Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer

August 29, 2023

Summary Report

February 2024

Contents

1. Introduction

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (hereafter referred to as Acumen) to develop and maintain measures for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). Acumen operates under the Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long-Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare contract (75FCMC18D0015/Task Order 75FCMC19F0003).

On August 29, 2023, Acumen hosted a SNF Listening Session, which was held to seek SNFs' input on the possible expansion of collecting and submitting Minimum Data Set (MDS) assessment data used for the SNF QRP. Registration was open to the SNF community through CMS's SNF QRP webpage, and over 1,000 participants registered. This report provides a summary of the participants' feedback during the Listening Session. The remainder of this section introduces the rationale for expanding MDS data collection and submission. Sections 2 through 5 present a summary of the presentation for each discussion topic, stakeholder input for each discussion question, and key findings. Specifically, Section 2 covers the identification of the resident population for expanded MDS data collection and submission. Section 3 summarizes the identification of the expanded resident population on the MDS. Section 4 covers the potential burden associated with expanding MDS data collection and submission. Finally, Section 5 summarizes the changes in level of care and how MDS data collection and submission might be affected.

In the 30 days following the Listening Session, CMS also invited additional feedback from participants on these topics via email using a dedicated email inbox, SNF-Listening-Session-2023@acumenllc.com. In total, six emailed comments were received. Feedback received via email is summarized and addressed in the applicable discussion topic sections of this report. CMS received a number of comments during the Listening Session and subsequently via email that were unrelated to the questions asked at the Listening Session; therefore, they are not included in this report.

1.1 Rationale for Expanding MDS Data Collection and Submission

CMS has received public input for the past 10 years on the need to standardize measurement data collection across all payers in the post-acute care (PAC) settings. For example, as part of its recommendations on Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement,[1] the National Quality Forum (NQF)-convened Measures Application Partnership (MAP) defined priorities and core measure concepts for PAC

[1] National Quality Forum. MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement. February 2012. https://www.qualityforum.org/Publications/2012/02/MAP_Coordination_Strategy_for_Post-Acute_Care_and_Long-Term_Care_Performance_Measurement.aspx

settings, including SNFs, in order to improve care coordination for residents. The MAP concluded that standardized measurement data collection is needed to support the flow of information and data among PAC providers and recommended CMS collect data from all payers. Since the implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and the development of the statutorily required quality measures, CMS has also received public input suggesting that the quality measures used in the SNF QRP should be calculated using data collected from all SNF residents, regardless of the residents' payer. This input has been provided through different mechanisms, including comments requested about quality measure development. Specifically, in response to the call for public comment on quality measures to satisfy the IMPACT Act domain of Transfer of Health Information and Care Preferences When an Individual Transitions,[2] the majority of comments expressed concern over the lack of standardization of patient populations across the PAC settings, and urged CMS to standardize the populations. Additionally, in February 2023, enrollment in Medicare Advantage (MA) plans reached 30.9 million, or 52% of all eligible Medicare beneficiaries.[3] MA enrollment has grown steadily since 2010, increasing almost threefold. Therefore, collecting quality data on all residents in the SNF setting would provide the most robust and accurate representation of quality in SNFs.

The concept of requiring quality data reporting on all patients regardless of payer is not new. As part of the Long-Term Care Hospital (LTCH) QRP, CMS currently collects quality data on all patients regardless of payer. CMS also collects quality data on all Hospice patients for the Hospice Quality Reporting Program (HQRP) regardless of payer. Eligible clinicians participating in the Merit-based Incentive Payment System (MIPS) who submit quality measure data on Qualified Clinical Data Registry (QCDR) measures, MIPS clinical quality measures (CQMs), or electronic clinical quality measures (eCQMs) must submit such data on a specified percentage of patients regardless of payer. Beginning October 1, 2024, Inpatient Rehabilitation Facilities (IRFs) will begin collecting quality data on all patients regardless of payer.[4] Likewise, home health agencies (HHAs) will begin all-payer data collection on January 1, 2025.[5]

However, implementation of a policy requiring quality data reporting on all patients regardless of payer presents unique challenges for CMS that have not been encountered in

[2] Centers for Medicare & Medicaid Services. Public Comment Summary Report Posting. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-Cross-Setting-Transfer-of-Health-Information-Quality-Measures-Public-Comment-Summary-Report-June-2017.pdf

[3] Medicare Payment Advisory Commission. Health Care Spending and the Medicare Program: A Data Book. https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf. July 2023, page 121.

[4] Fiscal year (FY) 2023 IRF PPS Final Rule (87 FR 47073 through 47082).

[5] Calendar year (CY) 2023 HH PPS Final Rule (87 FR 66862 through 66865).

other settings. Specifically, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requires nursing homes that are Medicare certified, Medicaid certified or both, conduct initial and periodic assessments for all their residents to identify resident care problems that can be addressed in an individualized care plan. Data collected from MDS assessments are also used for the SNF Prospective Payment System (PPS) Medicare reimbursement system and many state Medicaid reimbursement systems. The MDS has also been adapted for use by non-critical access hospitals (non-CAHs) with a swing bed agreement. Additionally, the data collected and submitted with the MDS are used to calculate a number of quality measures for purposes of the SNF Value-Based Purchasing (VBP) Program, the SNF QRP, and the Nursing Home Quality Initiative (NHQI).

2. Identifying the Resident Population for Expanded MDS Data Collection and Submission

This section summarizes participants' feedback on the Listening Session's first discussion topic and is organized into five subsections. Section 2.1 provides background information on CMS's extended care (SNF) benefit, and Sections 2.2 through 2.4 introduce the questions asked on this topic and summarize the information received during the August 29, 2023 meeting. Each subsection summarizes participants' comments in response to the questions, and Section 2.5 presents the key takeaways extracted from that discussion.

2.1 Overview of the CMS Extended Care (SNF) Benefit

Care in a SNF is covered by Medicare Part A when all of the following five factors are met:

1. The patient requires skilled nursing services or skilled rehabilitation services; that is, services that must be performed by or under the supervision of professional or technical personnel[6] and the services are ordered by a physician.
2. The services are rendered for a condition for which the patient received inpatient hospital services during a medically necessary stay of at least three consecutive calendar days or for a condition that arose while receiving care in a SNF for a condition for which the patient received inpatient hospital services. Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the three-day qualifying inpatient hospital stay.
3. The patient requires these skilled services on a daily basis.[7]

[6] Medicare Benefits Policy Manual (100-2); Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance. §§30.2-30.4.
[7] Medicare Benefits Policy Manual (100-2); Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance. §30.6.

4. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.[8]
5. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury; that is, they are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

CMS is not considering changing the coverage criteria for a Medicare Part A fee-for-service (FFS) covered stay, but intended to focus the discussion about collecting quality data on all residents who are admitted to a SNF, regardless of payer. In past years when the subject of data collection and submission on all residents regardless of payer was mentioned in rulemaking,[9,10] CMS received a number of questions about how "skilled services" would be defined for payers other than Medicare Part A FFS.

The definition of "skilled services" in the Medicare Benefit Policy Manual at §30.2 is as follows:

> *Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.) This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.*

CMS believes this definition would potentially provide some alignment between payers, especially between Medicare FFS and MA beneficiaries since all MA plans must use a similar definition, at least in relation to short-stay skilled residents, and those MA plans are required to cover at least what Medicare would provide.

2.2 Using the Definition of Skilled Services at §30.2, Do You Think It Would Be Feasible to Identify Residents Requiring an MDS Assessment for Purposes of the SNF QRP?

Several participants responding to this question stated that it would be feasible to use the §30.2 definition of skilled services to identify residents for purposes of MDS data collection.

[8] Medicare Benefits Policy Manual (100-2); Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance. §30.7.
[9] FY 2018 SNF PPS proposed rule (82 FR 36603 through 36604).
[10] FY 2020 SNF PPS proposed rule (84 FR 17678 through 17679).

However, these participants and others spoke to the discrepancy between Medicare's definition of skilled services and the application of that definition by Medicare Advantage Organizations (MAOs). Participants noted that they are often in a position of having to advocate for the necessity of ongoing skilled services when an MAO makes the decision to discharge a resident, stating the resident no longer requires daily skilled services. One participant referenced the Medicare Advantage Final Rule, published on April 5, 2023,[11] and noted that if MAOs are held accountable for following CMS definitions, it would be feasible to use this definition.

Another participant suggested that definitions should be standardized to improve consistency in application, while another participant noted the challenge SNFs might encounter in implementing a standardized definition across multiple payer sources.[12] This commenter suggested starting data collection with residents who are admitted for skilled therapy only with a goal of returning to their prior living situation or a lower level of care.

One participant agreed that it would be feasible to use the definition of skilled services at §30.2, but questioned how CMS intended to account for attribution in the SNF QRP if all residents, regardless of payer, were included in QRP measures. This participant, in addition to others, raised concerns that if CMS intends to combine the resident populations, there could be issues with how a SNF performs in the SNF QRP due to MAO criteria out of a SNF's control, creating additional challenges for SNFs to overcome. However, if CMS plans to compare the outcomes for beneficiaries based on payer type, that would be beneficial.

2.3 How Do Plans Other Than Medicare Define Skilled Services?

One participant said they are unable to answer this question because each insurance company has its own set of definitions. A few participants said they are frequently unaware of how MAOs define skilled services because the MAOs do not always share the criteria they use when authorizing a defined number of SNF days. One noted that MAOs tell SNFs the case mix categories[13] they will pay for, and they use their own guidelines and definitions for determining what qualifies as skilled services. Two participants said that some MAOs use diagnoses to define skilled services, while others use a defined time period, such as two weeks.

[11] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (88 FR 22120).
[12] This comment was submitted via email, and the provider submitting the comment did not provide additional information on why the implementation would be challenging. Because the comment was made following the live session, there was no opportunity to obtain clarification from the provider.
[13] The SNF PPS uses the Patient Driven Payment Model (PDPM) to classify patients into case mix groups for purposes of payment.

Another participant suggested CMS host a separate listening session with other payers, including MAOs, to gather information about how they define their terms and definitions.

2.4 Are There Other Considerations for CMS Related to Identifying Residents Requiring an MDS Assessment for Purposes of the SNF QRP?

One commenter thanked CMS for soliciting stakeholder feedback as it considers an expansion of data collection. Several participants reiterated their concerns with how CMS might use the data collected on all residents regardless of payer, given the increased focus on SNF QRP measure outcomes in the SNF VBP program, and they have concerns with how data from MAO residents will affect their scores. One participant noted that if SNFs find their QRP data are negatively affected, then SNFs may be selective about accepting residents with certain MAO benefits.

Three participants appreciated that collecting MDS data among all residents, regardless of payer, would be beneficial as it would highlight differences in quality due to potential premature discharges initiated by MAOs.

One participant referenced the Office of Inspector General (OIG) Workplan[14] for enhanced oversight of managed care programs, and believes these data are important to take into account when considering how MAOs are currently defining a SNF "skilled" level of care.

2.5 Key Takeaways Related to Identifying Residents Requiring an MDS Assessment for Purposes of the SNF QRP

- Participants generally supported the idea of a standardized definition of skilled services across all payers, and did not have concerns with using the Medicare definition of skilled services at §30.2 to identify residents for purposes of MDS data collection and submission.
- Participants raised concerns about MAOs' interpretation of the CMS definition of skilled services at §30.2, and provided examples of discrepancies in the application of that definition by MAOs.
- Several participants raised concerns about the possibility of including all residents, regardless of payer, in the SNF QRP measures since they believe including MAO data will negatively impact their measure scores. However, some participants said it would be beneficial since it would highlight differences in quality for CMS.

3. Identifying the Expanded Resident Population on the MDS

[14] US DHHS Office of Inspector General. Managed Care. https://oig.hhs.gov/reports-and-publications/featured-topics/managed-care/?hero=managed-care-ft.

This section summarizes participants' feedback on the second discussion topic and is organized into six subsections. Section 3.1 provides information on how the MDS currently collects payer information, and Sections 3.2 through 3.5 introduce the questions asked on this topic and summarize the information received during the August 29, 2023 meeting. Each subsection summarizes participants' comments in response to the questions, and Section 3.6 presents the key takeaways extracted from that discussion.

3.1 Payer Information Collected on the MDS v1.18.11

In past years when the subject of data collection and submission on all residents regardless of payer was mentioned in rulemaking,[15,16] commenters raised concerns that the primary payer information collected on the MDS may not be completely accurate given the challenges with coordinating the information from referral sources, but that there were also challenges encountered with information supplied by the SNF. One example provided at that time was miscommunication between the person completing the MDS and the SNF business office.

Currently there is no item on the MDS to accurately capture other payer information. The current version of the MDS, v1.18.11, includes items to record Medicare and Medicaid numbers only. Item A1400, Payer Information, is currently required on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) and approved for the IRF Patient Assessment Instrument (PAI) beginning October 1, 2024. This item provides for collection of payer information at a more granular level, including Medicare (traditional FFS), Medicare (managed care/Part C/MA), Medicaid (traditional FFS), Medicaid (managed care), workers' compensation, Title programs (e.g., Title III, V, or XX), other government (e.g., TRICARE, Veterans Affairs [VA], etc.), private insurance/Medigap, private managed care, self-pay, no payer source, unknown, and/or other.

3.2 Would Adding an Item Such as A1400 to the MDS Be Beneficial for Providing Information on the Resident's Source of Payment for Services Received in the SNF?

Several participants stated that an item such as A1400 would be useful to identify the payer source on the MDS, while one questioned if this information could be collected accurately and consistently across the PAC settings.

Participants also made several additional recommendations for the item. One participant suggested that more granularity in some payer types is needed. They gave the example of response option G, other government (e.g., TRICARE, VA, etc.), noting that VA health care

[15] FY 2018 SNF PPS proposed rule (82 FR 36603 through 36604).
[16] FY 2020 SNF PPS proposed rule (84 FR 17678 through 17679).

has three different types of contracting models, which pay for short stays comparable to Medicare Part A FFS and longer stays comparable to Medicaid.

Several participants recommended there also be an item to collect secondary payer source information. Another agreed and recommended that rather than instructing SNFs to "check all that apply" for this item, SNFs should instead indicate separately which payer sources are supplemental.

3.3 Who Is Primarily Responsible for Filling This Information Out on the MDS?

One participant offered that their SNF's business office and administrative coordinator are responsible for filling out this type of information on the MDS. Another noted that this task may be a shared responsibility in SNFs among case management, social services, the facility's business department, and nurses.

3.4 Do You Have Any Suggestions for How CMS Could Ensure the Payment Information Collected Is Accurate?

One participant recommended CMS link the UB-04 claims processing form to the MDS to ensure that payment information is reported accurately.

3.5 Are There Other Considerations for Changes to the MDS, Specifically Section A, That Would Be Necessary to Accommodate an All-Payer Proposal?

One participant recommended an item be added to the MDS to indicate whether the beneficiary, the SNF, or the payer initiated the suspension of SNF services.

Several participants noted that there would need to be a mechanism for recording a change in payer source. Examples included when a resident's Medicaid status is pending, and changes from no payer source to Medicaid, or when a resident is admitted under Medicare FFS but then switches to their VA benefit on day 21 to avoid the Medicare co-payment.

Finally, one participant recommended an item on the MDS to capture when residents are appealing the decision to end the skilled stay.

3.6 Key Takeaways Related to Identifying the Expanded Resident Population on the MDS

- Participants generally agreed that an item such as A1400 would be useful to identify the payer source on the MDS. Additional suggestions for the item were to add additional categories, add an indicator for secondary payer, and to modify the current guidance to "collect all that apply".

- SNFs currently use a variety of methods to complete the payer information on the MDS. Only one recommendation for ensuring accuracy was provided, and it was to match MDS and UB-04 claims.
- Participants provided other considerations for CMS, including addressing how a change in payer source would be accommodated, and adding an item to indicate who initiated the suspension of SNF services and an item to reflect when residents are appealing the decision to end the skilled stay.

4. Potential Burden Associated With Expanding MDS Data Collection and Submission

This section summarizes participants' feedback on the third discussion topic and is organized into five subsections. Section 4.1 provides background information on the current requirements for collecting and submitting MDS data, and Sections 4.2 through 4.4 introduce the questions asked on this topic and summarize the information received during the August 29, 2023 meeting. Each subsection summarizes participants' comments in response to the questions, and Section 4.5 presents the key takeaways extracted from that discussion.

4.1 Current Requirements for Collecting and Submitting MDS Data

For residents admitted to a SNF under the Medicare Part A FFS benefit, a SNF is required to complete a 5-day PPS assessment, and when the resident no longer requires skilled care, a SNF is required to complete a PPS Discharge assessment.

For residents admitted to a SNF under an MAO, commercial payer, or private payer, a 5-day PPS assessment and PPS Discharge assessment are not required by CMS. However, if the resident's stay extends to 14 days or longer, the facility is required to complete a Comprehensive Omnibus Budget Reconciliation Act (OBRA) assessment, and any other subsequent OBRA assessments that would be triggered during the stay. When a resident is physically discharged from the SNF, an OBRA Nursing Home Discharge assessment must be completed, regardless of payer.

When timepoints overlap, assessment types can be combined. For example, if a resident with an MAO benefit is expected to stay 14 days or more, the SNF can elect to combine the 5-day PPS assessment and Comprehensive OBRA assessment. However, CMS is aware that expanding MDS data collection and submission to all residents regardless of payer will increase SNF burden.

4.2 For What Percentage of Your Total Stays Do You Combine the 5-Day and Comprehensive Assessment?

One participant stated they do not complete a 5-day PPS or PPS Discharge assessment when the MA plan pays their SNF with a per diem rate or a flat rate based on level of care. If the

plan pays using the PDPM system, they do complete a 5-day PPS assessment but do not submit it, and they do not complete a PPS Discharge assessment. Another participant noted they do the same thing, but added that they are also completing the 5-day PPS assessment for Medicare secondary payers, but not submitting it to the Internet Quality Improvement and Evaluation System (iQIES).

Another participant said their centers may combine the 5-day PPS with the Comprehensive OBRA assessment, since burden of completing them separately is higher. However, this participant and another noted that a 5-day PPS assessment can be completed more quickly (and can therefore drive care delivery more quickly) when they may not have all the information needed for completing the requirements[17] of the Comprehensive OBRA assessment.

One participant noted that they currently fill out a 5-day PPS assessment for almost all beneficiaries on MA plans because in many cases providers find out too late that (i) the resident's MAO plan "termed" and the resident has switched back to traditional Medicare, or (ii) the payer changed in the middle of the stay.

Several participants pointed out that some states require the completion of the 5-day PPS assessment for other reasons, such as fulfilling Medicaid requirements; however, these requirements differ considerably across states. One of these participants noted that their state has very stringent guidelines around item coding, so they cannot combine assessments. Another participant said they typically combine all of their assessments when feasible. For example, this participant combines the 5-day PPS assessment and Comprehensive OBRA assessment if the resident is projected to stay seven7 days or more to reduce the burden associated with in-person assessments, unless the resident discharges or expires prior to the scheduled Assessment Reference Date (ARD).

4.3 For What Percentage of Non-Medicare FFS Residents Admitted for Short-Stay Skilled Services <14 Days Are You Already Completing a 5-day PPS Assessment?

One participant said they complete a 5-day PPS assessment on all residents, in case the payer source changes and they need the assessment after the resident has been discharged from skilled care. Another participant said they only complete one for MA or Medicare FFS beneficiaries. Several other participants noted they do not complete the 5-day PPS assessment unless the payer requires the PDPM case mix group.

[17] We interpret the participant to be referencing the Care Area Assessments.

4.4 Do Other Payers Require Portions of the MDS to Be Filled Out for Them Regardless of the Length of Stay? Or Do They Have Another Assessment Tool They Require You Use?

Several participants stated that other payers do not require portions of the MDS to be filled out. However, these payers may have their own independent forms they require the SNF to complete. The information in these forms can overlap with information collected on the MDS. One participant noted that the separate forms center primarily around functional items and therapy information. One participant suggested that even if CMS expands data collection and submission to all residents regardless of payer, the MAOs could still require SNFs to complete their own proprietary assessment tool, which would incrementally increase SNF burden.

Other participants pointed out that in many states that still use the Resource Utilization Group (RUG) PPS for Medicaid payment, providers are required to complete an Optional State Assessment (OSA) in addition to the required OBRA assessments beginning October 1, 2023.

One participant suggested SNFs may begin to show preference toward accepting Medicare FFS residents over MAO residents in order to avoid duplicative and complex assessment requirements.

4.5 Key Takeaways Related to Potential Burden Associated with Expanding MDS Data Collection and Submission

- Two participants stated they combine the 5-day PPS assessment and Comprehensive OBRA assessment to reduce the burden of completing two assessments. They described facility guidelines they use to guide the decision.
- Participants were generally split on whether they complete a 5-day PPS assessment for their residents receiving care under a non-Medicare FFS benefit. Several participants stated they may fill out a 5-day PPS assessment in order to obtain a PDPM group, or to have it in case they find out retrospectively that the resident had disenrolled from their MAO plan or it had been terminated. Other participants described state-specific requirements related to Medicaid payment that require them to follow prescriptive guidelines different from CMS.
- Several participants reported that while other payers do not require portions of the MDS to be filled out, they may have their own independent forms they require the SNF to complete and these can overlap with information collected on the MDS. Other participants pointed out that the OSA is required in several additional states for Medicaid payment after October 1, 2023, and this assessment cannot be combined with any other assessment type.

5. The Impact of Changes in Level of Care on MDS Data Collection and Submission Under an All-Payer Policy

This section summarizes participants' feedback on the fourth discussion topic and is organized into four subsections. Section 5.1 provides background information on unique resident populations represented in MDS data collection and submission, and Sections 5.2 through 5.3 introduce the questions asked on this topic and summarize the information received during the August 29, 2023 meeting. Each subsection summarizes participants' comments in response to the questions, and Section 5.4 presents the key takeaways extracted from that discussion.

5.1 Unique Nursing Home Resident Population

Nursing homes generally care for two resident populations. One population is admitted in order to receive skilled services in anticipation of returning to their previous residence; the second population is cared for continuously in the nursing home, which is their place of residence.

As a result, changes in level of care can occur frequently in SNFs. That is, a resident's level of care may change from skilled to non-skilled or from non-skilled to skilled without a hospitalization. While the latter example may be infrequent for Medicare FFS residents, other payers may not require a three-night qualifying hospital stay to trigger skilled care. Additionally, there is momentum in the healthcare field to "skill residents in place," treating some acute exacerbations and conditions, in order to avoid the risks associated with transitions from SNFs to acute care hospitals.

5.2 What Types of Changes in Level of Care Do You Encounter that an All-Payer Policy Should Consider?

One participant stated that identifying changes in level of care across different payers would be challenging, and noted that changes often occur due to changes in benefit availability rather than medical need.

5.3 Would There Be Benefits of Having Payer Source and Quality Data Reported on All Your Residents When a Change in Service Level Occurs Within Your SNF?

Participants did not specifically address this question.

5.4 Key Takeaways Related to Changes in Level of Care Under a Potential All Payer Policy

A participant noted that changes in level of care were most frequently driven by payer change rather than clinical changes in the resident.