Medicare Skilled Nursing Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2023

Overview and Resources

On July 29, 2022, the Centers for Medicare and Medicaid Services (CMS) released the final federal fiscal year (FFY) 2023 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.

An online version of the final rule is available at https://federalregister.gov/d/2022-16457.

Program changes adopted by CMS will be effective for discharges on or after October 1, 2022, unless otherwise noted. CMS estimates the overall economic impact of this final payment rate update to be an increase of $904 million (proposed as a decrease of $320 million) in aggregate payments to SNFs in FFY 2023 over FFY 2022, a reduction of $185.55 million (as proposed) due to the SNF Value-Based Purchasing Program (VBP) carve-out, and an increase of $30.95 million (as proposed) in aggregate cost to SNFs due to the QRP changes.

Note: Text in italics are extracted from either the April 15, 2022 or August 3, 2022 *Federal Register.*

SNF Payment Rates

Federal Register pages 47505 – 47511

The tables below show the adopted urban and rural SNF federal per-diem payment rates for FFY 2023 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:

Unadjusted Case-Mix Rate Component		Urban SNFs		
		PDPM		Percent Change
		Final FFY 2022	Final FFY 2023	
Nursing	**Nursing**	**$109.51**	**$115.15** (proposed at $113.91)	**+5.1%**
	Non-Therapy Ancillary (NTA)	**$82.62**	**$86.88** (proposed at $85.94)	
Therapy	**Physical Therapy (PT)**	**$62.82**	**$66.06** (proposed at $65.34)	
	Occupational Therapy (OT)	**$58.48**	**$61.49** (proposed at $60.83)	
	Speech Language Pathology (SLP)	**$23.45**	**$24.66** (proposed at $24.39)	
Non-Case-Mix		**$98.07**	**$103.12** (proposed at $102.01)	

Unadjusted Case-Mix Rate Component		Rural SNFs		
		PDPM		Percent Change
		Final FFY 2022	Final FFY 2023	
Nursing	**Nursing**	**$104.63**	**$110.02** (proposed at $108.83)	**+5.1%**
	Non-Therapy Ancillary (NTA)	**$78.93**	**$83.00** (proposed at $82.10)	
Therapy	**Physical Therapy (PT)**	**$71.61**	**$75.30** (proposed at $74.48)	
	Occupational Therapy (OT)	**$65.77**	**$69.16** (proposed at $68.41)	
	Speech Language Pathology (SLP)	**$29.55**	**$31.07** (proposed at $30.74)	
Non-Case-Mix		**$99.88**	**$105.03** (proposed at $103.89)	

The table below provides details of the adopted updates to the SNF payment rates for FFY 2023:

	Final SNF Rate Updates
Marketbasket Update	**+3.9%** (proposed at +2.8%)
Affordable Care Act (ACA)-Mandated Productivity Adjustment	**-0.3 percentage points (PPT)** (proposed at -0.4 PPT)
Forecast Error Adjustment	**+1.5 PPT** (as proposed)
Wage Index/Labor-Related Share Budget Neutrality	**1.0005** (proposed at 1.0011)
Overall Rate Change	***+5.1%** (proposed at +4.02%)*

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

Federal Register pages 47513 – 47516 and 54 – 60

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. The labor-related share for FFY 2023 is finalized at 70.8% (proposed at 70.7%) compared to 70.4% in FFY 2022.

In the past, CMS has implemented wage index transition policies with limited duration in order to phase in significant changes to the wage index in order to mitigate the short-term negative impact on affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of SNF payments, CMS is adopting to apply a 5% cap on any decrease of the FFY 2023 SNF wage index, and all future SNF wage indexes, compared with the previous year's wage index. This cap will be applied regardless of the reason for the decrease and would be implemented in a budget neutral manner. This also means that if a SNF's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the SNF's capped wage index in the prior FFY. Lastly, CMS finalized its proposal that a new SNF be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new SNF would not have a wage index in the prior FFY.

CMS is adopting a wage index and labor-related share budget neutrality factor of 1.0005 (proposed at 1.0011) for FFY 2023 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. This includes the budget neutrality for the adopted 5% cap on wage index decreases.

A complete list of the wage indexes adopted for payment in FFY 2023 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 47511 – 47513 and 47523 – 47534

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, SLP, 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 final FFY 2023 CMI updates for each component may be found in Tables 5 and 6 on pages 47512 - 47513 of the *Federal Register*.

For FFY 2023, CMS adopted a number of changes to the PDPM ICD-10 code mappings:

ICD-10 Code	ICD-10 Description	Current Category Mapping	Final Category Mapping
D75.839	Thrombocytosis, unspecified	Cardiovascular and Coagulations	Return to Provider
D89.44	Hereditary alpha tryptasemia	Medical Management	Return to Provider
F32.A	Depression, unspecified	Medical Management	Return to Provider
G92.9	Unspecified toxic encephalopathy	Acute Neurologic	Return to Provider
M54.50	Low back pain, unspecified	Non-surgical Orthopedic/Musculoskeletal	Return to Provider
K22.11	Ulcer of esophagitis with bleeding	Return to Provider	Medical Management
K25.0	Acute gastric ulcer with hemorrhage	Return to Provider	Medical Management
K25.1	Acute gastric ulcer with perforation	Return to Provider	Medical Management
K25.2	Acute gastric ulcer with both hemorrhage and perforation	Return to Provider	Medical Management
K26.0	Acute duodenal ulcer with hemorrhage	Return to Provider	Medical Management
K26.1	Acute duodenal ulcer with perforation	Return to Provider	Medical Management
K26.2	Acute duodenal ulcer with both hemorrhage and perforation	Return to Provider	Medical Management
K27.0	Acute peptic ulcer, site unspecified with hemorrhage	Return to Provider	Medical Management
K27.1	Acute peptic ulcer, site unspecified with perforation	Return to Provider	Medical Management
K27.2	Acute peptic ulcer, site unspecified with both hemorrhage and perforation	Return to Provider	Medical Management
K28.0	Acute gastrojejunal ulcer with hemorrhage	Return to Provider	Medical Management

K28.1	Acute gastrojejunal ulcer with perforation	Return to Provider	Medical Management
K28.2	Acute gastrojejunal ulcer with both hemorrhage and perforation	Return to Provider	Medical Management
K29.01	Acute gastritis with bleeding	Return to Provider	Medical Management

Recalibrating the PDPM Parity Adjustment

Federal Register pages 47525 – 47524

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. In order to calculate total SNF payments under PDPM and to provide the most accurate representation of what the SNF case-mix distribution would look like under the PDPM outside of a COVID-19 PHE environment for FFY 2023, CMS is finalizing its proposal to continue excluding the subset of the population with a COVID-19 diagnosis or Public Health Emergency (PHE)-related waiver, in conjunction with a one-year control period derived from FFYs 2020-2021. This control period uses 6 months of FFY 2020 claims data from October 2019 through March 2020 and 6 months of FFY 2021 claims data from April 2021 through September 2021.

CMS' analysis shows that the combined methodology would lead to a 4.6% adjustment factor, while using either the FFY 2020 or FFY 2021 data would lead to 4.9% and 5.3% adjustment factors, respectively. The adjustment factors based on population and data period as well as the budget impact based on the subset population and data period are shown in Tables 11 and 12 on page 47529 of the *Federal Register*. CMS is adopting this combined methodology and will recalibrate the parity adjustment with a 2-year phase-in period to ensure budget-neutrality of the PDPM. As a result, CMS will reduce the PDPM parity adjustment by 2.3 percent for FFY 2023 and by another 2.3 percent in FFY 2024. This change in methodology will reduce aggregate payments to SNFs by $780 million in FFY 2023.

Consolidated Billing

Federal Register pages 47519 – 47520

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 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 47516 and 47559 – 47597

Background: For FFYs 2019 and beyond, CMS is required by the Protecting Access to Medicare Act of 2014 (PAMA) to utilize a value-based purchasing (VBP) 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 60% of the withheld payments to SNFs as incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a SNF readmission measure.

CMS calculate 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 2023+ are set to the following one year period for each of the baseline and performance periods from the prior program year.

CMS adopted the following baseline and performance periods for the FFY 2025 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 2025**
October 1, 2021– September 30, 2022	**October 1, 2023 – September 30, 2024**	**FFY 2026**

CMS also adopted its proposal to automatically adopt the baseline and performance periods for a SNF VBP program year by advancing the beginning of the baseline and performance periods by 1 year from the previous program year.

In this FFY 2023 final rule, CMS adopted the following performance standards for the SNFRM for the FFY 2025 program year, based on the most recent available data from FFY 2019:

Measure ID	Final Performance Standards
SNFRM	**Achievement threshold** **0.79139** (proposed at 0.79270)
	Benchmark **0.82912** (proposed at 0.83028)

For the FFY 2026 SNF QRP, CMS is adopting the following two new measures for the SNF VBP:

- *"Skilled Nursing Facility (SNF) Healthcare Association Infections (HAI) Requiring Hospitalization (SNF HAI) measure"*
    - This measure is final to have a 1 year baseline period of October 1, 2021 – September 30, 2022 and a performance period of October 1, 2023 – September 30, 2024;
- *"Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure."*
    - This measure is final to have a 1 year baseline period of October 1, 2021 – September 30, 2022 and a performance period of October 1, 2023 – September 30, 2024.

Beginning with the FFY 2027 SNF QRP, CMS is adopting one new measure, *"Discharge to Community (DTC) - Post-Acute Care (PAC) Measure for Skilled Nursing Facilities"* with 2 year baseline and performance periods of October 1, 2020 – September 30, 2022 and October 1, 2023 – September 30, 2025, respectively.

Beginning with the FFY 2023 SNF VBP Program, CMS will implement case and measure minimums that SNFs must meet in order to be eligible to participate in the SNF VBP and to remove the low-volume adjustment policy from the SNF VBP Program. As a result of this implementation, SNFs with less than 25 eligible stays in the SNFRM measure would be excluded from the program, resulting in a payback percentage of 60 percent for the program year. For all adopted measures FFY 2026+, a minimum of 25 cases during the performance period will be required to be eligible.

For the FFY 2026 program, CMS will require a SNF to meet case count requirements in 2 of the 3 measures. In FFY 2027, a minimum of 3 of the 4 measures will be required to meet case counts in order for a SNF to participate in the program. SNFs who do not meet these requirements will not get a payment adjustment for that year.

In the FFY 2022 final rule, CMS adopted measure suppression factors for the SNF VBP program years overlapping with those years affected by the COVID-19 PHE and subsequently suppressed the SNFRM measure for the FFY 2022 SNF VBP program year due to the PHE. CMS is adopting its proposal to continue to suppress the SNFRM measure for the FFY 2023 SNF VBP program year due to "*Significant national shortages or rapid or*

unprecedented changes in: Healthcare personnel, and Patient case volumes or facility-level case mix" measure suppression factor. CMS will assign a performance score of zero to all participating SNFs in the FFY 2023 SNF VBP in order for all SNFs to receive an identical incentive payment multiplier of 1.2%, which is a 60% payback of revenue. CMS is also finalizing its proposal to codify the adopted measures for the FFY 2023 SNF VBP in the regulation text.

With the addition of new measures and new measure requirements, CMS is finalizing its' data suppression policy as follows:

- *"If a SNF does not have the minimum number of cases during the baseline period that applies to a measure for a program year, we would publicly report the SNF's measure rate and achievement score if the SNF had minimum number of cases for the measure during the performance period for the program year;*
- *If a SNF does not have the minimum number of cases during the performance period that applies to a measure for a program year, we would not publicly report any information on the SNF's performance on that measure for the program year; and*
- *If a SNF does not have the minimum number of measures during the performance period for a program year, we would not publicly report any data for that SNF for the program year."*

CMS is adopting its proposal to update the achievement points to SNFs based on their performance period measure rate for each measure beginning with FFY 2026 program year to allow a maximum of 10 points rather than 100, using the following formula:

$$\text{Achievement Score} = 9 \text{ x } \frac{\text{Performance Period Rate} - \text{Achievement Threshold}}{\text{Benchmark} - \text{Achievement Threshold}} + 0.5$$

CMS will also award improvement points to SNFs based on their performance rate out of 9 points rather than the previous 90, according to the following formula:

"$\text{Improvement Score} = 10 \text{ x } \frac{\text{Performance Period Rate} - \text{Baseline Period Rate}}{\text{Benchmark} - \text{Baseline Period Rate}} - 0.5$

All measures will be weighted equally to determine SNF performance scores. To ensure that the public understands the SNF performance scores and to accommodate additional quality measures without making changes to the scoring methodology, CMS will normalize SNF performance scores under the expanded SNF VBP Program by summing all raw point totals and converting them to a 100-point scale.

In order to avoid unreliable improvement scores due to increasing number of measures in the SNF VBP, CMS will not award improvements points to SNFs on measures in which at the SNF does not meet the case minimum for a program year beginning with the FFY 2026 program year. The SNF will only be eligible for achievement points on these measures.

Staffing Turnover Measures – Request for Information

Federal Register pages 47592 – 47593

Analysis by CMS showed that higher staff turnover is associated with an increased likelihood of receiving an infection control citation, and higher overall star ratings are associated with lover average staff turnover rates. Also, lower staff turnover rates are associated with higher overall nursing home quality.

In the FFY 2024 SNF final rule, CMS intends to propose a staffing turnover measure, "the percent of total nurse staff that have left the facility over the last year" for the SNF VBP.

In the FFY 2023 proposed rule, CMS specifically sought comment on:

- "*including the staff turnover measure that captures the percent of total nurse staff that have left the facility over the last year for the SNF VBP Program as currently specified or whether the measure should be revised before being final for including in the SNF VBP Program;"*
- *"Whether we should explore the development of composite measure that would capture multiple aspects of staffing, including both total nurse hours and the staff turnover measure rather than having separate but related measures related to nursing home staffing;"*
- *"Actions SNFs may take or have taken to reduce staff turnover in their facilities, and for SNFs that did reduce staff turnover, the reduction's observed impact on quality of care;"* and
- *"Considerations we should take into account related to the impact that including a Nursing Home Staff Turnover measure may have on health equity."*

CMS did not respond to comments received in the final rule, but will take them into account in future rule making.

National Healthcare Safety Network (NHSN) COVID-19 Vaccination Coverage among Healthcare Personnel Measure – Request for Information

Federal Register pages 47593 – 47594

In the FFY 2022 final rule, CMS adopted the NHSN COVID-19 Vaccination Coverage among Healthcare Personnel measure to the SNF QRP. The COVID-19 vaccination measure calculates the percentage of healthcare personnel who receive a complete COVID-19 vaccination course or the FFY 2022 program year. CMS sought public comments on its' proposal to include this measure in future years of the SNF VBP program. CMS did not respond to comments received in the final rule, but will take them into account in future rule making.

Exchange Function – Request for Information

Federal Register pages 47594 – 47595

In the FFY 2018 final rule, CMS adopted a logistic exchange function for translating SNFs' performance scores into value-based incentive payments. CMS sought public comments on whether a new functional form or modifications to the existing logistic exchange function may provide the best incentives to SNFs to improve on the Program's measures. CMS did not respond to comments received in the final rule, but will take them into account in future rule making.

Validation of SNF Measures and Assessment Data – Request for Information

Federal Register pages 47595 – 47596

CMS uses data form Medicare FFS claims, the minimum data set (MDS), and the payroll-based journaling (PBJ) system to calculate measures adopted for the SNF VBP program. CMS sought public comments on:

- "*adoption of additional validation procedures;"*
- *"use of both random and targeted selection of facilities for validation;"* and
- *"the implementation timeline for additional SNF VBP Program validation processes, as well as validation processes for other quality measures and assessment data."*

CMS did not respond to comments received in the final rule, but will take them into account in future rule making.

Infection Isolation – Request for Information

Federal Register pages 47534 - 47597

Over the years, CMS has implemented programs and policies aimed at reducing health care disparities, and expand social risk factor data collection. In an effort to advance to eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and to provide the care and support that enrollees need to thrive.

Health Equity – Request for Information

Federal Register pages 47553 - 47555

In the proposed rule, CMS sought public comment on whether or not the relative increase in resource utilization for each of the patients within a cohorted room, all with an active infection , is the same or comparable to that of the relative increase in resource utilization associated with a patient that is isolated due to an active infection. Some of the comments received are available on the pages listed above, however CMS did not respond to these comments in the final rule, but will take them into account in future rule making.

CMS specifically sought comment on:

- "*guiding principles for a general framework that could be utilized across quality programs to assess disparities in healthcare equality in a broader Required for Information (RFI);"*
- *"Whether we should consider incorporating adjustments into the SNF VBP Program to reflect the varied patient population that SNFs serve around the country and tie health equity outcomes to SNF payments under the program;" and*
- *"Which of these adjustments, if any, would be most effective for the SNF VBP Program at accounting for any health equity issues that we may observe in the SNF population."*

CMS did not respond to comments received in the final rule, but will take them into account in future rule making.

SNF Quality Reporting Program (QRP)

Federal Register pages 47535 – 47559

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 2023 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
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
NHSN	
HCP COVID-19 Vaccine	COVID_19 Vaccination Coverage among Healthcare Personnel (HCP)

Due to the COVID-19 PHE, CMS has finalized the compliance date for collection and reporting of the TOH-Provider and TOH-Patient as on or after October 1, 2023.

For the FFY 2024 SNF QRP, CMS is adopting the following addition to the list of measures and reporting requirements: Influenza Vaccination Coverage among Healthcare Personnel (HCP) measure as an "other measure" (proposed for FFY 2025 SNF QRP). CMS adopted the public display of this message beginning with October 2023 Care Compare.

Also, for the FFY 2024 SNF QRP, CMS is adopting its proposal to add a new paragraph to the reporting requirements for all the data completion thresholds required to meet the compliance threshold for the annual payment update, and certain conforming revisions. SNFs would have to meet or exceed two separate completion thresholds in order to avoid receiving a 2.0 percentage point reduction to their annual payment update:

- 80% completion of required quality measure and patient assessment data collected using the MDS, beginning with FFY 2018; and
- 100% of measures data collected and submitted using the CDC NHSN, beginning with FFY 2023.

Lastly, CMS is finalizing its proposal to publicly display the HCP Influenza Vaccine measure on Care Compare based on a 6 months of data.

SNF QRP Quality Measures under Consideration for Future Years – Request for Information

Federal Register page 47553

In the proposed rule, CMS sought public comment on the importance, relevance, and applicability of three potential measures:

- "Cross-Setting Function" measure that would incorporate self-care and mobility domains;
- "Health Equity" measure such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities; and
- The value of a "PAC-COVID-19 Vaccination Coverage among Patients" measure that would assess whether patients were up to date on their COVID-19 vaccine.

CMS did not respond to comments received in the final rule, but will take them into account in future measure development.

Overarching Principles for Measuring Equity and Healthcare Quality Disparities across CMS Quality Programs – Request for Information

Federal Register pages 47553 – 47555

In the proposed rule, CMS sought public comment on key principles and approaches on advancing the use of quality measure development and stratification to address health.

Specifically, CMS sought comment on:

- *"Identification of Goals and Approaches for Measuring healthcare Disparities and Using Measure. Stratification Across CMS Quality Reporting Programs.*
- *Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting.*
- *Principles for SRF and Demographic Data Selection and Use.*
- *Identification of Meaningful Performance Difference.*
- *Guiding Principles for Reporting Disparity Measures.*
- *Measures Related to Health Equity.*

CMS did not respond to comments received in the final rule, but will take them into account in future measure development.

CoreQ: Short Stay Discharge Measure – Request for Information

Federal Register page 47555

In order to measure patient satisfaction and to achieve the patient-centered care goal, CMS is considering the CoreQ: Short Stay Discharge Measure in future SNF QRP programs. This measure calculates the percentage of individuals discharged in a 6-month period from a SNF, within 100 days of admission, who are satisfied with their stay.

In the proposed rule, CMS sought public comment on any challenges or impacts of including the CoreQ: Short Stay Discharge measure in future programs year.

CMS did not respond to comments received in the final rule, but will take them into account in future measure development.

Changes to the Requirements for the Director of Food and Nutrition Services and Physical Environment Requirements in Long-Term (LTC) Facilities; and Request for Information on Mandatory Minimum Staffing Requirements for Long-Term Care (LTC) Facilities

Federal Register pages 47597 – 47600

In the proposed rule, CMS proposed to revise the standards for the requirements of the director of food and nutrition service to include an appropriate competencies and skills necessary to oversee the functions of the food and nutrition services. CMS is finalizing its proposal on the requirements for the director of food and nutrition services with modifications. Specifically, the director of food and nutrition services must meet the following requirements:

- *"In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers (existing); and*
- *Receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional (existing). In addition, the director will need to meet the conditions of one of the following five options, four of which are retained from the existing rule:*
- *Have 2 or more years of experience in the position of a director of food and nutrition services, and have completed a minimum course of study in food safety, by no later than 1 year following the effective date of this rule, that includes topics integral to managing dietary operations such as, but not limited to, foodborne illness, sanitation procedures, food purchasing/receiving, etc. (new; we note that this would essentially be the equivalent of a ServSafe Food Manager certification); or*
- *Be a certified dietary manager (existing) or*
- *Be a certified food service manager (existing) or*

- *Have similar national certification for food service management and safety from a national certifying body (existing); or*
- *Have an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning (existing).*"

In the May 4, 2016 *Medicare and Medicaid; Fire Safety Requirements for Certain Health Care Facility* final rule, CMS adopted the 2012 edition of the life safety code (LSC). Though the fire safety evaluation system (FSES), one of the references in the LSC, provides healthcare facilities an alternative approach to life safety, some LTC facilities that used it could not achieve a passing score due to the change in scoring. To allow existing LTC facilities that previously met the FSES requirements to continue to do so without incurring great expense to change their construction types, CMS is adopting its proposal that LTC facilities use the mandatory scoring values provided in Table 18 on page 47599.

In addition, CMS had issued a 'Request for Information' on setting minimum standards for staffing adequacy that nursing homes would be required to meet. Some of the comments received are available on the pages listed above, however CMS did not respond to these comments in the final rule, but will take them into account in future rule making.

####