U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF MANAGEMENT AND BUDGET
PAPERWORK REDUCTION ACT
CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISION OF THE MINIMUM DATA SET (MDS) 3.0 (v1.19.1)
NURSING HOME AND SWING BED PROSPECTIVE PAYMENT SYSTEM (PPS)
FOR THE COLLECTION OF DATA
PERTAINING TO THE
PATIENT DRIVEN PAYMENT MODEL (PDPM) & THE SKILLED NURSING FACILITY
QUALITY REPORTING PROGRAM (QRP)

SUPPORTING STATEMENT-PART A

MDS 3.0
FOR THE COLLECTION OF DATA PERTAINING TO
THE PDPM AND SNF QRP

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Supporting Statement A
Minimum Data Set 3.0 Nursing Home and Swing Bed Prospective Payment System (PPS)
For the collection of data related to the Patient Driven Payment Model and the Skilled Nursing Facility Quality Reporting Program (QRP)
CMS-10387, OMB 0938-1140

This package is a request for a revision to the currently approved Minimum Data Set (MDS) assessment instrument for the Skilled Nursing Facility (SNF). This package represents a request to implement the MDS 3.0 v1.19.1 beginning October 1, 2024 in order to meet the requirements of policies finalized in the Federal Fiscal Year (FY) 2024 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule (CMS-1779-F, RIN 0938-AV02). Specifically, CMS adopted two new measures and removed three measures from the SNF QRP. The changes associated with the policies finalized in the FY 2024 SNF PPS final rule, are summarized here and in the document included with the package, titled *Draft MDS 3.0 Item Set Change Table v1.19.1.pdf*:

- REMOVED: These items present in v1.18.11 are not present in v1.19.1.

GG0130.2.A	GG0130.2.B	GG0130.2.C	GG0130.2.E
GG0130.2.F	GG0130.2.G	GG0130.2.H	GG0170.2.A
GG0170.2.B	GG0170.2.C	GG0170.2.D	GG0170.2.E
GG0170.2.F	GG0170.2.G	GG0170.2.H	GG0170.2.I
GG0170.2.J	GG0170.2.K	GG0170.2.L	GG0170.2.M
GG0170.2.N	GG0170.2.O	GG0170.2.P	GG0170.2.R
GG0170.2.S			

- NEW: This item is new to the v1.19.1: O0350

A. Background

1. Background of the MDS in Nursing Homes (NH)

The MDS is a uniform instrument used in every Medicare/Medicaid certified nursing home in the United States to assess resident condition. It was developed in response to the Landmark Institute of Medicine (IOM) Report on Nursing Home Quality in 1987 where the MDS was seen as a critical component in efforts to improve the quality of care in nursing homes. From its inception, the MDS was intended to serve several purposes:

(1) Collect data to inform care plans
(2) To generate quality indicators to evaluate nursing homes and guide improvement interventions
(3) To serve as a data source for nursing home payment systems.

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the

submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and transmitting patient assessment data necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

The SNF QRP was established in CMS-1622-F (August 4, 2015; 80 FR 46390) and began collecting data from SNFs in FY 2016 using the MDS.

Regarding the SNF Quality Reporting Program (SNF QRP), **Table 1** lists the quality measures collected via the MDS 1.18.11, currently in use.

Table 1: Quality Measures Currently Collected via the MDS

Quality Measures Currently Adopted for the FY 2023 SNF QRP Short Name	Measure Name
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.
Change in Mobility Score	Application of 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 the 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- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)

Table 2 lists the quality measures that will be collected via the MDS 1.19.1.

Table 2: Quality Measures Collected via the MDS 1.19.11

Quality Measures Adopted for the FY 2025 SNF QRP Short Name	Measure Name
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
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- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)
DC Function	Discharge Function Score
Additional Quality Measure Adopted for the FY 2026 SNF QRP Short Name	**Measure Name**
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percentage of Patients/Residents Who Are Up to Date

Both the Patient Driven Payment Model (PDPM) in the SNF PPS and the SNF QRP collect data through the MDS 3.0. The PDPM was described and adopted for SNFs and Swing Beds in CMS-1696-F (August 8, 2018; 83 FR 39162).

2. Background of this PRA Package

This package is a request for a revision to the current MDS assessment instrument for the SNF and is associated with the August 7, 2023 (88 FR53200) "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024" final rule (CMS-1779-F, RIN 0938-AV02) that finalized policies for adoption of two SNF QRP measures and the removal of three SNF QRP measures. As a result of these changes, the total annual hour burden across facilities has decreased, and the annual cost burden across facilities has decreased. These changes are reflected in Table 7 in Section 15.

B. Justification

1. Need and Legal Basis

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and transmitting patient assessment data for the PPS 5-day (NP item set), the Swing Bed PPS (SP item set), the Interim Payment Assessment (IPA item set), the Swing Bed discharge (SD), and

the PPS discharge (NPE item set) assessments, necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the timeframes specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the timeframes specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act amended the Social Security Act (the Act) by adding section 1899B to the Act, which requires, among other things, SNFs to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. Under section 1899B(m) of the Act, modifications to the SNF assessment instrument, here the MDS, required to achieve standardization of patient assessment data are exempt from PRA requirements. Standardization has been met upon our adoption of the proposed data elements and standardized patient assessment data in CMS-1718-F. For FY 2020 and thereafter, the exemption of the SNF QRP from the PRA is no longer applicable such that the SNF QRP requirements and burden will be submitted to OMB for review and approval. The active ICR serves as the basis for which we now address the previously exempt requirements and burden.

2. Information Users

CMS uses the MDS 3.0 PPS Item Sets (NP, NPE, SP, SD, IPA) to collect the data used to reimburse skilled nursing facilities for SNF-level care furnished to Medicare beneficiaries and to collect information for quality measures and standardized patient assessment data under the SNF QRP.

In addition, the public/consumer is a data user, as CMS is required to make SNF QRP data available to the public after ensuring that a SNF has the opportunity to review its data prior to public display. Measure data is currently displayed on the Nursing Homes Including Rehab Services Compare website at https://www.medicare.gov/care-compare/?providerType=NursingHome. The public display of quality measure data by CMS imposes no additional burden on SNFs.

a) Consideration of Burden of Information Collection Requests

CMS continually looks for opportunities to minimize burden associated with collection of the MDS for information users through strategies that (1) simplify collection and submission

requirements, (2) improve MDS comprehension, (3) enhance communication, navigation, and outreach, (4) minimize learning costs, and (5) provide flexible time frames for data submission.

First, interviews are conducted with information users before new items are introduced. The interviews provide valuable evidence in order to ensure the item(s) are precise and result in meaningful information.

Second, improving MDS comprehension is a priority. A number of strategies are used, including standardizing the collection instructions across all SNFs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the MDS. Human-centered design best practices are used, such as prioritizing key communication in headings, text boxes, and bold text. Close attention is paid to the amount of information required in the forms so that only the necessary data is collected on the MDS.

Third, CMS looks for opportunities to improve communication with users and conducts outreach. CMS provides a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated SNF QRP webpage houses multiple modes of tools, such as instructional videos, case studies, user manuals, and frequently asked questions which support understanding of the MDS and can be used by current and new users of the MDS. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), as well as reminders and alerts related to the MDS completion. Finally, CMS provides a free internet-based system through which users can access on-demand reports for feedback on the collection of the MDS associated with their facility.

Fourth, CMS is aware of the learning costs that SNFs may incur when new data collection is required. CMS provides multiple free training resources and opportunities for SNFs to use, reducing the burden to SNFs in creating their own training resources. These training resources include live training, online learning modules, tip sheets, and/or recorded webinars and videos. Having the materials online and on-demand gives SNFs the flexibility to use the materials in a group setting or on an individual basis at times that work for them.

Fifth, CMS allows up to 4.5 months for SNFs to submit all data required in this information collection, providing ample time for data submission. CMS acknowledges that some small providers may experience difficulties complying with data collection requirements, and having additional time may reduce the stress and anxiety SNF providers may experience.

3. Improved Information Technology

CMS uses information technology to decrease the burden associated with data collection of the MDS. This is accomplished through strategies that (1) streamline information and submission processes, (2) minimize costly documentation requirements, and (3) utilize information technology for improving communication.

First, CMS creates data collection specifications for SNF electronic health record (EHR) software with 'skip' patterns to ensure the MDS is limited to the minimum data required to meet quality reporting requirements and to calculate SNF payment. These specifications are available free of charge to all SNFs and their technology partners. Further, these minimum requirements are standardized for all users of the MDS assessment forms. CMS also provides flexibility to SNFs by giving them the option of recording the required data on a printed form and later

transferring the data to electronic format or they can choose to directly enter the required data electronically to the CMS designated submission system, which is currently used by SNFS, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs).

Second, CMS has minimized costly documentation requirements by allowing SNFs to electronically self-attest to the accuracy of the data in the MDS prior to transmitting the MDS, eliminating the need for supportive documentation to be submitted with the MDS. CMS has also developed customized software that allows SNFs to encode, store and transmit the MDS data. The software is available free of charge on the CMS Website at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqimds30technicalinformation. Additionally, the software delivers real-time warnings to the SNF when the data is incomplete. SNFs receive warnings when the data is accepted by the system but may be incomplete for purposes of quality reporting submission. SNFs receive fatal warnings when the data collection form is not accepted by the system for any reason.

Third, we provide customer support for software and transmission problems encountered by the providers. SNFs have the ability to self-select their preferred method of communication. For example, we have dedicated help desks to respond to questions about issues SNFs may encounter with the software. We also offer SNFs the ability to sign up for listservs that send out timely and important new information, reminders, and alerts via electronic mail related to the software. CMS has also established a website to assist providers with questions regarding the MDS, at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual. This website publishes new information related to the MDS, houses archived versions of the tool, and is available at all times to SNFs.

4. Duplication of Efforts

The data required for reimbursement and monitoring the effects of the SNF PDPM on patient care and outcomes are not available from any other source.

This data collection for the QRP does not duplicate any other effort and the standardized data cannot be obtained from any other source. There are no other data sets that will provide comparable information on patients admitted to SNFs.

5. Small Businesses

As part of our PRA analysis for a revision to our existing approval, we considered whether the change impacts a significant number of small entities. In this filing we utilized the instructions that pertain to the Paperwork Reduction Act Submission Worksheet, Part II to determine the number of small entities. Specifically, a small entity can be defined as a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field. Data indicate that in 2022, 23% of the total SNF number were non-profit. This equates to 3,550 non-profit SNFs.

Provider participation in the submission of quality data is mandated by Section 3004 of the Affordable Care Act and Section 1899B(c)(2)(A) of the IMPACT Act. Small business providers viewing the data collection as a burden can elect not to participate. However, if a SNF does not submit the required quality data, this provider shall be subject to a 2% reduction in their payment update for the standard Federal rate for discharges from that SNF during that rate year.

6. Less Frequent Collection

Under the PDPM payment system we need to collect this information at the required frequency, that is, at the start of a resident's Part A SNF stay to classify the resident into a payment category, and upon discharge from a SNF stay for monitoring purposes. The IPA is an optional assessment for the PDPM and is not used for the SNF QRP.

For the SNF QRP, the data collection time points and data collection frequency are consistent with the PDPM payment system. Data is collected for the SNF QRP both at the start of a resident's Part A SNF stay and upon discharge from a resident's Part A SNF stay in order to calculate the quality measures adopted under the SNF QRP and to obtain standardized patient assessment data.

7. Special Circumstances

There are no special circumstances that would require the PPS 5-Day and PPS discharge assessments to be conducted more than once during a resident's stay.

8. Federal Register/Outside Consultation

The FY 2024 SNF PPS Notice of Proposed Rulemaking (88 FR 21316) published on April 10, 2023. CMS received no comments related to the proposed burden estimate in the proposed rule.

The FY 2024 SNF PPS Final Rule (88 FR 53200) was published on August 7, 2023. Two new measures (see B.1.a. and B.1.c.) and three measure removals (see B.1.b.) were finalized. As a result, SNFs will collect MDS data using the MDS 1.19.1 beginning with October 1, 2024. This final rule can be found here: https://www.federalregister.gov/documents/2023/08/07/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities#h-231.

CMS informed the provider community on July 31, 2023. A reference to the announcement can be found on the SNF QRP webpage found here: https://www.cms.gov/medicare/quality/snf-quality-reporting-program/spotlights-announcements.

The 60-day comment period Federal Register notice published XXXXXXXXXX.

The 30-day comment period Federal Register notice published XXXXXXX.

9. Payment/Gifts to Respondent

There will be no gifts and no payment to respondents for the use of the MDS.

10. Confidentiality

The system of records (SOR) establishes privacy stringent requirements. The MDS SOR was published in the Federal Register on May 22, 1998 (63 FR 28396). A SOR modification notice was subsequently published in the Federal Register on July 16, 1998 (63 FR 38414), Aug 18, 2000 (65 FR 50552), February 13, 2002 (67 FR 6714), and March 19, 2007 (72 FR 12801).

CMS has also provided, as part of the current Manual, a section that addresses in writing statements of confidentiality consistent with the Privacy Act of 1974. To address concerns about confidentiality of resident data, we provide that a facility and a State may not release resident-identifiable information to the public and may not release the information to an agent or contractor without certain safeguards (42 CFR 483.20(f)(5) and 483.315(j)).

11. Sensitive Questions

There are no sensitive questions on the MDS 3.0 v1.19.1.

12. Collection of Information Requirements and Annual Burden Estimates

The active information collection request (approved August 21, 2023) sets out burden estimates for the item sets NP, NPE, and IPA, which are the item sets used for the PDPM. We continue to use the number of items (272) on the OMRA (NO/SO) item set as a proxy for all assessments, consistent with the active information collection request.

We have updated the MDS burden estimates on skilled nursing facilities. The assessment-level burden hours approved for the previous version MDS 3.0 v1.18.11 remain intact in the estimate. However, the updated MDS burden estimates reflect updated information:

- We used FY 2022 data to calculate the frequency and number of assessments completed;
- We updated the salary estimate using the U.S. Bureau of Labor Statistics (BLS) from May 2020 to May 2022.
- We have accounted for two new measures and three measure removals from the SNF QRP as finalized in the FY 2024 SNF PPS Final Rule (88 FR 53200).
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As a result, the total burden has increased. We provide additional details about the changes in Section 15 of this package.

Wage Estimates

For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates.[1] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 3.

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

Table 3. U.S. Bureau of Labor and Statistics' May 2022 National Occupational Employment and Wage Estimates.

Occupation title	Occupation code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse (RN)	29-1141	$42.80	$42.80	$85.60
Licensed Vocational Nurse (LVN)	29-2061	$26.86	$26.86	$53.72
Speech Language Pathologist (SLP)	29-1127	$43.01	$43.01	$86.02
Physical Therapist (PT)	29-1123	$47.10	$47.10	$94.20
Occupational Therapist (OT)	29-1122	$44.61	$44.61	$89.22

Assumptions

According to the On-Line Survey and Certification System (OSCAR), there were approximately 15,471 skilled nursing facilities in FY 2022. Based on our SNF monitoring information, there were approximately 1,747,812 5-day scheduled PPS assessments and 1,637,941 discharge assessments completed and submitted by Part A SNFs in FY 2022. Based on FY 2022 data, an Interim Payment Assessment (IPA) was completed for approximately 4.8% of patients admitted for a Part A PPS stay have, resulting in 83,430 IPAs completed.

We estimate that the total number of 5-day scheduled PPS assessments, IPAs, and PPS discharge assessments that would be completed under the PDPM across all facilities is 3,469,183 (1,747,812 + 83,430 + 1,637,941, respectively).

Collection of Information Requirements and Associated Burden Estimates

Based on our understanding of the MDS 3.0 and after discussions with clinicians, we estimate that it will take 51 minutes (0.85 hours) to complete a single PPS Assessment.

MDS 3.0 PPS Burden Estimates for the SNF PDPM

There were 15,471 SNFs which sought reimbursement under the year to date projected SNF PPS during FY 2022. The total estimated time for MDS 3.0 PPS Assessment preparation and coding across 15,471 facilities is 2,948,806 hours per year (3,469,183 assessments x 0.85 hours).

Table 4. MDS 3.0 PPS Burden Estimates for the SNF PDPM.

Number of SNFs seeking payment	Estimated total number of assessments completed under PDPM	Estimate of time to complete a single PPS Assessment (hours)	Total Estimated Time to complete PPS Assessment preparation and coding
15,471	3,469,183	0.85	$42.80

MDS 3.0 Burden Estimates for the SNF QRP

a) Discharge Function Score Measure Beginning with the FY 2025 SNF QRP

In the FY 2024 SNF PPS Final Rule (88 FR 53233 to 53243), CMS finalized the adoption of the Discharge Function Score measure beginning with the FY 2025 SNF QRP. This new measure will be calculated with existing data elements reported by SNFs for other payment and quality reporting purposes. As a result, the adoption of this measure has no effect on burden and costs for SNFs.

b) Removal of the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients Beginning with the FY 2025 SNF QRP

In the FY 2024 SNF PPS Final Rule (88 FR 53244 to 53246), CMS finalized the removal of the Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients measure and the Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients measure beginning with the FY 2025 SNF QRP. SNFs will no longer be required to submit data on these measures beginning with patients discharged on October 1, 2023. While these two measures are removed from the SNF QRP, the data elements used to calculate the measures will still be reported by SNFs for other payment and quality reporting purposes. As a result, the removal of these measures have no effect on burden and costs for SNFs.

c) Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function Measure Beginning with the FY 2025 SNF QRP

In the FY 2024 SNF PPS Final Rule (88 FR 53243 to 53244), CMS finalized the removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure beginning with the FY 2025 SNF QRP. SNFs will no longer be required to submit data on this measure beginning with patients admitted on October 1, 2023. While this measure is removed from the SNF QRP, some of the data elements used to calculate the measure will still be reported by SNFs for other payment and quality reporting purposes. As a result, the estimated burden and cost for SNFs for complying with requirements of the FY 2025 SNF QRP will decrease. Specifically, we believe there will be 0.005 hour reduction in clinical staff time to report data per patient stay.

Using data from fiscal year 2022, we estimate 1,747,812 5-day scheduled PPS assessments from 15,471 SNFs annually and 113 5-day scheduled PPS assessments per SNF. This equates to a decrease of 8,739.06 hours in burden for all SNFs (0.005 hour × 1,747,812 5-day scheduled PPS assessments) and 0.56 hours burden reduction for each SNF (8,739.06 total hours / 15,471 SNFs). We believe the MDS item affected by the removal of the Application of Functional Assessment/Care Plan measure is completed by Occupational Therapists (OT), Physical Therapists (PT), Registered Nurses (RN), Licensed Practical and Licensed Vocational Nurses (LVN), and/or Speech-Language Pathologists (SLP) depending on the functional goal selected. Therefore, we averaged the national average for these labor types and established a composite cost estimate of $90.31. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: OT 45

percent; PT 45 percent; RN 5 percent; LVN 2.5 percent; SLP 2.5 percent. For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates.[2] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 3.

In Table 5, we estimate that the total cost would be reduced by $789,224.51 for all SNFs annually ($90.31 composite hourly rate x 8,739.06 hours), or $51.01 per SNF annually ($789,224.51 total reduction/15,471 SNFs) based on the proposed removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure.

Table 5. Burden Hours and Cost Calculation for MDS v1.19.1 for the FY 2025 SNF QRP:

Number of SNFs in U.S. in 2022	15,471
Average number of MDS 5-day PPS item sets submitted per each SNF for the FY 2025 SNF QRP	113
Estimated number of MDS 5-day PPS item sets submitted for all SNFs for the FY 2025 SNF QRP	1,747,812
Hours to complete the data element associated with the removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure retired in the FY 2024 SNF PPS final rule	0.005
Decrease in Hours for each SNF annually	(.56)
Decrease in Hours for all SNFs annually	(8,739.06)
Previous Total Hours for all SNFs annually	2,866,194.00
New Total Hours for all SNFs annually	2,857,454.94
Previous Cost Burden for all SNFs per year	$209,974,004.11
New Cost Burden for all SNFs for the FY 2025 SNF QRP	$209,184,779.60

d) Adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning with the FY 2026 SNF QRP

In the FY 2024 SNF PPS Final Rule (88 FR 53256 to 53265), CMS finalized the adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure beginning with the FY 2026 SNF QRP. As a result, the estimated burden and cost for SNFs for complying with requirements of the FY 2026 SNF QRP will be increased. Specifically, we believe that there will be an additional 0.005 hours of clinical staff time to report data at discharge per patient stay.

Using data from fiscal year 2022, we estimate 1,637,941 discharge assessments from 15,471 SNFs annually and 106 discharge assessments per SNF. This equates to an increase of 8,189.71 hours in burden for all SNFs (0.005 hour × 1,637,941 discharges) and 0.53 hours additional burden for each SNF (8,189.71 hours / 15,471 SNFs). We believe the MDS item affected by the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure will be completed by Registered Nurses (RN) and Licensed Practical and Licensed Vocational Nurses (LVN). Therefore, we averaged the national average for these labor types and established a composite cost estimate of $69.66. This composite estimate was calculated by weighting each

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

salary based on the following breakdown regarding provider types most likely to collect this data: RN 50 percent and LVN 50 percent. For the purposes of calculating the costs associated with the data collection requirements, we used the mean hourly wages for these staff accounting for overhead and fringe benefits. These amounts are detailed in Table 3. We estimate that the total cost would be increased by $570,495.20 for all SNFs annually (8,189.71 hours x $69.66) or $36.88 per SNF annually ($570,495.20 total increase/15,471 SNFs) based on the adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.

Table 6. Burden Hours and Cost Calculation for SNF-MDS v1.19.1 beginning with the FY 2026 SNF QRP:

Number of SNFs in U.S. in 2022	15,471
Average number of MDS PPS Discharge item sets submitted per each SNF for the FY 2026 SNF QRP	106
Estimated number of MDS PPS Discharge item sets submitted for all SNFs for the FY 2026 SNF QRP	1,637,941
Hours to complete the data element associated with the addition of the COVID-19: Percent of Patients/Residents Who Are Up To Date measure adopted in the FY 2024 SNF PPS final rule	0.005
Increase in Hours for each SNF annually	0.53
Increase in Hours for all SNFs annually	3,896
Previous Total Hours for all SNFs annually	2,857,454.94
New Total Hours for all SNFs annually	2,861,350.94
Previous Cost Burden for all SNFs per year	$209,184,779.60
New Cost Burden for all SNFs for the FY 2026 SNF QRP	$209,755,274.80

Basic Requirements for all Claims. In evaluating the impact of billing changes in the UB-04 common claim form (approved by OMB under control number 0938-0997) our long-standing policy is to focus on changes in billing volume.

Information Collection/Reporting Instruments and Instruction Guidance Documents
The Information Collection/Reporting Instruments for the PDPM and SNF QRP effective 10/1/2024 are the MDS 3.0 forms/Item Sets: NP, NPE, IPA.

- NP PPS (NP) Version 1.19.1 effective 10/1/2024 (Revised, see the Change Table for details)
- NPE Part A PPS Discharge (NPE) Version 1.19.1 effective 10/1/2024 (Revised, see the Change Table for details)
- IPA Version 1.19.1 effective 10/1/2024 (Unchanged, see section 15 for details)
- LTC RAI User's Manual Version 1.19.11 (Revised) to be posted at: https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

Additional SNF QRP Programmatic Burden

As requested by OMB, CMS acknowledges there is SNF QRP programmatic burden associated with other data collection methods, including the Centers for Disease Control's (CDC) National Healthcare Safety Network (NHSN).

The FY 2022 SNF PPS final rule (86 FR 42424) requires that SNFs submit data on the COVID-19 Vaccination Coverage among HCP measure beginning with the FY 2023 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

The FY 2023 SNF PPS final rule (87 FR 47502) requires that SNFs submit data on the Influenza Vaccination Coverage among HCP measure beginning with the FY 2024 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

13. Capital Costs (Maintenance of Capital Costs)

Facilities are currently required to collect, compile, and transmit MDS data. Therefore, there are no capital costs. Any other cost can be considered a cost of doing business.

14. Cost to Federal Government

The Department of Health & Human Services (DHHS) will incur costs associated with the administration of the SNF quality reporting program including costs associated with the IT system used to process SNF submissions to CMS and analysis of the data received.

CMS has engaged the services of an in-house CMS contractor to create and manage an online reporting/IT platform for the MDS. This contractor works with the CMS Center for Clinical Standards and Quality, Division of Post-Acute and Chronic Care (DCPAC) in order to support the IT needs of multiple quality reporting programs. When SNF providers transmit the data contained within the MDS to CMS it is received by this contractor. Upon receipt of all data sets for each quarter the contractor performs some basic analysis which helps to determine each provider's compliance with the reporting requirements of the SNF QRP. The findings are communicated to the SNF QRP lead in a report. Contractor costs include the development, testing, roll-out, and maintenance of the Resident Assessment Validation and Entry System (jRAVEN) that is made available to SNF providers free of charge providing a means by which SNFs can submit the required quality measure data to CMS.

DCPAC had also retained the services of a separate contractor for the purpose of performing a more in-depth analysis of the SNF quality data, as well as the calculation of the quality measures, and future public reporting of the SNF quality data. Said contractor will be responsible for obtaining the SNF quality reporting data from the in-house CMS contractor. They will perform

statistical analysis on this data and prepare reports of their findings, which will be submitted to the SNF QRP lead.

DCPAC has retained the services of a third contractor to assist us with provider training and support services related to the SNF QRP.

In addition to the contractor costs, the total includes the cost of the following Federal employees:

- GS-13 (locality pay area of Washington-Baltimore-Northern Virginia) at 100% effort for 3 years, or $336,315.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33.33% effort for 3 years, or $132,368.

The estimated cost to the federal government for the contractor is as follows:

CMS in-house contractor – Maintenance and support of IT platform that supports the MDS	$750,000
Data analysis contractor	$1,000,000
Provider training & helpdesk contractor	$1,000,000
GS-13 Step 1 Federal Employee (100% X 3 years at $112,105 annually)	$336,315
GS-14 Step 1 Federal Employee (33.33% X 3 years at $132,368 annually)	$132,368
Total cost to Federal Government:	**$3,218,683**

15. Program Changes

Since the MDS 3.0 v1.18.11 was approved, CMS has adopted two new measures for the SNF QRP and removed three measures from the SNF QRP. We also continue to monitor the number of SNFs and the number of beneficiaries seeking SNF services. After a decline in SNF admissions due to the COVID-19 public health emergency, the number of inpatient hospital discharges referred to SNFs has increased slightly as represented by the 2.5% increase in the total number of assessments reported in this ICR from the previous ICR.

We also updated the personnel for calculating the transmission function of the MDS 3.0 Item Set to reflect current SNF practice, so that it no longer includes a Health Information Technologist. As a result, we can remove the tables separating the functions of preparation, coding, and transmission as it no longer reflects current practice and the widespread use of point-of-service electronic medical records. Finally, we also updated the salary estimate using the U.S. BLS from May 2020 to May 2022, and reflected such wage updates in burden estimates.

These updates resulted in the following changes to the current burden estimate:

- A decrease of one SNF, with the current number at 15,471.
- This ICR estimates 1,747,812 SNF PPS 5-day assessments, an increase of 88,366 assessments over the last approved package.
- This ICR estimates 1,637,941 SNF PPS Discharge assessments, an increase of 55,086 assessments over the last approved package.
- This ICR estimates 83,430 SNF PPS IPA assessments, a decrease of 46,262 assessments over the last approved package.

- This ICR updates U.S. BLS data from May 2020 to May 2022 resulting in an adjusted hourly wage for Registered Nurses of $79.56, an increase of $8.66.
- Based on changes made to the FY 2024 SNF PPS Final Rule, this ICR incorporates new U.S. BLS data for LVNs, SLPs, PTs, OTs (see Table 1) and removes the Health Information Technician from the burden estimates.
- This ICR updates the personnel involved in coding and transmission of the MDS, removing the Health Information Technician, and replacing these functions with RN and LVN personnel.

As a result of these changes (see Table 7), the total annual hour burden across facilities has increased by 82,612 hours (2,948,806 minus 2,866,194), and the annual cost burden across facilities has decreased by $218,729.31 ($209,755,274.80 minus $209,974,004.11).

Table 7. Burden Hours and Cost Calculation for MDS v1.19.1 for the FY 2025 and FY 2026 SNF QRPs:

Previous Total Hours for all SNFs per year	2,866,194.00
New Total Hours for all SNFs per year	2,861,350.94
Previous Cost Burden for all SNFs per year	$209,974,004.11
New Cost Burden for all SNFs per year	$209,755,274.80

We have also updated the data submission system to the iQIES for the SNF QRP. This was a replacement of the legacy QIES ASAP data submission system and imposes no additional requirements or burden on the part of SNFs.

16. Publication and Tabulation Dates

Not applicable.

17. Expiration Date

The PRA Disclosure statement can be found in the Downloads section on the CMS Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual webpage at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

18. Certification Statement

There are no exceptions.

C. Collection of Information Employing Statistical Methods

In collecting the data for payment and quality purposes, we do not employ any statistical sampling methods.

APPENDIX A:
MDS 3.0 ITEM SET V1.19.1 ASSOCIATED CHANGE TABLE

See attached MDS 3.0_Item Set Change History_v1.19.1 October 2024.pdf, titled *MDS 3.0 Item Set Change History for October 2024 Version 1.19.1*.

APPENDIX B:
GLOSSARY

ASAP: Assessment Submission and Processing
CDC: Centers for Disease Control & Prevention
CMS: Centers for Medicare & Medicaid Services
DCPAC: Division of Post-Acute and Chronic Care
DHHS: Department of Health & Human Services
FY: Fiscal Year
IOM: Institute of Medicine
IPA item set: Interim Payment Assessment item set
iQIES: Internet Quality Improvement and Evaluation System
IT: Information Technology
jRAVEN: Resident Assessment Validation and Entry System
LTC: Long-Term Care
MDS: Minimum Data Set
NC item set: Nursing Home Comprehensive assessment item set
ND item set: Nursing Home PPS Discharge item Set
NH: Nursing Home
NHSN: National Healthcare Safety Network
NO item set: Nursing Home OMRA item set
NOD item set: Nursing Home End of Therapy OMRA combined with Discharge assessment item set
NP item set: Nursing Home PPS 5-day item set
NPE item set: Nursing Home PPS Discharge item set
NQ item set: Nursing Home Quarterly item set
NQF: National Quality Forum
NS item set: Nursing Home Start of Therapy OMRA item set
NSD item set: Nursing Home Start of Therapy OMRA combined with Discharge assessment item set
NT item set: Nursing Home Tracking item set
OBRA: Omnibus Reconciliation Act of 1987
OMB: Office of Management and Budget
OMRA: Other Medicare Required Assessment
OSCAR: On-Line Survey and Certification System
PDPM: Patient Driven Payment Model
PHE: Public Health Emergency
PPS: Prospective Payment System
PRA: Paperwork Reduction Act
QIES: Quality Improvement and Evaluation System
QRP: Quality Reporting Program
RAI: Resident Assessment Instrument

RN: Registered Nurse
SD item set: Swing Bed PPS Discharge item set
SNF: Skilled Nursing Facility
SO item set: Swing Bed OMRA item set
SOD item set: Swing Bed End of Therapy OMRA combined with Discharge assessment item set
SP item set: Swing Bed PPS 5-day item set
SS item set: Swing Bed Start of Therapy OMRA item set
SSD item set: Swing Bed Start of Therapy OMRA combined with Discharge assessment item set
ST item set: Swing Bed Tracking item set
TOH Information: Transfer of Health Information
UB-04: Universal Bill Form 04