Medicare Skilled Nursing Facility Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2022

Overview and Resources

On April 8, 2021, the Centers for Medicare and Medicaid Services (CMS) released the proposed federal fiscal year (FFY) 2022 payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

A copy of the proposed 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.

An online version of the proposed rule is available at https://federalregister.gov/d/2021-07556.

Program changes proposed by CMS would be effective for discharges on or after October 1, 2021, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $444 million in aggregate payments to SNFs in FFY 2022 over FFY 2021 with a reduction of $191.64 million due to the SNF Value-Based Purchasing Program (VBP).

Comments on the proposed rule are due to CMS by June 7, 2021 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1746-P".

Note: Text in italics is extracted from the *Federal Register.*

SNF Payment Rates

Federal Register pages 19,957 – 19,961 and 19,969 – 19,984

Incorporating the proposed updates with the effect of a budget neutrality adjustment, the tables below show the proposed urban and rural SNF federal per-diem payment rates for FFY 2021 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	Proposed FFY 2022	
Nursing	**Nursing**	**$108.16**	**$109.55**	**+1.3%**
	Non-Therapy Ancillary (NTA)	**$81.60**	**$82.64**	
Therapy	**Physical Therapy (PT)**	**$62.04**	**$62.84**	
	Occupational Therapy (OT)	**$57.75**	**$58.49**	
	Speech Language Pathology (SLP)	**$23.16**	**$23.46**	
Non-Case-Mix		**$96.85**	**$98.10**	

Unadjusted Case-Mix Rate Component		Rural SNFs		
		PDPM		Percent Change
		Final FFY 2021	Proposed FFY 2022	
Nursing	**Nursing**	**$103.34**	**$104.66**	**+1.3%**
	Non-Therapy Ancillary (NTA)	**$77.96**	**$78.96**	
Therapy	**Physical Therapy (PT)**	**$70.72**	**$71.63**	
	Occupational Therapy (OT)	**$64.95**	**$65.79**	
	Speech Language Pathology (SLP)	**$29.18**	**$29.56**	
Non-Case-Mix		**$98.64**	**$99.91**	

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

	Proposed SNF Rate Updates
Marketbasket Update	**+2.3%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.2 percentage points**
Forecast Error Adjustment	**-0.8 percentage points**
Wage Index/Labor-Related Share Budget Neutrality	**0.9999**
Overall Rate Change	***+1.3%***

For FFY 2022, CMS is also proposing to update 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 is proposing to 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 19,963 – 19,965 and 19,982– 19,983

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 proposing to update the SNF marketbasket base year to FFY 2018, which would also affect the calculation of the labor share. The labor-related share for FFY 2022 is proposed at 70.1% compared to 71.3% in FFY 2021.

CMS is proposing a wage index and labor-related share budget neutrality factor of 0.9999 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 proposed 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

Federal Register pages 19,961 – 19,963 and 19,984 – 19,990

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

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 FFY 2022 proposed CMI updates for each component may be found in Tables 6 and 7 on pages 19,962-19,963 of the *Federal Register*.

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

ICD-10 Code	ICD-10 Description	Current Category Mapping	Proposed 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 19,985 – 19,990

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%). CMS is requesting 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 (*Federal Register* pages 19,987 – 19,989).

As a 5.0% reduction to FFY 2022 SNF payments could create a financial burden on providers, CMS is also considering 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 invites public comment on the approach to mitigating the PDPM parity adjustment recalibration, if adopted.

CMS is also inviting 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. CMS is also seeking 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.

Consolidated Billing

Federal Register pages 19,967 – 19,968

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 proposing 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 19,965 and 20,006 – 20,014

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 proposing 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 proposed rule, CMS is proposing 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	Proposed Performance Standards
SNFRM	**Achievement threshold** **0.79270**
	Benchmark **0.83028**

For FFY 2023, CMS is proposing to adopt measure suppression factors for SNF VBP program years overlapping with those years affected by the COVID-19 PHE. Additionally, CMS is also proposing to adopt 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 proposed 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."*

In addition, CMS seeks comments on the adoption of a measure suppression policy that would affect any future national PHE, and whether CMS should have flexibility under such a policy to suppress quality measures outside of rulemaking. CMS is also seeking comment on if in future years a form of regional adjustment for this policy should be adopted, and if suppression should have a more granular basis, rather than suppressing a measure entirely.

Tied to this proposed suppression policy, CMS is proposing to 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 proposed policy, CMS would 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. CMS is not proposing any changes to the FFY 2023 program year at this time.

For the FFY 2023 SNF VBP Program, CMS is proposing 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.

CMS is seeking comment on the adoption of additional SNF VBP measures for future program years. The additional measures currently under consideration may be found in Table 31 on page 20,010 – 20,011 of the *Federal Register*.

Phase One Review and Correction Claims "Snapshot" Policy

Federal Register pages 20,014 – 20,015

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 is *"proposing 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 proposed 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 proposal 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, including the Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, and Hospital Value-Based Purchasing (VBP) Program."*

SNF Quality Reporting Program (QRP)

Federal Register pages 19,990 – 20,006

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

Please be aware that 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 proposing the following changes to the list of measures and reporting requirements:

- **Add:** SNF Healthcare-Associated Infections Requiring Hospitalizations measure (SNF HAI)
    - Proposal is to use FFY 2019 data to calculate the measure due to being the most recent fiscal year not exempted due to the PHE. FFY 2021 claims would be used beginning with the FFY 2024 SNF QRP.
    - Measure is proposed to be publicly reported beginning with FFY 2019 discharges for the April 2022 refresh of the Care Compare website, with FFY 2021 discharges going up with the October 2022 refresh.
- **Add:** COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure
    - Proposal to submit data used to calculate this measure using NHSN's standard data submission requirements, using the CDC/NHSN web-based surveillance system.
    - Proposed 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 is proposed to 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. 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, this measure would be reported using four rolling quarters of data.
- **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 organizes 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 may 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 28 on page 20,003 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 is proposing to utilize their "COVID-19 Affected Reporting (CAR) Scenario" (page 20,004) in order to determine when updates of these measures will resume. This proposal would allow for CMS to begin updating the Care Compare website with the January 2022 refresh, with fewer quarters of data available. CMS' proposed revised reporting schedules can be found below.

Quarter Refresh	Proposed MDS Assessment Quarters (Number of quarters)
October 2020	Q1 2019 – Q4 2019 (4 quarters)
January 2021	
April 2021	
July 2021	
October 2021	
January 2022	Q3 2020 – Q1 2021 (3 quarters)
April 2022	Q3 2020 – Q2 2021 (4 quarters)

Quarter Refresh	Proposed Claims-based Quarters (Number of quarters)	Quarter Refresh	Proposed Claims-based Quarters (Number of quarters)
October 2020	Q4 2017 – Q3 2019 (8 quarters)	Jul 2022	Q4 2018 – Q3 2019, Q3 2020 (6 quarters)
January 2021		October 2022	Q4 2019, Q3 2020 – Q3 2021 (6 quarters)
April 2021		January 2023	
July 2021		April 2023	
October 2021		July 2023	
January 2022	Q4 2018 – Q3 2019, Q3 2020 (6 quarters)	October 2023	Q4 2020 – Q3 2022 (8 quarters)
April 2022			

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, CMS is issuing 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

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

Federal Register pages 19,998 – 20,000

To remain SNF QRP alignment with the Meaningful Measures 2.0 framework, CMS is seeking 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 is proposing 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."*

Specifically, CMS is seeking input on the following steps to enable the full digital transformation of CMS' quality measurements:

- *"What EHR/IT systems do you use, and do you participate in a health information exchange (HIE)?*
- *How do you currently share information with other providers?*
- *In what ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to SNFs?*
- *What additional resources or tools would post-acute care settings, including but not limited to SNFs, and health IT vendors find helpful to support the testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?*
- *Would vendors, including those that service post-acute care settings, such as SNFs, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?"*

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

Federal Register pages 20,000 – 20,001

CMS is requesting 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 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."*

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