Medicare Skilled Nursing Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2022

Overview and Resources

On July 29, 2021, the Centers for Medicare and Medicaid Services (CMS) released the final federal fiscal year (FFY) 2022 payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

A copy of the final rule and other resources related to the SNF PPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

As of August 4, 2021, an online version of the final rule is available at https://federalregister.gov/d/2021-16309.

Program changes adopted by CMS would be effective for discharges on or after October 1, 2021, unless otherwise noted. CMS estimates the overall economic impact of this adopted payment rate update to be an increase of $410 million in aggregate payments to SNFs in FFY 2022 over FFY 2021 and a reduction of $191.64 million due to the SNF Value-Based Purchasing Program (VBP) carve-out.

Note: Text in italics are extracted from either the April 15, 2021 or August 4, 2021 *Federal Register.*

SNF Payment Rates

Federal Register pages 42,427 – 42,433, 42,438 and 42,444 – 42,463

Incorporating the adopted updates with the effect of a budget neutrality adjustment, the tables below show the adopted urban and rural SNF federal per-diem payment rates for FFY 2022 compared to the rates currently in effect. These rates apply to hospital-based and freestanding SNFs, as well as to payments made for non-Critical Access Hospital (CAH) swing-bed services:

Case-Mix Rate Component		Urban SNFs		
		PDPM		Percent Change
		Final FFY 2021	Final FFY 2022	
Nursing	**Nursing**	**$108.16**	**$109.51**	**+1.26%**
	Non-Therapy Ancillary (NTA)	**$81.60**	**$82.62**	
Therapy	**Physical Therapy (PT)**	**$62.04**	**$62.82**	
	Occupational Therapy (OT)	**$57.75**	**$58.48**	
	Speech Language Pathology (SLP)	**$23.16**	**$23.45**	
Non-Case-Mix		**$96.85**	**$98.07**	

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<table>
<tr><th colspan="2" rowspan="3">Unadjusted Case-Mix Rate Component</th><th colspan="3">Rural SNFs</th></tr>
<tr><th colspan="2">PDPM</th><th>Percent Change</th></tr>
<tr><th>Final
FFY 2021</th><th>Final
FFY 2022</th><th></th></tr>
<tr><td rowspan="2">Nursing</td><td>Nursing</td><td>$103.34</td><td>$104.63</td><td rowspan="6">+1.26%</td></tr>
<tr><td>Non-Therapy Ancillary (NTA)</td><td>$77.96</td><td>$78.93</td></tr>
<tr><td rowspan="3">Therapy</td><td>Physical Therapy (PT)</td><td>$70.72</td><td>$71.61</td></tr>
<tr><td>Occupational Therapy (OT)</td><td>$64.95</td><td>$65.77</td></tr>
<tr><td>Speech Language Pathology (SLP)</td><td>$29.18</td><td>$29.55</td></tr>
<tr><td colspan="2">Non-Case-Mix</td><td>$98.64</td><td>$99.88</td></tr>
</table>

The table below provides details of the adopted updates to the SNF payment rates for FFY 2022:

	Final SNF Rate Updates
Marketbasket Update	**+2.7%** *(proposed at +2.3%)*
Affordable Care Act (ACA)-Mandated Productivity Adjustment	**-0.7 percentage points (PPT)** *(proposed at -0.2 PPT)*
Forecast Error Adjustment	**-0.8 percentage points**
Wage Index/Labor-Related Share Budget Neutrality	**1.0006** *(proposed at 0.9999)*
Overall Rate Change	***+1.26%*** *(proposed at +1.3%)*

For FFY 2022, CMS is also adopting an update to the base year used to develop the SNF market basket from FFY 2014, to FFY 2018.

The FFY 2014-based SNF market basket used the Moody's AAA Corporate Bond Yield index as the price proxy for the For-profit Interest cost category. For the FFY 2018-based market basket, CMS will use the iBoxx AAA Corporate Bond Yield index, which closely resembles the Moody's AAA Corporate Bond Yield index, as the Moody's AAA Corporate Bond series is no longer available for use under license to IHS Global Inc. (IGI), and therefore, IGI discontinued the publication of the associated historical data and forecasts of this series.

Wage Index, Labor-Related Share, and Revised CBSA Delineations

Federal Register pages 42,436 – 42,439 and 42,461 – 42,463

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the SNF rates that CMS considers to be labor-related. As mentioned above, for FFY 2022, CMS is adopting an update of the SNF marketbasket base year to FFY 2018, which also affects the calculation of the labor share. The labor-related share for FFY 2022 is finalized at 70.4% (proposed at 70.1%) compared to 71.3% in FFY 2021.

CMS is adopting a wage index and labor-related share budget neutrality factor of 1.0006 for FFY 2022 to ensure that aggregate payments made under the SNF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

A complete list of the wage indexes adopted for payment in FFY 2022 is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Case-Mix Adjustment

FR pages 42,434 – 42,436 and 42,464 – 42,471

CMS uses a classification system to adjust payments to account for the relative resource utilization of different types of patients. The case-mix components of the Patient Driven Payment Model (PDPM) address costs

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associated with an individual's specific needs and characteristics, while the non-case-mix component addresses consistent costs that are incurred for all residents, such as room and board and various capital-related expenses.

The PDPM classifies each resident into five components (PT, OT, OLP, Nursing, and NTA) and provides a single payment based on the sum of these individual characteristics. The payment for each component is calculated by multiplying the CMI for the resident's group by the component federal base payment rate and then by the specific day in the variable per diem adjustment schedule noted below. These payments are added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate.

The adopted FFY 2022 CMI updates for each component may be found in Tables 6 and 7 on pages 42,435 – 42,436 of the *Federal Register*.

For FFY 2022, CMS is adopting a number of changes to the PDPM ICD-10 code mappings:

ICD-10 Code	ICD-10 Description	Current Category Mapping	Adopted Category Mapping
D57.42	Sickle-cell thalassemia beta zero without crisis	Medical Management	Return to Provider
D57.44	Sickle-cell thalassemia beta plus without crisis	Medical Management	Return to Provider
K20.81	Other esophagitis with bleeding	Return to Provider	Medical Management
K20.91	Esophagitis, unspecified with bleeding	Return to Provider	Medical Management
K21.01	Gastro-esophageal reflex disease with esophagitis, with bleeding	Return to Provider	Medical Management
M35.81	Multisystem inflammatory syndrome	Non-Surgical Orthopedic/ Musculoskeletal	Medical Management
P91.821	Neonatal cerebral infarction, right side of brain	Return to Provider	Acute Neurologic
P91.822	Neonatal cerebral infarction, left side of brain	Return to Provider	Acute Neurologic
P91.823	Neonatal cerebral infarction, bilateral	Return to Provider	Acute Neurologic
U07.0	Vaping-related disorder	Return to Provider	Pulmonary
G93.1	Anoxic brain damage, not elsewhere classified	Return to Provider	Acute Neurologic

Recalibrating the PDPM Parity Adjustment

Federal Register pages 42,466 – 42,471

With the implementation of the SNF PDPM, CMS introduced a standardized multiplier and parity adjustment to ensure that PDPM was budget neutral in comparison to the prior RUG-IV case-mix methodology. CMS' standard methodology for recalibrating parity adjustments involves comparing total payments under a new case-mix model, with what those payments would have been under the prior model. For the SNF PPS, CMS compared FFY 2020 PDPM payments to FFY 2020 RUG-IV payments. In order to calculate total SNF payments under PDPM, CMS used FFY 2020 claims, and removed the subset of the population with a COVID-19 diagnosis or Public Health Emergency (PHE)-related waiver. For the RUG-IV payment calculation, CMS believes it would be inappropriate to use FFY 2020 claims data for RUG-IV classifications, and therefore CMS instead used FFY 2019, inflated by the FFY 2020 update factor.

Under this comparison, CMS discovered a 5.3% increase in SNF spending under PDPM, relative to RUG-IV for FFY 2020, and a 5.0% increase when removing the subset of the population diagnosed with COVID-19 or with a PHE-related waiver. Using this methodology, the PDPM parity adjustment factor would decrease from 46% to 37%, resulting in an estimated decrease to FFY 2022 SNF spending of $1.7 billion (5.0%). In the proposed rule, CMS had requested public comment on the methodology used to obtain these values, including on the use of FFY 2019 data to develop the RUG-IV comparative case-mix distributions.

As a 5.0% reduction to FFY 2022 SNF payments could create a financial burden on providers, CMS had also considered two types of transitional strategies for implementation of the potential prospective budget neutrality adjustment. This strategy could take the form of either a delayed implementation where the reduction would be adopted now and implemented in a future year; or a phased implementation under which the adjustment would be phased in over some number of years; or a combination of the two. CMS again invited public comment on the approach to mitigating the PDPM parity adjustment recalibration, if adopted.

CMS had also invited public comment on changes to SNF behavior following implementation of the PDPM, which has led to an increase in SNF spending not necessarily related to the COVID-19 crisis. In addition, CMS sought comment on the potential impact of using reported FFY 2020 patient assessment data from the Minimum Data Set (MDS) to reclassify beneficiaries under RUG-IV for the calculation of a SNF parity adjustment.

While CMS has not yet made a determination, comments received by CMS may be seen on pages 42,469 – 42,471 of the *Federal Register*.

Consolidated Billing

Federal Register pages 42,430 – 42,433 and 42,442 – 42,444

CMS requires a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) that must include services its residents receive during a Part A stay. A small list of services are currently excluded from consolidated billing and are separately billable under Part B when furnished to a SNF's Part A resident. CMS continues to invite public comment to identify additional HCPCS codes that might meet criteria for exclusion from SNF consolidated billing. These HCPCS codes can be from any of the five service categories specified by CMS: chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors.

The Consolidated Appropriations Act, 2021 added certain blood clotting factors for the treatment of patients with hemophilia and other bleeding disorders to the list of items and services excluded from Part A per diem payment effective FFY 2022. Due to the addition of the blood clotting factors service category, CMS is adopting its proposal to make a proportional reduction of $0.02 to the unadjusted urban and rural SNF rates to reflect the new exclusions, which would result in an estimated $1.2 million decrease to SNF PPS payments

The latest list of excluded codes can be found on CMS' SNF Consolidated Billing website at https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling.

SNF Value-Based Purchasing Program

Federal Register pages 42,439 and 42,502 – 42,517

Background: For FFYs 2019 and beyond, CMS is required by the Protecting Access to Medicare Act of 2014 (PAMA) to utilize a VBP (Value-Based Purchasing) program for SNFs under which value-based incentive payments are made to the SNFs. CMS withholds 2% of SNFs' fee-for-service Part A Medicare payments to fund the program. CMS redistributes between 50% and 70% of the withheld payments to SNFs as incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure.

CMS calculates rates for the sole SNF VBP measure, Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM), using one year of data for each of the baseline and performance periods. The baseline and performance periods for each program year for FFYs 2022+ are set to the following one year period for each of the baseline and performance periods from the prior program year.

CMS is finalizing these baseline and performance periods for the FFY 2024 program year (which uses older baseline period data than traditional used due to the COVID-19 PHE exceptions):

Baseline period	Performance Period	Payment Period
October 1, 2018– September 30, 2019	**October 1, 2021 – September 30, 2022**	**FFY 2024**

In this FFY 2022 final rule, CMS is adopting the following performance standards for the SNFRM for the FFY 2024 program year, based on the most recent available data from FFY 2019:

Measure ID	Finalized Performance Standards
SNFRM	**Achievement threshold 0.79271**
	Benchmark 0.83033

For FFY 2023, CMS is adopting measure suppression factors for SNF VBP program years overlapping with those years affected by the COVID-19 PHE. Additionally, CMS is also adopting these factors for the Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, HAC Reduction Program, and the End-Stage Renal Disease Quality Incentive Program in order to maintain program consistency. The adopted measure suppression factors are:

- *"Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years.*
- *Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.*
- *Rapid or unprecedented changes in:*
    - *Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or*
    - *The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.*
- *Significant national shortages or rapid or unprecedented changes in:*
    - *Healthcare personnel;*
    - *Medical supplies, equipment, or diagnostic tools or materials; or*
    - *Patient case volumes or facility-level case mix."*

Tied to this finalized suppression policy, CMS will suppress the SNFRM for the FFY 2022 SNF VBP program year due to the COVID-19 PHE (CMS has previously issued an Interim Final Rule that updated the FFY 2022 SNF VBP program performance period to April 1, 2019 – December 1, 2019 and July 1, 2020 – September 30, 2020). Under this adopted policy, CMS will continue to withhold 2% of payments from participating SNFs, but would then award all SNFs a 1.2% payback. SNFs subject to the Low-Volume Adjustment policy (fewer than 25 eligible stays) would instead receive the full 2% back. SNFs will not be ranked for the FFY 2022 program. CMS is not making any changes to the FFY 2023 program year at this time.

For the FFY 2023 SNF VBP Program, CMS has adopted a 90-day lookback period for risk adjustment of the SNFRM when it applies to FFY 2021, instead of the full 365 days prior to hospital discharge to the SNF, due to the COVID-19 PHE.

The Consolidated Appropriations Act of 2021 allows for up to 9 additional measures to be added to the SNF VBP program beginning FFY 2024. In the SNF proposed rule, CMS had sought comment on the adoption of additional SNF VBP measures for future program years. The additional measures under consideration may be found in Table 30 on page 42,509 of the *Federal Register*. Comments on these measures may be seen on pages 42,509 – 42,511 of the *Federal Register*.

Phase One Review and Correction Claims “Snapshot” Policy

Federal Register pages 42,516 – 42,517

In the FFY 2017 SNF PPS final rule, CMS adopted a two-phase review and corrections process for SNFs’ quality measure data and SNF performance information, as well as a process for requesting and submitting Phase One corrections.

CMS has adopted its proposal *“to include a Phase One Review and Correction claims ‘snapshot’ policy beginning with the baseline period and performance period quality measure quarterly reports issued on or after October 1, 2021. This proposed policy would limit the Phase One Review and Correction to errors made by CMS or its contractors when calculating a SNF’s readmission measure rate and will not allow corrections to the underlying administrative claims data used to calculate those rates. Under this… policy, the administrative claims data we use to calculate a SNF’s readmission measure rate for purposes of a baseline period or performance period for a given SNF VBP program year would be held constant (that is, frozen in a ‘snapshot’) from the time we extract it for that purpose. This… would align the review and correction policy for the SNF VBP Program with the review and correction policy we have adopted for other value-based purchasing programs”*

SNF Quality Reporting Program (QRP)

Federal Register pages 42,471 – 42,502

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates a quality reporting program for SNFs. Beginning in FFY 2018, the IMPACT Act requires a 2 percentage point penalty, is applied to the standard market basket rate adjustment, for those SNFs that fail to submit required quality data to CMS.

Summary Table of Domains and Measures Currently Adopted for the FFY 2022 SNF QRP	
Short Name	**Measures**
Resident Assessment Instrument Minimum Data Set Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631)
Change in Mobility Score	Application of Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Change in Self-Care Score	Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health Information to the Patient PAC
Claims-Based Measures	
MSPB SNF	Total Estimated Medicare Spending per Beneficiary (MSPB)

DTC	Discharge to Community
PPR	Potentially Preventable 30-Day Post Discharge Readmission Measure

Due to the COVID-19 PHE, CMS has delayed the compliance date for collection and reporting of the TOH-Provider and TOH-Patient measures for at least two full fiscal years following the end of the PHE.

For the FFY 2023 SNF QRP, CMS is making the following changes to the list of measures and reporting requirements:

- **Add:** SNF Healthcare-Associated Infections Requiring Hospitalizations measure (SNF HAI)
    - Adopted the use of FFY 2019 data to calculate the measure due to being the most recent fiscal year not exempted due to the PHE. FFY 2021 claims will be used beginning with the FFY 2024 SNF QRP.
    - Measure will be publicly reported beginning with FFY 2019 discharges for the April 2022 refresh of the Care Compare website, with FFY 2021 discharges to be publically reported with the October 2022 refresh.
- **Add:** COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure
    - Hospitals will submit data used to calculate this measure using NHSN's standard data submission requirements, using the CDC/NHSN web-based surveillance system.
    - Has an initial data submission period of October 1, 2021 – December 31, 2021 (FFY 2023 SNF QRP), with full calendar year submissions required beginning with calendar year (CY) 2022 (FFY 2024 SNF QRP).
    - Measure will be publicly reported beginning with data collected for the period of October 1, 2021 – December 31, 2021 with the October 2022 refresh of the Care Compare website. CMS had proposed that thereafter, this measure would be displayed based on one quarter of data, and would be updated quarterly with an additional quarter of data added to the measure. After four full quarters of data are available, CMS had proposed this measure would be reported using four rolling quarters of data. However, CMS has instead finalized that they shall only report the most recent quarter of data for each refresh during this timeframe, until four full quarters of data are available.
- **Update:** Change to the denominator for the "Transfer of Health (TOH) Information to the Patient – Post-Acute Care (PAC)" measure to exclude residents discharged home under the care of an organized home health service or hospice in order to align the measure with other quality reporting programs and to avoid counting the patient in both of the Transfer of Health measures in the SNF QRP.

Due to the temporary reporting exemptions put into place due to the COVID-19 PHE, SNF QRP data from January 1, 2020 – June 30, 2020 will not be publicly reported. This restriction would affect a number of quarterly Care Compare website refreshes for the MDS assessment-based measures and claims-based measures as shown in Table 26 on page 42,499 of the *Federal Register*. As a result, CMS has frozen the MDS assessment-based data available on the Care Compare website at what was available with the October 2020 quarterly update. CMS will utilize their "COVID-19 Affected Reporting (CAR) Scenario" (*Federal Register* page 213) in order to determine when updates of these measures will resume. This will allow for CMS to begin updating the Care Compare website with the January 2022 refresh, with fewer quarters of data available. CMS' revised reporting schedules can be found below, note that not all data updates will resume in January 2022.

<table>
<tr><th>Quarter Refresh</th><th>Adopted MDS Assessment Quarters (Number of quarters)</th></tr>
<tr><td>October 2020</td><td rowspan="5">Q1 2019 – Q4 2019 (4 quarters)</td></tr>
<tr><td>January 2021</td></tr>
<tr><td>April 2021</td></tr>
<tr><td>July 2021</td></tr>
<tr><td>October 2021</td></tr>
<tr><td>January 2022</td><td>Q3 2020 – Q1 2021 (3 quarters)</td></tr>
<tr><td>April 2022</td><td>Q3 2020 – Q2 2021 (4 quarters)</td></tr>
</table>

<table>
<tr><th>Quarter Refresh</th><th>Adopted Claims-based Quarters (Number of quarters)</th><th>Quarter Refresh</th><th>Adopted Claims-based Quarters (Number of quarters)</th></tr>
<tr><td>October 2020</td><td rowspan="5">Q4 2017 – Q3 2019 (8 quarters)</td><td>Jul 2022</td><td>Q4 2018 – Q3 2019, Q3 2020 (6 quarters)</td></tr>
<tr><td>January 2021</td><td>October 2022</td><td rowspan="4">Q4 2019, Q3 2020 – Q3 2021 (6 quarters)</td></tr>
<tr><td>April 2021</td><td>January 2023</td></tr>
<tr><td>July 2021</td><td>April 2023</td></tr>
<tr><td>October 2021</td><td>July 2023</td></tr>
<tr><td>January 2022</td><td rowspan="2">Q4 2018 – Q3 2019, Q3 2020 (6 quarters)</td><td>October 2023</td><td>Q4 2020 – Q3 2022 (8 quarters)</td></tr>
<tr><td>April 2022</td><td colspan="2"></td></tr>
</table>

Quarter Refresh	Quarters for the SNF HAI Measure (Number of quarters)
April 2022	Q4 2018 – Q3 2019 (4 quarters)
July 2022	Q4 2018 – Q3 2019 (4 quarters)
October 2022	Q4 2020 – Q3 2021 (4 quarters)

Additionally, with the proposed rule, CMS had issued a Request for Information (RFI) on the inclusion of the following measures into later years of the SNF QRP:

Assessment-Based Quality Measures and Measure Concepts
Frailty
Patient reported outcomes
Shared decision making process
Appropriate pain assessment and pain management processes
Health equity

In this final rule, CMS did not respond to any specific comments on the SNF QRP RFI, though they intend to use them to inform future rulemaking.

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Management Programs – Request for Information

Federal Register page 42,491

To remain SNF QRP alignment with the Meaningful Measures 2.0 framework, in the SNF proposed rule CMS requested feedback on future plans to define digital quality measures (dQMs) for the SNF QRP, as well as on the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the SNF QRP and aligning with other quality programs wherever possible. FHIR is a common language and process for health information technology that allows for exchange of clinical information through application programming interfaces so that clinicians can digitally submit quality information one time and it can then be used in many ways to enable collaboration and information sharing.

CMS had proposed the following definition: "*Digital quality measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes a calculation that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments…, patient portals or applications… health information exchanges (HIEs) or registries, and other sources."*

FHIR-based standards would allow for the *"exchange of clinical information through application programming interfaces (APIs), aligning with other programs where possible, to allow clinicians to digitally submit quality information one time that can be used in many ways. We believe that in the future proposing such a standard within the SNF QRP could potentially enable collaboration and information sharing, which is essential for delivering high-quality care and better outcomes at a lower cost."*

In this final rule, CMS states that they will continue to take comments received on this RFI into account as they develop future proposals or policy guidance, but did not directly respond to any that had been submitted.

Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs – Request for Information

Federal Register pages 42,491 – 42,492

In the SNF proposed rule, CMS had requested public comment on potential revisions to the SNF QRP to make reporting of health disparities based on social risk factors and race/ethnicity more comprehensive and actionable for providers and patients. CMS states it is committed to achieving equity in health care outcomes and supporting providers in quality improvement activities to reduce health inequities.

Specifically, CMS is currently seeking comment on:

- *"Recommendations for quality measures, or measurement domains that address health equity, for use in the SNF QRP.*
- *…SNFs must report certain standardized patient assessment data elements (SPADEs) on SDOH, including race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of SNF residents, for use in the SNF QRP.*
- *Recommendations for how CMS can promote health equity in outcomes among SNF residents. For example, we are interested in feedback regarding whether including facility-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow facilities to identify gaps in the quality of care they provide…*
- *Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.*

- *…the existing challenges providers' encounter for effective capture, use, and exchange of health information, including data on race, ethnicity, and other social determinants of health, to support care delivery and decision making."*

In this final rule, CMS states that they are continuing to take comments on this RFI, though they did not respond to any that have already been submitted.

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