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Special Bulletin

April 9, 2021

CMS Releases Skilled Nursing Facility PPS Proposed Rule for FY 2022

The Centers for Medicare & Medicaid Services (CMS) April 8 issued its fiscal year (FY) 2022 proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS). The proposed rule would increase SNF payments by 1.3% in FY 2022, with varying updates for hospital-based providers.

AHA Take: This relatively brief rule proposes the required payment updates, a few payment policy changes and an important request for input from the field. We plan to provide significant feedback on the potential recalibration of CMS's budget neutrality calculations from its implementation of the redesigned SNF PPS payment model. For hospital-based SNFs, which played a central role in local responses to the COVID-19 pandemic, and the field as a whole, it is vital that payments – including any recalibration of budget neutrality – provide adequate financial support. Finally, we are concerned that while CMS' proposed quality measures address important topics, they are inappropriate for use in the SNF Quality Reporting Program at this time.

Highlights from the rule follow.

FY 2022 Payment Update. CMS proposes to increase net payments to SNFs by 1.3% ($444 million) in FY 2022 relative to FY 2021. This includes a 2.3% market-basket update offset by a statutorily mandated cut of 0.2 percentage points for productivity and a small decrease to account for the consolidated billing change described below. The net increase also includes a proposed 0.8 percent reduction to adjust for a market

Key Takeaways

The proposed rule would:

- Increase SNF payments by 1.3% ($444 million) in FY 2022, with 1.6% and 1.1% increases proposed for rural and urban hospital-based SNFs, respectively.
- Make no material changes to the design of the patient-driven payment model (PDPM) case-mix system implemented in FY 2020.
- Update the ICD-10 mapping used to classify patients under the PDPM framework.
- Seek input from the field on how to ensure that the PDPM is budget neutral to the prior payment system, while also accounting for the financial demands of the COVID-19 pandemic.
- Implement the statutorily-required Part A billing exemption for blood clotting factors and related services and items.
- Adopt two quality measures, one on COVID-19 vaccination among health care personnel and one on healthcare-associated infections.

basket forecast error in FY 2020, for which the finalized market basket of 2.8 percent was 0.8 greater than the actual market basket.

Patient-driven Payment Model (PDPM). On Oct. 1, 2019, CMS implemented a new payment model for the SNF PPS, the PDPM, which bases each patient's unique payment amount on a composite clinical profile. As with its FY 2021 rulemaking, CMS proposes no changes to PDPM design. However, this rule does share the agency's observations on the first year under PDPM in combination with the impact of the COVID-19 pandemic and its intention to continue monitoring provider behavior. This includes an analysis of patient outcomes and aggregate SNF PPS payments, and may include future offsets. PDPM, which is significantly different from the prior payment model, is described in our FY 2019 SNF PPS final rule Regulatory Advisory.

Technical Updates to the ICD-10 Mapping to PDPM Case-mix Indices. The rule proposes revisions to the International Classification of Diseases, Version 10 code mappings used under PDPM. The codes are used to classify patients into case-mix groups, including to assign patients to clinical categories used for categorization under the PDPM components of physical therapy, occupational therapy, speech language pathology and non-therapy ancillary components.

Recalibrating the PDPM Parity Adjustment. In the FY 2020 final rule, in pursuit of budget neutrality, CMS applied a "parity adjustment"[1] to PDPM payments to attempt to set aggregate spending equal to what they would have been under the prior case-mix system. However, this rule notes that the most currently available data indicate that PDPM payments will be 5% more ($1.7 billion) in FY 2020 than they otherwise would have paid. As part of its current retrospective budget-neutrality considerations, the agency acknowledges the significant strains that the COVID-19 pandemic placed on the field, and their impact on spending in FY 2020. Therefore, the agency is soliciting feedback on a potential methodology to recalibrate the PDPM parity adjustment in a manner that accounts for the impact of the pandemic without compromising the accuracy of the adjustment. CMS also seeks comment on whether any necessary adjustment should be delayed or phased in to provide payment stability.

New Consolidated Billing Exemption. As required by the Consolidated Appropriations Act of 2021, this rule establishes a new category of exclusions to add to the SNF consolidated billing policy, effective October 1, 2021. Specifically, the Act creates a new category for blood clotting factors (BCF) for the treatment of patients with hemophilia and other bleeding disorders, and related items and services. The consolidated billing policy includes a short list of expensive and rare services that are separately billable under Part B when furnished to a SNF's Part A resident. The rule specifies particular healthcare common procedure coding system codes to include in this category, which may be expanded in the future, as well as a related, proportional payment reduction to maintain aggregate SNF PPS payments equal to what they otherwise would be. Since CMS estimates that only 84 beneficiaries annually receive BCF treatments in SNFs, the

[1] The FY 2020 final rule applied a multiplier of 46% to the PDPM case mix indices, using FY 2018 claims as the base, to attempt to set payments for that year equal to what they what they would have been under the prior "RUG-IV" case-mix system, assuming no changes in the population, provider behavior, and coding.

agency projects minimal impact on aggregate SNF payments. To calculate the fiscal impact of policy change, CMS used FY 2020 data, while recognizing the impact of the COVID-19 pandemic during this period, because these are the only data reflecting SNF operations under the PDPM model.

COVID-19 Vaccination among Health Care Personnel (HCP) Measure. CMS proposes to adopt a quality measure assessing the rate of COVID-19 vaccination among HCP beginning with the FY 2023 SNF QRF. This process measure, which is also proposed in all other clinical settings, would evaluate the cumulative number of HCP eligible to work in the SNF for at least one day during the reporting period who received a complete vaccination course; it would exclude persons with contraindications to COVID-19 vaccination as described by the Centers for Disease Control and Prevention (CDC). SNFs would submit data through the CDC National Healthcare Safety Network submission framework, which SNFs currently use to report other data. SNFs would submit this data for at least one week each month, and the CDC would calculate a summary measure of the data each quarter. This rate would be publicly reported on the SNF *Care Compare* website.

The measure is not endorsed by the National Quality Forum and has not been submitted to the NQF for consideration, although it was reviewed by the NQF's Measure Applications Partnership in this most recent cycle. Despite the lack of testing or development of this measure, CMS considered it necessary to propose the measure as soon as possible "given the novel nature of the SARS-CoV-2 virus, and the significant and immediate risk it poses in SNFs." If finalized, SNFs would be required to submit data beginning October 1, 2021, and performance would be publicly reported beginning with the October 2022 *Care Compare* refresh.

Healthcare-associated Infections (HAI) Requiring Hospitalization Measure. CMS proposes to adopt beginning with the FY 2023 SNF QRP a measure assessing the risk-standardized rate of HAIs acquired during SNF care that result in hospitalization. The measure would use Medicare fee-for-service claims demonstrating an inpatient hospitalization occurring during the period beginning on day four after SNF admission and within three days of SNF discharge. If finalized, CMS would publicly report this measure using four quarters of claims data beginning with the October 2022 *Care Compare* refresh; SNFs would not be required to collect or submit data for this measure. The measure is not endorsed by the NQF.

Other SNF Quality Reporting Program (QRP) Proposals. CMS proposes to update the denominator of the Transfer of Health Information to the Patient (TOH-Patient) measure to exclude patients discharged to their homes under the care of a home health agency or hospice. This measure, first adopted in the FY 2020 SNF PPS final rule to begin reporting with the FY 2022 SNF QRP, evaluates the timely transfer of a medication list to the patient, family and/or caregiver at the time of discharge to the home, board and care home, assisted living, group home, transitional living, home under the care of a home health agency or hospice. A similar measure, Transfer of Health Information to the Provider, was adopted in the same rule and assesses whether the medication list was transferred to a subsequent facility. However, both measures count

patients discharged to the home under the care of a home health agency or hospice; to avoid counting the patient in both measures, CMS would remove these patients from the denominator of the TOH-Patient measure.

Finally, CMS offers a few proposals regarding publicly reported data affected by COVID-19 reporting exemptions. In March 2020, CMS issued guidance granting an exception to the IRF QRP reporting requirements from the last quarter of 2019 through the second quarter of 2020, stating that the agency would not publicly report any IRF QRP data that might be greatly impacted by the exceptions from the first two quarters of 2020. In addition, CMS determined that freezing the data displayed on the *Care Compare* website—that is, holding the data constant after the October 2020 refresh without update—would be the best way to account for exempted data reporting. However, these data are increasingly out-of-date and less useful; therefore, CMS proposes to calculate assessment-based measures using data from Q3 of 2020 through Q1 of 2021 and claims-based measures using Q4 of 2018 through Q4 of 2019 and Q3 of 2020 for the January 2022 *Care Compare* refresh. Beginning with the April 2022 refresh, CMS would resume reporting with four quarters of data for assessment-based measures; public reporting based on eight quarters of data for claims-based measures would resume with the October 2023 refresh.

Request for Information—Fast Healthcare Interoperability Resource (FHIR). CMS is seeking feedback on the agency's future plans to adopt a standardized definition of "digital quality measures" and on the potential use of FHIR. FHIR is a free and open source standards framework that establishes a common language and process for all health information technology.

Request for Information—Health Equity. CMS is seeking comment on the possibility of revising measure development and the collection of standardized patient assessment data elements (SPADEs) that address gaps in health equity. Specifically, the agency invites public comment on recommendations for quality measures, additional SPADEs or measurement domains that address health equity, ways to reduce disparities and improve patient outcomes, and the challenges to capture and use relevant health data for improving health equity.

SNF Value-based Purchasing (VBP) Program. CMS believes that scores on the lone quality measure used in the SNF VBP program (30-day All-cause Readmissions) have been distorted by the COVID-19 pandemic, which would result in skewed payment incentives and inequitable payments. Therefore, the agency proposes to adopt a policy for the duration of the public health emergency (PHE) to suppress the use of this measure data for purposes of scoring and payment adjustments in the program. Under this policy, CMS would assign each eligible SNF an identical performance score (zero) and payment adjustment (1.2 percent). Those SNFs with fewer than 25 eligible stays during the performance period would receive a net-neutral payment incentive adjustment. CMS also proposes to use FY 2019 as the baseline period for the FY 2024 program year instead of FY 2020 because data from the first six months of 2020 are

excepted from the calculation of the program's one measure due to the COVID-19 PHE and thus would not yield enough information to accurately calculate performance.

Next Steps

CMS will accept comments on the SNF proposed rule through June 7. AHA's SNF members will receive an invitation for a conference call to discuss the rule and inform AHA's comments.

Please contact Rochelle Archuleta, AHA director of policy, at 202-626-2320 or rarchuleta@aha.org with any questions.