast error adjustment and reduced by the productivity adjustment to determine the payment rates for FY 2025. The impact to Medicare is included in the total column of Table 38. The annual update in this rule applies to SNF PPS payments in FY 2025. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2025 SNF PPS payment impacts appear in Table 38. Using the most recently available claims data, in this case FY 2022 we apply the current FY 2024 CMIs, wage index and labor-related share value to the number of payment days to simulate FY 2024 payments. Then, using the same FY 2022 claims data, we apply the FY 2025 CMIs, wage index and labor-related share value to simulate FY 2025 payments. We tabulate the resulting payments according to the classifications in Table 38 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2024 payments to the simulated FY 2025 payments to determine the overall impact. The breakdown of the various categories of data in Table 38 is as follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes contained in this proposed rule on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).

• The second column shows the number of facilities in the impact database.

• The third column shows the effect of the proposed update to the SNF PPS wage index due to adopting the updated census data and revised CBSAs in OMB Bulletin 23–01. This represents the effect of only the proposed adoption of the revised CBSAs, independent of the effect of the annual update to the wage index.

• The fourth column shows the effect of the annual update to the wage index, including the proposed updates to the labor related-share discussed in section V.A above. This represents the effect of using the most recent wage data available as well as accounts for the 5 percent cap on wage index transitions. The total impact of this change is 0.0 percent; however, there are distributional effects of the change.

• The fifth column shows the effect of all of the changes on the FY 2025 payments. The update of 4.1 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments would increase by 4.1 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 38, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes in this proposed rule, rural providers would experience a 4.9 percent increase in FY 2025 total payments.

TABLE 38—IMPACT TO THE SNF PPS FOR FY 2025

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

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

5. Impacts for the Skilled Nursing Facility Quality Reporting Program (SNF QRP) for FY 2027

Estimated impacts for the SNF QRP are based on analysis discussed in section VI. of this proposed rule. In accordance with section 1888(e)(6)(A)(i) of the Act, the Secretary must reduce by 2 percentage points the annual payment update applicable to a SNF for a fiscal year if the SNF does not comply with the requirements of the SNF QRP for that fiscal year.

As discussed in section VI.C.3. of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category and modify the Transportation item collected as a standardized patient assessment data element under the SDOH category beginning with admission assessments completed on October 1, 2025. Although the proposed increase in burden will be accounted for in a revised information collection request under OMB control number (0938–1140), we are providing impact information. With 1,966,662 admissions to and 754,287 planned discharges from 15,393 SNFs annually, we estimate an annual burden increase of 35,561.81 hours [(1,966,662 admissions × 0.02 hour) minus (754,287 planned discharges × 0.005 hour)] and an increase of $2,322,541.48 (35,561.81 hours × $65.31/hr). For each SNF, we estimate an annual burden increase of 2.31 hours (35,561.81 hours/15,393 SNFs) at an additional cost of $150.88 ($2,322,541.48 total burden/15,393 SNFs).

As discussed in in section VI.E.3. of this proposed rule, we are also proposing to require SNFs to participate in a validation process that would apply to data submitted using the MDS and SNF Medicare fee-for-service claims as a SNF QRP requirement. Specifically, we are proposing to adopt a similar validation process for the SNF QRP that we have adopted for the SNF VBP beginning with the FY 2027 SNF QRP. This proposal is in accordance with section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260) which requires that the measures and data submitted under the SNF QRP Program (section 1888(e)(6) of the Act) be subject to a validation process.

In section VI.E.3(a). of this proposed rule, we propose to require SNFs to participate in a validation process for assessment-based measures beginning with the FY 2027 SNF QRP. We are proposing that our validation contractor would select, on an annual basis, up to 1,500 SNFs and request that each SNF selected for the validation process submit up to 10 medical records. Although the proposed increase in burden will be accounted for in a new information collection request, we are providing impact information. We estimate the burden per selected SNF could range from 3 hours up to 7.5 hours for SNFs utilizing electronic health records and 5 hours up to 12.5 hours for SNFs who do not utilize electronic health records.

We also anticipate that a sample of 10 medical records would consist of SNF stays that vary in length of stay. We estimate the length of stay for each of the selected medical records could range from 1 day up to or exceeding 366 days. We also estimate that approximately 85 percent of nursing homes utilize some form of electronic health records (EHR),[75] and would not incur the costs of printing and shipping records. However, selected SNFs who do not utilize EHRs may incur printing and shipping costs if they are unable to submit the records via an electronic portal, and we estimate the cost to print and ship a sample of up to 10 records would range between $842.67 up to $4,114.35. Therefore, depending on the length of stay of the sample and whether the selected SNF uses an EHR, we estimate the total cost to submit medical records would range between $335,699.85 and $477,368.10 for all 1,500 selected SNFs and $263.29 [$335,699.85/(1,500 × 0.85 SNFs)] and $2,121.64 [$477,368.10/(1,500 × 0.15 SNFs)] per selected SNF. On average, we estimate the total cost would be increased by $813,067.95 for all 1,500 selected SNFs [[($263.29 × (1,500 × 0.85)] plus [$2,121.64 × (1,500 × 0.15)]] and $542.05 per selected SNF ($813,067.95/1,500 SNFs) annually.

In section VI.E.3(b). of this proposed rule, we propose to require SNFs to participate in a validation process for Medicare fee-for-service claims-based measures beginning with the FY 2027 SNF QRP. All Medicare fee-for-service claims-based measures are already reported to the Medicare program for payment purposes, and therefore there is no additional burden for providers.

We invite public comments on the overall impact of the SNF QRP proposals for FY 2027 displayed in Table 39.

TABLE 39—ESTIMATED IMPACTS FOR THE FY 2027 SNF QRP

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

6. Impacts for the Minimum Data Set Beginning October 1, 2025

As discussed in section IX.A.3. of this proposed rule, we are removing MDS items that are not needed for case-mix adjusting the SNF per diem payment for PDPM but were not accounted for in the FY 2019 SNF PPS final rule (83 FR 39165 through 39265). We are providing impact information here and in Table 40. With 1,966,662 admissions to 15,393 SNFs annually, we estimate an annual burden decrease of 216,332.82 hours (1,966,662 admissions × 0.11 hour) and a decrease of $14,128,696.47 (216,332.82 hours × $65.31/hr). For each SNF, we estimate an annual burden decrease of 14.05 hours (216,332.82 hours/15,393 SNFs) for a reduction in cost of $917.87 ($14,128,696.47 total burden/15,393 SNFs).

[75] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6591108/#:~:text=In%20a%20nationwide%20sample%2C%20we,EHR%20adoption%20by%20nursing%20facilities.*

TABLE 40—ESTIMATED IMPACTS FOR THE PROPOSED CHANGES TO THE MDS DATA SET COLLECTION AND SUBMISSION BEGINNING OCTOBER 1, 2025

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

7. Impacts for the SNF VBP Program

The estimated impacts of the FY 2025 SNF VBP Program are based on historical data and appear in Table 41. We modeled SNF performance in the Program using SNFRM data from FY 2019 as the baseline period and FY 2023 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621).

For the FY 2025 program year, we will reduce each SNFs adjusted Federal per diem rate by 2 percent. We will then redistribute 60 percent of that 2 percent withhold to SNFs based on their measure performance. Additionally, in the FY 2023 SNF PPS final rule (87 FR 47585 through 47587), we finalized a case minimum requirement for the SNFRM, as required by section 1888(h)(1)(C)(ii) of the Act. As a result of these provisions, SNFs that do not meet the case minimum specified for the SNFRM for the FY 2025 program year will be excluded from the Program and will receive their full Federal per diem rate for that fiscal year. As previously finalized, this policy will maintain the overall payback percentage at 60 percent for the FY 2025 program year. Based on the 60 percent payback percentage, we estimated that we would redistribute approximately $281.53 million (of the estimated $469.22 million in withheld funds) in value-based incentive payments to SNFs in FY 2025, which means that the SNF VBP Program is estimated to result in approximately $187.69 million in savings to the Medicare Program in FY 2025.

Our detailed analysis of the impacts of the FY 2025 SNF VBP Program is shown in Table 41.

TABLE 41—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2025

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

TABLE 41—ESTIMATED SNF VBP PROGRAM IMPACTS FOR FY 2025—Continued

Characteristic	Number of facilities	Mean risk-standardized readmission rate (SNFRM) (%)	Mean performance score	Mean incentive payment multiplier	Percent of total payment
Non-Profit	2,361	19.88	37.0019	0.99376	18.74

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

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

In the FY 2024 SNF PPS final rule (88 FR 53324 through 53325), we adopted a validation process that applies to SNF VBP measures calculated using MDS data beginning with the FY 2027 program year. Specifically, we finalized that, on an annual basis, the validation contractor will randomly select up to 1,500 SNFs for validation and that for each SNF selected, the validation contractor will request up to 10 medical records. This new medical record submission requirement for the purposes of SNF VBP MDS validation would result in new burden on SNFs for the FY 2027 program year. We refer readers to the SNF QRP section at XI.A.5. of this proposed rule for details on the estimated annual burden increase that would result from this new chart submission requirement. We are not including additional details on burden in this section, to avoid double counting burden with the SNF QRP since the same charts will be utilized for both the SNF QRP and SNF VBP Program. We also note that this burden would be accounted for in the information collection request that is being developed and will be submitted to OMB for approval.

8. Impacts for Nursing Home Enforcement Revisions

A nursing home certified to participate in the Medicare and Medicaid programs as a SNF and NF is expected to be in compliance with Federal requirements as a condition of receiving payment for services provided to beneficiaries. If a facility is determined to be out of compliance and an enforcement decision is reached to impose a CMP, the proposed regulatory revisions would take effect.

We view the anticipated results of this rule as beneficial to nursing home residents. Specifically, we believe that additional flexibility to impose CMPs will allow us to better tailor the response to facility noncompliance in a way that assures that appropriate resident care occurs as well as lasting facility compliance is achieved. We also recognize that not all of the potential effects of this rule can be anticipated. It is difficult to quantify the full future effect of this rule on facilities' compliance activities or costs. If a facility is in substantial compliance, there is no basis to use any enforcement remedy. However, should a remedy be indicated, several alternative remedies may be considered in addition to a CMP. Since CMP amounts, once selected as an appropriate enforcement response, are based on when noncompliance occurred and the level of noncompliance, we are unable to predict the number or amount of CMPs that will be imposed. However, we do expect that the total amount of CMPs imposed would increase as a result of these proposals.

In 2022, the number of facilities that had CMPs imposed was 6,113 (41 percent). The average total amount of the CMPs imposed for each facility in 2022 was $17,775. The total dollar amount of PD CMPs imposed on facilities in 2022 was $186.4 million and the total dollar amount of PI CMPs was $40.6 million. Additionally, 45 percent of surveys in 2022 that had multiple findings of harm and were imposed a PI CMP as the remedy of choice only received one PI CMP. Under the proposed revisions, we anticipate an increased workload to CMS and States, and increased CMP amounts to providers when multiple instances of noncompliance resulting in harm or immediate jeopardy (IJ) are cited.

We calculated the additional costs for providers, CMS, and states by analyzing the number of surveys in CY2022 that would have had additional PI CMPs imposed by identifying surveys with multiple citations of noncompliance resulting in harm or immediate jeopardy (IJ), but only one PI CMP was imposed, or a PD CMP was imposed. We then multiplied the number of these surveys by the average number of citations resulting in harm or IJ, and by the average PI CMP amount. This calculation resulted in a total of approximately $25 million for all nursing homes for CY2022. We estimate this will result in a total increased cost to CMS and the States of $163,800 per year.

9. Alternatives Considered

As described in this section, we estimate that the aggregate impact of the provisions in this proposed rule will result in an increase of approximately $1.3 billion (4.1 percent) in Part A payments to SNFs in FY 2025. This reflects a $1.3 billion (4.1 percent) increase from the update to the payment rates.

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, a market basket update, a wage index, and the urban and rural distinction used in the development or adjustment of the Federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY; accordingly, we are not pursuing alternatives for this process.

With regard to the proposal to adopt four new items as standardized patient assessment data elements under the SDOH category and modify the Transportation standardized patient assessment data element in the SDOH category beginning with the FY 2027 SNF QRP, we believe these proposals advance the CMS National Quality Strategy Goals of equity and engagement. We considered the alternative of delaying the proposal to collect these items but given the fact they would encourage meaningful

collaboration between healthcare providers, residents, caregivers, and community-based organizations to address SDOH prior to discharge from the SNF, we believe further delay is unwarranted.

With regard to the proposal to remove 22 items from the MDS beginning October 1, 2025, we routinely review the MDS for opportunities to simplify data submission requirements. We have identified that these items are no longer used in the calculation of the SNF per diem payment for PDPM but were not accounted for in the FY 2019 SNF PPS final rule (83 FR 39165 through 39265), and therefore no alternatives were considered.

With regard to the proposal to require SNFs participating in the SNF QRP to participate in a validation process beginning with the FY 2027 SNF QRP, we are required to implement a process to satisfy Section 1888(h)(12) of the Act (as added by Division CC, section 111(a)(4) of the Consolidated Appropriations Act, 2021 (Pub. L. 116–120)). Because the validation process is statutorily required, no alternatives were considered.

With regard to the proposals for the SNF VBP Program, we discussed alternatives considered within those sections. In section VII.E.3. of the proposed rule, we discussed other approaches to incorporating health equity into the Program.

10. Accounting Statement

As required by OMB Circular A–4 (available online at *https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/*), in Tables 42 through 46, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule for FY 2025. Tables 38 and 42 provide our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this proposed rule, based on the data for 15,503 SNFs in our database. Tables 39, 43, and 44 provide our best estimate of the additional cost to SNFs to submit the data for the SNF QRP as a result of the policies in this proposed rule. Table 45 provides our best estimate of the possible changes in Medicare payments under the SNF VBP as a result of the policies for this program. Table 46 provides our best estimate of the Nursing Home Enforcement provisions.

TABLE 42—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2024 SNF PPS FISCAL YEAR TO THE 2025 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$1.3 billion.
From Whom To Whom?	Federal Government to SNF Medicare Providers.

TABLE 43—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE PROPOSED CHANGES TO THE FY 2027 QRP PROGRAM

Category	Transfers/costs
Estimated Costs to SNFs for Proposed Changes to the FY 2027 QRP Program and to Selected SNFs for the Validation Process*	$3,135,609.43
Estimated Costs to SNFs for Proposed Changes to the FY 2027 QRP Program Who Are Not Selected for the Validation Process	2,322,541.48

* Up to 1,500 SNFs would be selected for the Validation Process.

TABLE 44—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS FOR THE REMOVAL OF MDS ITEMS NO LONGER NEEDED FOR CASE-MIX ADJUSTING THE PER DIEM SNF PAYMENT BEGINNING OCTOBER 1, 2025

Category	Transfers/costs
Savings to SNFs for Removing MDS Items	($14,128,696.47)

TABLE 45—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE FY 2025 SNF VBP PROGRAM

Annualized Monetized Transfers	$281.53 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

* This estimate does not include the 2 percent reduction to SNFs' Medicare payments (estimated to be $469.22 million) required by statute.

TABLE 46—ACCOUNTING STATEMENT: NURSING HOME ENFORCEMENT PROPOSALS

Category	Transfers/penalties
Estimated Increased Amount of Penalties	$25 million.*
From Whom To Whom?	SNF Medicare Providers to Federal Government.
Estimated additional cost to CMS and State Survey Agencies	$163,800.

* This estimate includes the estimated increase in the amount of PI CMPs that may be imposed under these proposed revisions.

11. Conclusion

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2024 (88 FR 53200). Based on the above, we estimate that the overall payments for SNFs under the SNF PPS in FY 2025 are projected to increase by approximately $1.3 billion, or 4.1 percent, compared with those in FY 2024. We estimate that in FY 2025, SNFs in urban and rural areas would experience, on average, a 4.0 percent increase and 4.9 percent increase, respectively, in estimated payments compared with FY 2024. Providers in the rural Middle Atlantic region would experience the largest estimated increase in payments of approximately 7.5 percent. Providers in the urban Outlying region would experience the smallest estimated increase in payments of 1.7 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by reason of their non-profit status or by having revenues of $30 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as that term is used in the RFA, according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $34 million or less in any 1 year. (For details, see the Small Business Administration's website at *https://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards*). In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2024 (88 FR 53200). Based on the above, we estimate that the aggregate impact for FY 2025 will be an increase of $1.3 billion in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 38 that all providers would experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2025 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2023 Report to Congress (available at *https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf*), MedPAC states that Medicare covers approximately 10 percent of total patient days in freestanding facilities and 16 percent of facility revenue (March 2023 MedPAC Report to Congress, 207). As indicated in Table 38, the effect on facilities is projected to be an aggregate positive impact of 4.1 percent for FY 2025. As the overall impact on the industry as a whole, and thus on small entities specifically, meets the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule will have a significant impact on a substantial number of small entities for FY 2025.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This proposed rule will affect small rural hospitals that: (1) furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2024 (88 FR 53200)), the category of small rural hospitals is included within the analysis of the impact of this proposed rule on small entities in general. As indicated in Table 38, the effect on facilities for FY 2025 is projected to be an aggregate positive impact of 4.1 percent. As the overall impact on the industry as a whole meets the 3 to 5 percent threshold discussed above, the Secretary has determined that this proposed rule will have a significant impact on a substantial number of small rural hospitals for FY 2025.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold is approximately $183 million. This proposed rule will impose no mandates on State, local, or Tribal governments or on the private sector.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. This proposed rule will have no substantial direct effect on State and local governments, preempt State law, or otherwise have federalism implications.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of last year's proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on that proposed rule. For these reasons, we believe that the number of commenters on this year's proposed rule is a fair estimate of the number of reviewers of last year's proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

The mean wage rate for medical and health service manages (SOC 11–9111) in BLS OEWS is $61.53, assuming benefits plus other overhead costs equal 100 percent of wage rate, we estimate that the cost of reviewing this rule is $123.06 per hour, including overhead

and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it would take approximately 4 hours for the staff to review half of the proposed rule. For each SNF that reviews the rule, the estimated cost is $492.24 (4 hours × $123.06). Therefore, we estimate that the total cost of reviewing this regulation is $39,871.44 ($460.88 × 81 reviewers).

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 25, 2024.

List of Subjects

42 CFR Part 413

Diseases, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 488

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

■ 1. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395m, 1395x(v), 1395x(kkk), 1395hh, 1395rr, 1395tt, and 1395ww.

■ 2. Section 413.337 is amended by revising paragraph (f) to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(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 of this part.

■ 3. Section 413.338 is amended—

■ a. In paragraph (a) by—

■ i. Revising the definitions of ''Health equity adjustment (HEA) bonus points'' and ''Measure performance scaler'';

■ ii. Removing the definition of ''Performance score'';

■ iii. Adding the definition of ''SNF performance score'';

■ iv. Revising the definitions of ''SNF readmission measure'', ''Top tier performing SNF'', and ''Underserved multiplier'';

■ b. Removing paragraphs (d)(4) through (6);

■ c. Redesignating paragraphs (f)(1) through (4) as paragraphs (f)(2) through (5);

■ d. Adding a new paragraph (f)(1) and revising paragraphs newly redesignated paragraphs (f)(2) and (3);

■ e. Revising paragraph (j)(3);

■ f. By adding paragraphs (l), (m), and (n).

The revisions and additions read as follows:

§ 413.338 Skilled nursing facility value-based purchasing program.

(a) * * *

* * * * *

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.

* * * * *

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.

* * * * *

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.

* * * * *

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.

* * * * *

(f) * * *

(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 each of these reports to review and submit corrections to the calculation of the measure rates contained in that report. The data used to calculate measure rates are not subject to review and correction under this paragraph. 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.

* * * * *

(j) * * *

(3) Beginning with the FY 2027 program year, 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.

* * * * *

(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 (l)(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 measure 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 CEO or CEO-designated personnel, including all applicable names, email addresses, telephone numbers, and the SNF's physical mailing address (which cannot be a PO 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 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;

(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 CMS incorporates non-substantive technical updates made to the measure between the time that CMS first announces the performance standards for the measure for a fiscal year and the time that CMS calculates SNF performance on the measure at the conclusion of the performance period for that measure for a fiscal year.

■ 4. Section 413.360 is amend by—

■ a. Revising paragraph (f)(1) introductory text;

■ b. Adding paragraph (f)(1)(iv);

■ c. Revising paragraph (f)(3); and

■ d. Adding paragraph (g).

The additions and revision read as follows:

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

* * * * *

(f) * * *

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

* * * * *

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

* * * * *

(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) of this Part.

(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 calendar year 3 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 of this part.

(ii) For each SNF selected under paragraph (g)(1) of this section, 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 of this part. CMS will submit its request in writing to the selected SNF.

(iii) A SNF that receives a request for medical records under paragraph (g)(2) 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.

(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).

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 5. The authority citation for part 488 continues to read as follows:

Authority: 42 U.S.C 1302 and 1395hh.

■ 6. Section 488.401 is amended by adding the definition of ''Instance or instances of noncompliance'' in alphabetical order to read as follows:

§ 488.401 Definitions.

* * * * *

Instance or instances of noncompliance means a factual and temporal occurrence(s) when a facility is not in substantial compliance with the requirements for participation. Each instance of noncompliance is sufficient to constitute a deficiency and a deficiency may comprise of multiple instances of noncompliance.

* * * * *

■ 7. Section 488.408 is amended by revising paragraph (e)(2)(ii) to read as follows:

§ 488.408 Selection of remedies.

* * * * *

(e) * * *

(2) * * *

(ii) For each instance of noncompliance, CMS and the State may impose a civil money penalty of $3,050-$10,000 (as adjusted annually under 45 CFR part 102) per day, $1,000-$10,000 (as adjusted annually under 45 CFR part 102) per instance of noncompliance, or both, in addition to imposing the remedies specified in paragraph (e)(2)(i) of this section. For multiple instances of noncompliance, CMS may impose any combination of per instance or per day civil money penalties for each instance within the same survey. The aggregate civil money penalty amount may not exceed $10,000 (as adjusted annually under 45 CFR part 102) for each day of noncompliance.

* * * * *

■ 8. Revise § 488.430 to read as follows:

§ 488.430 Civil money penalties: Basis for imposing penalty.

(a) CMS or the State may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, or both, regardless of whether or not the deficiencies constitute immediate jeopardy. When a survey contains multiple instances of noncompliance, CMS or the State may impose any combination of per instance or per day civil money penalties for each instance of noncompliance within the same survey.

(b) CMS or the State may impose a civil money penalty for the number of days of past noncompliance, including the number of days of immediate jeopardy, since the last three standard surveys.

■ 9. Section 488.434 is amended by revising paragraphs (a)(2)(iii) and (v) to read as follows:

§ 488.434 Civil money penalties: Notice of penalty.

(a) * * *

(2) * * *

(iii) Either the amount of penalty per day of noncompliance or the amount of the penalty per instance of noncompliance or both;

* * * * *

(v) The date(s) of the instance(s) of noncompliance or the date on which the penalty begins to accrue;

* * * * *

■ 10. Section 488.440 is amended by revising paragraph (a)(2) to read as follows:

§ 488.440 Civil money penalties: Effective date and duration of penalty.

(a) * * *

(2) A civil money penalty for each instance of noncompliance is imposed in a specific amount per instance.

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Xavier Becerra,

Secretary, Department of Health and Human Services.

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