AHCA Summary of FY 2023 Skilled Nursing Center Prospective Payment System Proposed Rule

April 11, 2022

The Centers for Medicare & Medicaid Services (CMS) has issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2023 update.

The proposed rule includes a net market basket increase of 3.9 percent but reduced by a proposed 4.6 percent adjustment (e.g., parity adjustment) to maintain budget neutrality the transition from RUG to the Patient-Driven Payment Model (PDPM). The proposed 4.6 percent reduction in base rates is lower than the five percent proposed by CMS last year. With the proposed parity adjustment, CMS estimates that the net market basket update would decrease Medicare SNF payments by approximately $320 million in FY 2023. Of note, CMS once again offers comment opportunities on delaying or phasing in the parity adjustment. CMS also discusses additional SNF value-based purchasing program measures, requests for information on a minimum staffing study and health equity, as well as proposes updates to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act quality reporting.

Below, please find a highlights section and overview of CMS proposals below. Comments, suggestions, and questions may be directed to Mike Cheek.

HIGHLIGHTS

- The proposed rule provides for **a net market basket increase for SNFs of 3.9 percent beginning October 1, 2022, but for a proposed parity adjustment of 4.6 percent.**

- The 3.9 percent market basket update reflects an unadjusted market basket increase of 2.8 percent increased by 1.5 percent forecast error adjustment, as well as a reduction of 0.4 percentage points, in accordance with the multifactor productivity adjustment required by Section 3401(b) of the Affordable Care Act (ACA).

- However, due to the proposed parity adjustment, CMS estimates that the net market basket update would decrease Medicare SNF payments by approximately $320 million in FY 2023.

- CMS discussed the lengths taken to address concerns raised in last year's rulemaking in addressing data challenges associated with the impact of COVID-19 on costs and data trends. CMS is proposing a modified "Control-Period-based Adjustment Factor" approach to establishing an accurate parity adjustment factor. After applying the new approach, CMS continues to note higher than expected PDPM spending, indicating the transition from RUG IV to PDPM was not budget neutral and requires an updated parity adjustment. CMS is proposing an immediate 4.6 percent parity adjustment to begin in FY 2023 to be applied equally across all components and with no transition period. However, CMS is requesting comments on the modified parity adjustment approach, whether the adjustment should be applied equally across all components, and if stakeholders believe delayed implementation or a phase-in period is still warranted.

- Regarding PDPM case-mix updates, CMS proposes minor technical updates to the diagnosis code mappings used under PDPM.

- As discussed in the PDPM payment system, the Medicare Modernization Act (MMA) 128 percent adjustment was eliminated and is now included and accounted for in PDPM as a 12.8 percent increase to the nursing component. Also, a diagnosis of HIV/AIDS offers the most points – eight – in the 50 item Non-Therapy Ancillary list of conditions and extensive services.

- Regarding Consolidated Billing, CMS discusses a broader approach to considering additions to exclusions.

- In addition, CMS proposes a method to reduce the operational instability caused by significant reduction in wage index updates.

- For the FY 2023 SNF VBP Program Year, CMS proposes suppressing readmission rates and applying a flat cut of 0.8 percent to all SNFs. This is a repeat of what was done in FY 2022, because the effects of the COVID pandemic continue to impact the ability to measure performance.

- For the FY 2026 SNF VBP Program Year, CMS is seeking input on a proposal to add two measures – SNF Healthcare Associated Infections (HAI) Requiring Hospitalization (SNF HAI) and Total Staffing Hours per Resident Day (HPRD). In FY 2027, CMS proposes adding a third measure – Discharge to Community. By statute, the money and reimbursement at risk under VBP remains the same with the possible addition of any measures to VBP.

- For SNF QRP, CMS proposes one new measure and makes modifications to others.

- CMS is seeking comments on revising the requirements for long-term care (LTC) facilities to establish mandatory minimum staffing levels.

Below is a more detailed discussion of the proposed rule. After each section, contact information for AHCA staff related to each topic with contact information for questions is provided.

DISCUSSION

I. The SNF Market Basket

A. The SNF PPS Market Basket Update

Absent the parity adjustment, the proposed rule provides for a net market basket increase for SNFs of 3.9 percent beginning October 1, 2022. This market basket update reflects a full market basket increase of 2.8 percentage points, plus an increase of 1.5 percent forecast error adjustment and a 0.4 percentage point multifactor productivity adjustment required by Section 3401(b) of the ACA. CMS estimates that the net market basket update would decrease Medicare SNF payments by approximately $320 million in FY 2023.

Additionally, Section 1888(e)(5)(A) of the ACA requires CMS to establish and update a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. CMS regularly updates the SNF market basket index to encompass the most used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), CMS rebased and revised the market basket index, which included updating the base year from FY 2010 to 2014. Last year, CMS revised and rebased market basket index, which included updating the base year 2014 to 2018. This year, CMS reiterates is indication that the proposed market basket updates, unadjusted and adjusted, may change based upon more up to date data becomes available.

B. Forecast Error Adjustment to the SNF Market Basket

The regulations at 42 CFR §413.337(d)(2) provide for an adjustment to account for market basket forecast error. Adjustments account for the forecast error from the most recently available fiscal year for which there is final data and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. CMS originally used a 0.25 percentage point threshold for this purpose but adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent fiscal years. The adjustment reflects both upward and downward adjustments, as appropriate. Table 1 shows the impact the forecast error incurred due to a 1.5 percent difference between the forecasted market basket and the actual increase.

Table 3

Difference Between the Forecasted & Actual Market Basket Increases for FY 2021

INDEX	FORECASTED FY 2021 INCREASE*	ACTUAL FY 2010 INCREASE**	FY 2021 DIFFERENCE
SNF	2.2	3.7	1.5

*Published in **Federal Register**; based on second quarter 2020 IGI forecast (2014-based index).
**Based on the first quarter 2021 IHS Global Insight forecast, with historical data through the fourth quarter 2021 (2014-based index).

C. Multifactor Productivity Adjustment – Now "Total Factor Productivity Adjustment"

Section 3401(b) of the ACA requires that in FY 2012 (and in subsequent FYs), the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the ACA, sets forth the definition of this productivity adjustment.

The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in the annual economy-wide private nonfarm business multi-factor productivity (the MFP adjustment). This is projected by the Secretary for the 10-year period ending with the applicable fiscal year, calendar year, cost-reporting period, or other annual period. Of note, beginning with the November 18, 2021 release of productivity data, the Bureau of Labor Statistics (BLS) replaced the term "multifactor productivity adjustment" with "total factor productivity adjustment (TFP)." BLS made a change in terminology, only, and no change in data or methodology.

The resulting TFP-adjusted SNF market basket update is equal to the forecast error adjusted market basket update of 1.5 percent less than TFP 0.4 percentage point. The final updated percentages are further adjusted by the wage index budget neutrality factor. Additionally, the market basket update percentage and related federal rate per diem rates may change between the April 11, 2021 Proposed Rule and the Final Rule. This is due to any significant changes in the IGI projection data. CMS uses the most recent IGI data available.

D. Federal Rate Per Diem Components

CMS used the SNF market basket, adjusted for the forecast error correction and the TFP adjustment, as described above, to adjust each per diem component of the federal rates which are forward to reflect the change in the average prices for FY 2023. CMS indicates it would further adjust the rates by a wage index budget neutrality factor. Table 2 provides the proposed FY23 unadjusted rates.

Table 2

FY 2023 Unadjusted Federal Rate Per Diem – Urban

COMPONENT	NURSING	NTA	PT	OT	SLP	NON-CASE-MIX
PER DIEM AMOUNT	$113.91	$85.94	$65.34	$60.83	$24.39	$102.01

FY 2023 Unadjusted Federal Rate Per Diem – Urban

COMPONENT	NURSING	NTA	PT	OT	SLP	NON-CASE-MIX
PER DIEM AMOUNT	$108.83	$82.10	$74.48	$68.41	$30.74	$103.89

E. Consolidated Billing

As enacted by Section 4432(b) of the Balanced Budget Act of 1997 (BBA, P.L. 10533), the original list of exclusions (at section 1888(e)(2)(A)(ii) of the Act) carved out entire categories of services from consolidated billing – primarily, those of physicians and certain other types of medical practitioners. These excluded services are separately billable to the Part B carrier. CMS goes on to note the Consolidated Appropriations Act (CCA) established an additional category of exclusion codes for certain blood clotting factors for the treatment of patients with hemophilia and other bleeding disorders along with items and services related to furnishing such factors. CMS invites comment through the current rulemaking cycle "any new services that would actually represent a substantive change in the scope of exclusions from SNF consolidated billing." CMS goes on to note that "By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions."

II. Other SNF PPS Issues

A. Wage Index and Improving Stability

CMS indicates that in the past they have proposed and finalized temporary transition policies to mitigate significant changes to payments due to the changes in the SNF PPS wage index. Specifically, in 2021, CMS implemented a one-year transition to mitigate any negative effects of wage index changes by applying a 5 percent cap on any decrease in a SNF's wage index from the final wage index from FY 2020. In the FY 2023 proposed rule, CMS notes that the Agency "recognizes that changes to the wage index have the potential to create instability and significant negative impacts on certain providers even when labor market areas do not change." CMS also

notes that an area's wage index can fluctuate due to external factors beyond a providers' control, such as the COVID-19 public health emergency (PHE).

Due to these factors, CMS is proposing a permanent "approach to smooth year-to-year changes in providers' wage indexes to mitigate instability." CMS proposes making permanent the FY 2021 temporary policy of capping all wage index decreases at 5 percent. In effect, this means that if a SNF's prior FY wage index is calculated with the application of the 5 percent cap, then the following year's wage index would not be less than 95 percent of the SNF's capped wage index in the prior FY.

A. Patient-Driven Payment Model (PDPM) Payment Policy

On October 1, 2019, CMS implemented the new case-mix classification model called the Patient Driven Payment Model (PDPM). When finalizing PDPM, CMS stated that this new payment model would be implemented in a budget neutral manner, meaning that the transition to this new payment model would not result in an increase or decrease in aggregate SNF spending. Since PDPM implementation, currently available data suggest an unintended increase in payments of approximately 4.6 percent, or $1.4 billion, in FY 2021. As with past payment model transitions, CMS has conducted the data analysis to recalibrate the parity adjustment used to achieve budget neutrality under PDPM.

Parity Adjustment Discussion and Proposed Implementation Detail

CMS discussed the lengths taken to address concerns raised in last year's rulemaking in addressing data challenges associated with the impact of COVID-19 on costs and data trends. CMS is proposing a modified "Control-Period-based Adjustment Factor" approach to establishing an accurate parity adjustment factor. After applying the new approach, CMS continues to note higher than expected PDPM spending, indicating the transition from RUG IV to PDPM was not budget neutral and requires an updated parity adjustment. CMS is proposing an immediate 4.6 percent parity adjustment to begin in FY 2023, to be applied equally across all components, and with no transition period. However, CMS is requesting comments on the modified parity adjustment approach, whether the adjustment should be applied equally across all components, and if stakeholders believe delayed implementation or a phase-in period is still warranted. Below are highlights of key points discussed in the parity adjustment approach.

Background

On October 1, 2019, CMS implemented the Patient Driven Payment Model (PDPM) under the SNF PPS, a new case-mix classification model that replaced the prior case-mix classification model, the Resource Utilization Groups, Version IV (RUG-IV). CMS proposed and finalized implementing PDPM in a budget neutral manner.

Since PDPM implementation, CMS has closely monitored SNF utilization data to determine if the parity adjustment finalized in the FY 2020 SNF PPS final rule (84 FR 38734 through 38735) provided for a budget neutral transition between RUG-IV and PDPM as intended. In this proposed rule CMS notes they have observed significant differences between the expected SNF PPS payments and case-mix utilization based on historical data, and the actual SNF PPS payments and case-mix utilization under PDPM, based on FY 2020 and FY 2021 utilization data.

In the FY 2022 SNF PPS proposed rule (86 FR 19987 through 19989), CMS solicited comments from stakeholders on a potential methodology for recalibrating the PDPM parity adjustment to account for these potential effects without compromising the accuracy of the adjustment. After considering the feedback and recommendations received, summarized in the FY 2022 SNF PPS final rule (86 FR 42469 through 42471), CMS is now proposing an updated recalibration methodology. In this proposed rule, CMS presents results from its data monitoring efforts to provide transparency on its efforts to parse out the effects of PDPM implementation from the effects of the COVID-19 PHE.

Proposed FY 2023 Parity Adjustment Recalibration Methodology
CMS acknowledges that the COVID-19 PHE had significant impacts on nursing home care protocols and many other aspects of SNF operations. A key aspect the proposed revised recalibration methodology, involves parsing out the impacts of the COVID-19 PHE and the PHE-related 3-day stay and benefit period waivers from those which occurred solely, or at least principally, due to the implementation of PDPM.

For the FY 2023 SNF proposed rule, CMS defines the COVID-19 population to include stays that have the interim COVID-19 code B97.29 from January 1, 2020, to March 31, 2020, or the new COVID-19 code U07.1 from April 1, 2020, onward recorded as a primary or secondary diagnosis on their SNF claims, MDS 5-day admission assessments, or MDS interim payment assessments.

In response to prior public comments and based on additional data collection through FY 2021, CMS has identified a recalibration methodology that the agency believes better accounts for COVID-19 related effects. CMS proposes a revised approach that continues to exclude stays that used a section 1812(f) of the Act modification, or that included a revised COVID-19 diagnosis definition (as described in the prior paragraph), with a newly proposed 1-year "control period" derived from both FY 2020 and FY 2021 data. Specifically, CMS used six months of FY 2020 data from October 2019 through March 2020 and six months of FY 2021 data from April 2021 through September 2021 (which the CMS claims data suggests were periods with relatively low COVID-19 prevalence) to create a full one-year period with no repeated months to account for seasonality effects. As shown in Table 11 of the proposed rule, CMS believes this combined approach provides the most accurate representation of what the SNF case-mix distribution would look like under PDPM outside of a COVID-19 PHE environment.

TABLE 11: Adjustment Factors Based on Population and Data Period

Data Period	Full SNF Population	Subset SNF Population	Difference
FY 2020-based Adjustment Factor	5.21%	4.90%	-0.31%
FY 2021-based Adjustment Factor	5.65%	5.25%	-0.40%
Control Period-based Adjustment Factor	4.58%	4.60%	0.02%

Table 12 of the proposed rule shows that while using the subset population method would lead to a 4.9 percent adjustment factor ($1.8 billion) using FY 2020 data and a 5.3 percent adjustment

factor ($1.9 billion) using FY 2021 data, introducing the control period reduces the adjustment factor to 4.6 percent ($1.7 billion).

TABLE 12: Budget Impact Based on Subset Population and Data Period

Data Period and Population	Adjustment Factor	Budget Impact (Reduction)
FY 2020 Data, Subset Population	4.9%	$1.8 billion
FY 2021 Data, Subset Population	5.3%	$1.9 billion
Control Period Data, Subset Population	4.6%	$1.7 billion

CMS further discussed various analyses that the agency argues demonstrate that the proposed Control Period-based Adjustment Factor approach mitigates most of the COVID-era impacts on the subset population used for the parity adjustment analysis. In addition to the proposed rule text, CMS posted more detailed analytic files for public review here and furthermore stated, "Therefore, we believe that using the control period is a closer representation of SNF patient case-mix outside of a COVID-19 PHE environment than using either FY 2021 or FY 2022 data alone." **CMS is requesting comments on this approach.**

Methodology for Applying the Recalibrated PDPM Parity Adjustment

As discussed in the FY 2022 SNF PPS proposed rule (86 FR 19988), CMS continues to believe it would be appropriate to apply the recalibrated parity adjustment across all PDPM CMIs in equal measure, as the initial increase to the PDPM CMIs to achieve budget neutrality was applied equally, and therefore, this method would properly implement and maintain the integrity of the PDPM classification methodology as it was originally designed. Tables 5 and 6 in this proposed rule set forth what the PDPM CMIs and case-mix adjusted rates would be if CMS were to apply the recalibration methodology in equal measure in FY 2023.

TABLE 5: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN (Including the Proposed Parity Adjustment Recalibration)

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$94.74	1.41	$85.77	0.64	$15.61	ES3	3.84	$437.41	3.06	$262.98
B	1.61	$105.20	1.54	$93.68	1.72	$41.95	ES2	2.90	$330.34	2.39	$205.40
C	1.78	$116.31	1.60	$97.33	2.52	$61.46	ES1	2.77	$315.53	1.74	$149.54
D	1.82	$118.92	1.45	$88.20	1.38	$33.66	HDE2	2.27	$258.58	1.26	$108.28
E	1.34	$87.56	1.33	$80.90	2.21	$53.90	HDE1	1.88	$214.15	0.91	$78.21
F	1.52	$99.32	1.51	$91.85	2.82	$68.78	HBC2	2.12	$241.49	0.68	$58.44
G	1.58	$103.24	1.55	$94.29	1.93	$47.07	HBC1	1.76	$200.48	-	-
H	1.10	$71.87	1.09	$66.30	2.7	$65.85	LDE2	1.97	$224.40	-	-
I	1.07	$69.91	1.12	$68.13	3.34	$81.46	LDE1	1.64	$186.81	-	-
J	1.34	$87.56	1.37	$83.34	2.83	$69.02	LBC2	1.63	$185.67	-	-
K	1.44	$94.09	1.46	$88.81	3.5	$85.37	LBC1	1.35	$153.78	-	-
L	1.03	$67.30	1.05	$63.87	3.98	$97.07	CDE2	1.77	$201.62	-	-
M	1.20	$78.41	1.23	$74.82	-	-	CDE1	1.53	$174.28	-	-
N	1.40	$91.48	1.42	$86.38	-	-	CBC2	1.47	$167.45	-	-
O	1.47	$96.05	1.47	$89.42	-	-	CA2	1.03	$117.33	-	-
P	1.02	$66.65	1.03	$62.65	-	-	CBC1	1.27	$144.67	-	-
Q	-	-	-	-	-	-	CA1	0.89	$101.38	-	-
R	-	-	-	-	-	-	BAB2	0.98	$111.63	-	-
S	-	-	-	-	-	-	BAB1	0.94	$107.08	-	-
T	-	-	-	-	-	-	PDE2	1.48	$168.59	-	-
U	-	-	-	-	-	-	PDE1	1.39	$158.33	-	-
V	-	-	-	-	-	-	PBC2	1.15	$131.00	-	-
W	-	-	-	-	-	-	PA2	0.67	$76.32	-	-
X	-	-	-	-	-	-	PBC1	1.07	$121.88	-	-
Y	-	-	-	-	-	-	PA1	0.62	$70.62	-	-

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL (Including the Proposed Parity Adjustment Recalibration)

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$108.00	1.41	$96.46	0.64	$19.67	ES3	3.84	$417.91	3.06	$251.23
B	1.61	$119.91	1.54	$105.35	1.72	$52.87	ES2	2.90	$315.61	2.39	$196.22
C	1.78	$132.57	1.60	$109.46	2.52	$77.46	ES1	2.77	$301.46	1.74	$142.85
D	1.82	$135.55	1.45	$99.19	1.38	$42.42	HDE2	2.27	$247.04	1.26	$103.45
E	1.34	$99.80	1.33	$90.99	2.21	$67.94	HDE1	1.88	$204.60	0.91	$74.71
F	1.52	$113.21	1.51	$103.30	2.82	$86.69	HBC2	2.12	$230.72	0.68	$55.83
G	1.58	$117.68	1.55	$106.04	1.93	$59.33	HBC1	1.76	$191.54	-	-
H	1.10	$81.93	1.09	$74.57	2.7	$83.00	LDE2	1.97	$214.40	-	-
I	1.07	$79.69	1.12	$76.62	3.34	$102.67	LDE1	1.64	$178.48	-	-
J	1.34	$99.80	1.37	$93.72	2.83	$86.99	LBC2	1.63	$177.39	-	-
K	1.44	$107.25	1.46	$99.88	3.5	$107.59	LBC1	1.35	$146.92	-	-
L	1.03	$76.71	1.05	$71.83	3.98	$122.35	CDE2	1.77	$192.63	-	-
M	1.20	$89.38	1.23	$84.14	-	-	CDE1	1.53	$166.51	-	-
N	1.40	$104.27	1.42	$97.14	-	-	CBC2	1.47	$159.98	-	-
O	1.47	$109.49	1.47	$100.56	-	-	CA2	1.03	$112.09	-	-
P	1.02	$75.97	1.03	$70.46	-	-	CBC1	1.27	$138.21	-	-
Q	-	-	-	-	-	-	CA1	0.89	$96.86	-	-
R	-	-	-	-	-	-	BAB2	0.98	$106.65	-	-
S	-	-	-	-	-	-	BAB1	0.94	$102.30	-	-
T	-	-	-	-	-	-	PDE2	1.48	$161.07	-	-
U	-	-	-	-	-	-	PDE1	1.39	$151.27	-	-
V	-	-	-	-	-	-	PBC2	1.15	$125.15	-	-
W	-	-	-	-	-	-	PA2	0.67	$72.92	-	-
X	-	-	-	-	-	-	PBC1	1.07	$116.45	-	-
Y	-	-	-	-	-	-	PA1	0.62	$67.47	-	-

CMS discusses considering comments to apply adjustments in a more targeted manner by individual component as depicted in Table 14 of the proposed rule but in the end, continue to prefer to adjust each component equally. **CMS is requesting comment on this approach.**

TABLE 14: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes

PDPM Group	PT CMI	OT CMI	SLP CMI	Nursing CMG	Nursing CMI	NTA CMI
A	1.53	1.49	0.62	ES3	3.72	2.97
B	1.70	1.63	1.67	ES2	2.81	2.32
C	1.88	1.69	2.45	ES1	2.68	1.69
D	1.92	1.53	1.34	HDE2	2.20	1.22
E	1.42	1.41	2.14	HDE1	1.82	0.88
F	1.61	1.60	2.73	HBC2	2.05	0.66
G	1.67	1.64	1.87	HBC1	1.70	-
H	1.16	1.15	2.62	LDE2	1.90	-
I	1.13	1.18	3.23	LDE1	1.58	-
J	1.42	1.45	2.74	LBC2	1.58	-
K	1.52	1.54	3.39	LBC1	1.31	-
L	1.09	1.11	3.86	CDE2	1.71	-
M	1.27	1.30	-	CDE1	1.48	-
N	1.48	1.50	-	CBC2	1.42	-
O	1.55	1.55	-	CA2	1.00	-
P	1.08	1.09	-	CBC1	1.23	-
Q	-	-	-	CA1	0.86	-
R	-	-	-	BAB2	0.95	-
S	-	-	-	BAB1	0.91	-
T	-	-	-	PDE2	1.44	-
U	-	-	-	PDE1	1.35	-
V	-	-	-	PBC2	1.12	-
W	-	-	-	PA2	0.65	-
X	-	-	-	PBC1	1.03	-
Y	-	-	-	PA1	0.60	-

Delayed and Phased Implementation

CMS noted in the FY 2012 SNF PPS final rule (76 FR 48493), that the Agency believes it is imperative to act in a well-considered but expedient manner once excess payments are identified. However, CMS acknowledged that applying a reduction in payments without time to prepare could create a financial burden for providers, particularly considering the ongoing COVID-19 PHE. Therefore, in the FY 2022 SNF PPS proposed rule (86 FR 19988 through 19990), CMS solicited comments on two potential mitigation strategies to ease the transition to prospective budget neutrality: delayed implementation and phased implementation. CMS noted that for either of these options, the adjustment would be applied prospectively, and the CMIs would not be adjusted to account for deviations from budget neutrality in years before the payment adjustments are implemented.

In this proposed rule CMS is not proposing either a delay or phase-in. After some discussion, CMS states, *"We therefore believe that delaying the implementation of the proposed recalibration or phasing the recalibration in over some amount of time would only serve to prolong these payments in excess of the intended policy."* **However, in consideration of other potential COVID-era impacts, CMS is requesting comments on the Agency's proposal to**

recalibrate the parity adjustment by 4.6 percent in FY 2023 and whether stakeholders believe delayed implementation or phase-in period is warranted or not.

B. Request for Information – Infection Isolation

During the COVID-19 PHE, a number of stakeholders raised concerns with the definition of "infection isolation" as it relates to the treatment of SNF patients being cohorted due to either the diagnosis or suspected diagnosis of COVID-19. CMS is unclear on if the relative increase in resource intensity for each patient being treated within a cohorted environment is the same relative increase as it would be for treating a single patient isolated due to an active infection.

CMS is taking this opportunity to invite the public to submit comments about isolation due to active infection and how the PHE has affected the relative staff time resources necessary for treating these patients. Specifically, CMS is inviting comments 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.

C. Updating ICD-10 Code Mappings and Lists

In the FY19 rule, CMS noted that the federal interdepartmental ICD-10 Coordination and Maintenance Committee updates ICD-10 medical codes sets in June of each year. These changes become effective on October 1 of the same year. In the FY20 file rule, CMS noted intent to update any ICD-10 code mappings and lists used under PDPM, as well as the SNF GROUPER software. CMS will make non-substantive changes to ICD-10 codes using sub-regulatory processes but will use its formal rule making process for substantive changes to ICD-10 codes on the code mappings and lists under PDPM.

This year, CMS is proposing several changes to the PDPM ICD-10 code mappings and lists. On October 1, 2021, CMS proposed assignment of return to provider for Thrombocytosis, unspecified (D75.839), Hereditary alpha tryptasemia (D89.44) as well as Depression, Unspecified (F32.A). Other codes moved to return to provider include Unspecified toxic encephalopathy (G92.9) and Low back pain, unspecified (M54.50). In FY 2022, CMS proposed to reclassify Other esophagitis with bleeding (K20.81), Esophagitis unspecified with bleeding ((K21.01), Gastro-esophageal reflux disease with esophageal reflux disease with esophageal, with bleeding from return to provider to Medical Management. CMS goes on to discuss other proposed changes to ICD-10 code mappings and lists which it elected not to modify. CMS invites comments on all proposed changes.

Please email pdpm@ahca.org with questions about this section.

III. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP Program)

The Skilled Nursing Facility Value Based Purchasing Program (SNF VBP), which was part of the Protecting Access to Medicare Act of 2014 (PAMA), established a 2 percent withhold to SNF Part A payments that can be partially earned back based on a SNF's rehospitalization rate and level of improvement.

In the FY23 proposed rule, CMS proposes suppressing Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) rates for another year due to the lingering impact of COVID on patient case volumes and facility-level case mix. With FY 2021 SNFRM rates suppressed, all nursing homes would receive a performance score of zero.

SNFs with fewer than 25 eligible stays for SNFRM during FY 2021, would receive a net-neutral payment incentive multiplier consistent with the previously established Low-Volume Adjustment policy and a proposed case and measure minimum standard for SNF VBP.

SNFs with 25 or more eligible stays for SNFRM during FY 2021 would receive a 0.8 percent payment cut. The cut is based on returning 60 percent of the 2 percent withhold [2 percent - 1.2 percent = 0.8 percent]. Applying this cut allows the VBP program to comply with the program's statutory requirements.

Under the Consolidated Appropriations Act passed in 2021, up to nine new measures can be added to SNF VBP starting in FY 2024. CMS proposes adding two measures (SNF HAI & Total Nurse HPRD) in FY 2026 and one measure (Discharge to Community) in FY 2027. These are all existing measures currently part of QRP and/or Five-Star.

IV. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

The SNF QRP is applied to post-acute patients. It is part of the IMPACT act that requires standardized measures across post-acute providers and levies a two-percentage point reduction in their annual update for SNFs that do not meet reporting requirements. CMS is proposing to adopt a new measure and make revisions to others.

SNF QRP Quality Measure Proposals Beginning with the FY 2025 SNF QRP

New Measure: Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #0431)
CMS proposes to adopt one new measure for the SNF QRP beginning with the FY 2025 SNF QRP: the Influenza Vaccination Coverage among Healthcare Personnel (HCP) (NQF #0431) measure as an "other measure" under section 1899B(d)(1) of the Act. In accordance with section 1899B(a)(1)(B) of the Act, the data used to calculate this measure are standardized and interoperable. The proposed measure supports the "Preventive Care" Meaningful Measure area and the "Promote Effective Prevention and Treatment of Chronic Disease" health care priority. The Influenza Vaccination Coverage among HCP measure is a process measure, developed by the Centers for Disease Control and Prevention (CDC), and reports on the percentage of HCP who receive the influenza vaccination. This measure is currently used in other post-acute care (PAC) Quality Reporting Programs (QRPs), including the Inpatient Rehabilitation Facility (IRF) QRP and the Long-Term Care Hospital (LTCH) QRP. The measure is described in more detail in section VI.C.1. of this proposed rule.

> CMS proposes that SNFs submit data for the measure through the CDC/NHSN data collection and submission framework. In alignment with the data submission frameworks utilized for this measure in the IRF and LTCH QRPs, SNFs would use the HCP influenza data reporting module in the NHSN HPS Component and complete two forms. SNFs would complete the first form (CDC 57.203) to indicate the type of data they plan on reporting to the NHSN by selecting the "Influenza Vaccination Summary" option under "Healthcare Personnel Vaccination Module" to create a reporting plan. SNFs would then complete a second form (CDC 57.214) to report the number of HCP who have worked at the health care facility for at least 1 day between October 1 and March 31 (denominator) and the number of HCP who fall into each numerator category. To meet the minimum data submission requirements, SNFs would enter a single influenza vaccination summary report at the conclusion of the measure reporting period. If SNFs submit data more frequently, such as on a monthly basis, the information would be used to calculate one summary score for the proposed measure which would be publicly reported on Care Compare. For more information regarding proposed data submission requirements for this measure and its public reporting plan, we refer readers to sections VI.G.2. and VI.H.2. of this proposed rule. Details related to the use of NHSN for data submission can be found at the CDC's NHSN Healthcare Personnel Safety (HPS) Component webpage.
> **CMS invites public comment on our proposal to add a new measure, Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431), to the SNF QRP beginning with the FY 2025 SNF QRP.**

This measure requires that the provider submit a minimum of one report to the NHSN by the data submission deadline of May 15 for each influenza season following the close of the data collection period each year to meet our requirements. Although facilities may edit their data after May 15, the revised data will not be shared with CMS.145 SNFs would submit data for the measure through the CDC/NHSN web-based surveillance system. SNFs would use the Influenza Vaccination Summary option under the NHSN HPS Component to report the number of HCP who receive the influenza vaccination (numerator) among the total number of HCP in the facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact (denominator). **CMS invites public comment on this proposal.**

Revise Measure: Transfer of Health (TOH) Information to the Provider-PAC
In addition, CMS proposes to revise the compliance date for the collection of the Transfer of Health (TOH) Information to the Provider-PAC measure, the TOH Information to the Patient-PAC measure, and certain standardized patient assessment data elements from October 1st of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE to October 1, 2023. CMS believes the COVID-19 PHE revealed why the TOH Information measures and standardized patient assessment data elements are important to the SNF QRP. The new data elements will facilitate communication and coordination across care settings, as well as provide information to support our mission of analyzing the impact of the COVID-19 PHE on patients to improve the quality of care in SNFs.

CMS proposes to revise the compliance date from the May 8th, 2020 COVID-19 IFC from October 1st of the year that is at least 2 full FYs after the end of the COVID-19 PHE to October 1, 2023. This revised date would begin the collection of data on the TOH Information to Provider-PAC measure and TOH Information to Patient-PAC measure, and certain standardized patient assessment data elements on the updated version of the MDS assessment instrument referred to as MDS 3.0 v1.18.11. **CMS invites public comment on this proposal.**

Finally, CMS proposes to make **certain revisions to regulation text at § 413.360** to include a new paragraph to reflect all the data completion thresholds required for SNFs to meet the compliance threshold for the annual payment update, as well as certain conforming revisions.

At § 413.360(f)(1), CMS proposes to add new language to state that SNFs must meet or exceed two separate data completeness thresholds: One threshold set at 80 percent for completion of required quality measures data and standardized patient assessment data collected using the MDS submitted through the CMS-designated data submission system, beginning with FY 2018 and for all subsequent payment updates; and a second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN, beginning with FY 2023 and for all subsequent payment updates. At § 413.360(f)(2), CMS proposes to add new language to state that these thresholds (80 percent for completion of required quality measures data and standardized patient assessment data on the MDS; 100 percent for CDC NHSN data) will apply to all measures and standardized patient assessment data requirements adopted into the SNF QRP. At § 413.360(f)(3),

CMS proposes to add new language to state that a SNF must meet or exceed both thresholds to avoid receiving a 2-percentage point reduction to their annual payment update for a given fiscal year. **CMS invites public comment on this proposal.**

Request for Information - SNF QRP Quality Measures under Consideration for Future Years: Request for Information (RFI)

CMS is seeking input on the importance, relevance, and applicability of the concepts under consideration listed in Table 16 in the proposed rule. More specifically, CMS is seeking input on a cross-setting functional measure that would incorporate the domains of self-care and mobility. Our measure development contractor for the cross-setting functional outcome measure convened a Technical Expert Panel (TEP) on June 15 and June 16, 2021, to obtain expert input on the development of a functional outcome measure for PAC. During this meeting, the possibility of creating one measure to capture both self-care and mobility was discussed. CMS is also seeking input on measures of health equity, such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities. Finally, CMS is seeking input on the value of a COVID-19 Vaccination Coverage measure that would assess whether SNF patients were up to date on their COVID-19 vaccine.

TABLE 16: Future Measures and Measure Concepts Under Consideration for the SNF QRP

Quality Concepts
Cross-Setting Function
Health Equity Measures
PAC – COVID-19 Vaccination Coverage among Patients

Please email Dan Ciolek with questions on this section.

VI. Requests for Information- Revising the Requirements for Long-Term Care (LTC) Facilities to Establish Mandatory Minimum Staffing Levels

CMS intends to propose minimum standards for staffing adequacy that nursing homes would be required to meet. Several past studies are noted but CMS acknowledges the care needs of, and the type of care provided to LTC facility residents has changed, thus CMS is reevaluating the evidence. CMS will conduct a new research study to help inform policy decisions related to determining the level and type of staffing needed to ensure safe and quality care and is expecting to issue proposed rules within 1 year.

In this request for information, CMS is seeking public input on addressing direct care staffing requirements, especially those for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs), through the requirements for participation for LTC facilities. CMS also seeks input on which individuals should be considered direct care staff, beyond nurses and CNAs.

CMS acknowledges that while many studies indicate that consistent, adequate direct care facility staffing is vital to resident health and safety, they are seeking additional information to make fully informed policy proposals and provide 17 questions as well as invite input on other aspects of staffing in LTC facilities that should be considered in this request for information. Some of the areas CMS is requesting comments on are as follows: determine the relevance of older studies, benefits of adequate staffing, consideration of resident and facility factors, facility assessment impact, cost of implementing staffing thresholds, projected savings from reduced rehospitalizations, factors that impact recruiting and retention and good faith efforts related to recruiting, considerations of turnover, type of staff considered in the count, measurement of staffing, evaluation of state level staffing, RN requirements, consequences to minimum staffing ratio, geographic disparities in workforce, and outcomes and care process to consider when determining level of staff needed.

CMS seeks public input from a broad range of commenters including, but not limited to nursing home residents and caretakers, nursing staff, nurse aides, physicians, nursing home administrators, owners and operators, and researchers. CMS is particularly interested in data, evidence, and experience on the issues identified above and any others that are relevant to defining and ensuring adequate staffing in LTC facilities

Please email regulatory@ahca.org with questions on this section.

Conclusion

AHCA is working to ensure coordinated discussions among various CMS divisions in order to maximize our advocacy impact. We hope you find this document useful and look forward to your valuable thoughts and comments. Additional details on the proposed rule will be released in the coming week as needed.