American Hospital Association™
Advancing Health in America

Regulatory Advisory

April 29, 2021

Skilled Nursing Facility PPS Proposed Rule for FY 2022

At A Glance

At Issue

On April 8, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2022 proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS). Comments on the proposed rule are due to CMS by June 7. The final rule is expected around Aug. 1 and will take effect Oct. 1. Highlights of the proposed rule are listed under Key Takeaways; a deeper discussion follows this page.

Our Take

We appreciate the relatively streamlined rule, which allows the field to continue to focus on its COVID-19 response. We also recognize CMS' efforts to address the impact of the pandemic through several of its proposals. In fact, our comment letter will address the potential future recalibration of CMS' budget neutrality calculations regarding the FY 2020 implementation of the redesigned SNF PPS case-mix system – the patient-driven payment model (PDPM). Hospital-based SNFs report that the new PDPM framework helped support their fight against COVID-19, which was invaluable in supporting their host hospitals' pandemic responses.

Regarding the SNF Quality Reporting Program, AHA agrees that the topics the proposed measures address are important, but the measures themselves are not appropriate for adoption; CMS should reconsider its proposals.

What You Can Do

- ✓ Share this advisory with your senior management team to examine the impact these payment changes may have on your organization for FY 2022.
- ✓ Plan to participate in the AHA member call May 13 at 11 a.m. ET to discuss this rule and weigh in on our comment letter. Register here.
- ✓ Submit a comment letter to CMS explaining the impact this rule would have on your patients, staff and facility.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org for questions on payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org for quality-related questions.

Key Takeaways

The proposed rule seeks to:

- 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.
- Not make material changes to the design of the PDPM case-mix system implemented in FY 2020.
- Update the ICD-10 mapping used to classify patients under the PDPM framework.
- Gather stakeholders' input on how to recalibrate the PDPM "parity adjustment" that is designed to ensure budget neutrality under the new model while also ensuring SNFs can meet the financial demands of the COVID-19 pandemic.
- Implement Part A billing exemption for blood clotting factors and related services and items.
- Adopt two quality measures: 1) COVID-19 vaccination among health care personnel and 2) healthcare-acquired infections.
- Suppress performance for the SNF Value-based Purchasing program and assign uniform payment adjustments to all SNFs.

Proposed FY 2022 Payment Update

Market-basket Update

CMS proposes that SNF PPS payments in FY 2022 be updated by 1.3%, which translates into a $444 million increase over FY 2021 payments. This net increase includes a 2.3% market-basket update that would be offset by a 0.2% productivity adjustment. CMS also proposes a negative 0.8% market-basket forecast error adjustment for FY 2022 since the difference between the projected and actual market basket for FY 2020 exceeded its threshold of 0.5 percentage points, 2.8 and 2.0%, respectively. For this and future rounds of rulemaking, CMS invites comments on whether it should eliminate the forecast error adjustment altogether or raise the threshold from 0.5 to 1.0 percentage points.

Rebasing and Revising the SNF Market Basket. For FY 2022 and subsequent fiscal years, CMS proposes to rebase the market basket to reflect 2018 Medicare-allowable total cost data (routine, ancillary and capital-related) from freestanding SNFs and to revise applicable cost categories and price proxies used to determine the market basket. The proposed rule includes a lengthy and technical explanation of this process. The resulting change to the market basket, as well as the individual weights for each category is minimal, as reported in the rule and recreated below:

FY	2014-based SNF Market Basket	Proposed 2018-based SNF Market Basket
Historical Data:		
FY 2017	2.7	2.5
FY 2018	2.6	2.6
FY 2019	2.3	2.4
FY 2020	2.0	2.1
Forecast:		
FY 2021	2.4	2.4
FY 2022	2.4	2.3
FY 2023	2.7	2.6

Source: IHS Global Inc. fourth quarter 2020 forecast with historical data through the third quarter 2020.

Labor-related Share

The proposed reduction in the labor-related share that would result from the rebasing and revising of the SNF market basket is 1.2 percentage points (71.3% in FY 2021 compared to 70.1% in FY 2022). The proposed changes to the components of the labor share are illustrated in table below, recreated from the proposed rule.

	Weighting in Labor-Related Share, FY 2021[1]	Weighting in Labor-Related Share, FY 2022[2]
Wages and Salaries	51.1	51.2
Employee Benefits	9.9	9.5

	Weighting in Labor-Related Share, FY 2021[1]	Weighting in Labor-Related Share, FY 2022[2]
Professional Fees: Labor-Related	3.7	3.5
Administrative & Facilities Support Services	0.5	0.6
Installation, Maintenance & Repair Services	0.6	0.4
All Other: Labor-Related Services	2.6	1.9
Capital-Related	2.9	3.0
Total:	71.3	70.1

[1] Based on the second quarter 2020 IHS Global Inc. forecast of the 2014-based SNF market basket, with historical data through first quarter 2020.
[2] Based on the fourth quarter 2020 IHS Global Inc. forecast of the proposed 2018-based SNF market basket.

Area Wage Index

Consistent with the approach used in recent years, CMS proposes to maintain the same wage index methodology for FY 2022: continue using the same year's pre-reclassified inpatient PPS hospital wage data, unadjusted for other policies including occupational mix and the rural floor. In addition, the SNF wage index for FY 2022 would be calculated using hospital wage data from cost reports beginning in FY 2018. CMS notes that to instead use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources that is not feasible at this time. The proposed SNF PPS wage index tables applicable for FY 2022 are exclusively available on the CMS webpage.

Issues Relating to PDPM

On Oct. 1, 2019, CMS implemented a redesigned SNF PPS case-mix system, the patient-driven payment model (PDPM), which sets a unique payment amount for each case based on a composite clinical profile of the patient. The composite is comprised of five domains: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing and non-therapy ancillary (NTA) services. The PDPM is described in the AHA FY 2019 SNF PPS final rule Regulatory Advisory.

As with its FY 2021 rulemaking, CMS is proposing no changes to the PDPM design. However, this rule does share agency observations regarding first-year experiences under PDPM in combination with the impact of the COVID-19 pandemic. For example, as discussed below, the agency observes that FY 2020 SNF PPS payments appear to be on course to significantly exceed expected spending. Specifically, CMS has observed significant differences between expected SNF PPS payments and case-mix utilization, based on historical data, and the actual SNF PPS payments and case-mix utilization under the PDPM, based on the FY 2020 data available thus far.

Recalibrating the PDPM Parity Adjustment

In the FY 2020 final rule, in pursuit of budget neutrality, CMS applied a "parity adjustment"[1] to this first year of PDPM payments to attempt to set aggregate spending equal to what they would have been under the prior case-mix system. However, CMS states that "rather than simply achieving parity, the FY 2020 parity adjustment may have inadvertently triggered a significant increase in overall payment levels under the SNF PPS." In fact, the rule notes that the most currently available data indicate that fee-for-service Medicare will pay 5% more ($1.7 billion) in FY 2020 than the agency otherwise would have paid to SNFs. Further, the rule concludes that "…a recalibration of the PDPM parity adjustment is warranted to ensure that the adjustment serves its intended purpose to make the transition between RUG-IV and PDPM budget neutral."

With regard to the impact of the COVID-19 public health emergency (PHE) on SNF utilization in FY 2020, CMS found that while COVID-19 certainly affected SNF operations in a material way, the vast majority of cases lacked a COVID-19 diagnosis and/or the use of a PHE SNF waiver:

- Approximately 90% of SNF stays had no COVID-19 ICD-10 diagnosis code (either as a primary or secondary diagnosis);
- 84% of SNF stays did not utilize a PHE waiver, as identified by the presence of a "DR" condition code on the SNF claim; with 87% of beneficiaries not using the 3-day stay waiver, versus two% in prior years;
- Through FY 2019, the average number of therapy minutes SNF patients received per day was 91 minutes. However, beginning almost immediately upon PDPM implementation, the average number of therapy minutes SNF patients received per day dropped to 62. The rule notes both the immediacy and ubiquity of this change, without any concurrent change in the SNF population; and
- Beginning with PDPM implementation, concurrent and group therapy increased from 1% each to approximately 32% and 29%, respectively, beginning in the first month of PDPM implementation. These rates then dropped when the PHE started. The rule notes that no significant changes in health outcomes occurred for metrics, such as falls with major injury, the percentage of stays ending with Stage 2-4 or unstageable pressure ulcers or deep tissue injury, the percentage of stays readmitted to an inpatient hospital setting within 30 days of SNF discharge, or similar metrics.

Further, when removing those cases with a PHE-related waiver and those with a COVID-19 diagnosis from the FY 2020 dataset, the observed increase in SNF payments is approximately the same as that for the total population. Thus, CMS concludes that the "new" population of SNF beneficiaries (that is, COVID-19 patients

[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 strive to achieve budget neutrality relative to the prior "RUG-IV" case-mix system, assuming no changes in the population, provider behavior and coding.

and those using a section 1812(f) waiver) does not appear to be the cause of the increase in SNF payments after implementation of PDPM. Therefore, the agency believes that PDPM alone is impacting certain aspects of SNF patient classification and care provision.

Table 23 in the rule, recreated below, demonstrates the gap between the expected and actual PDPM case-mix index (CMI) levels for certain PDPM case-mix elements. In addition, the actual CMI thus far in FY 2020 is shown both inclusive and exclusive of patients diagnosed with COVID-19 or stays that utilized a COVID-19-related waiver.

Component	Expected CMI (FY 2019)	Actual CMI (FY 2020)	CMI excluding COVID-19 and Waiver Stays
PT	1.53	1.50	1.52
OT	1.52	1.51	1.52
SLP	1.39	1.71	1.67
Nursing	1.43	1.67	1.62
NTA	1.14	1.20	1.21

This gap is quite large for the SLP, Nursing and NTA CMIs irrespective of whether the COVID-19 and waiver stay cases are included. As such, CMS concludes that these increases in average case mix for these components are the result of PDPM and not the COVID-19 PHE.

Potential Future Recalibration Method. When considering how to recalibrate the FY 2020 parity adjustment, CMS clarifies that the relevant issue is determining whether the SNF case-mix distribution that year is distinctly different from what it would have been were it not for the COVID-19 PHE. In other words, while different people were able to access the Part A SNF benefit because of the 3-day stay and other PHE waivers, the agency must consider whether the relative case-mix distribution of beneficiaries in FY 2020 differs from what it would have been absent the PHE.

With regard to FY 2020 payments, CMS projects a 5.3% increase in aggregate spending under PDPM versus the prior model, when considering the full SNF population. If those cases using a COVID-19 waiver or diagnosed with COVID-19 are eliminated, the increase is 5.0%. CMS believes it would be more appropriate to pursue a recalibration using the subset population exclusive of COVID-19 waiver patients or patients diagnosed with COVID. As such, the rule discusses, but does not propose, a 5.0% reduction in the PDPM parity adjustment factor from 46% to 37%. Hypothetically, if this adjustment were applied for FY 2022, CMS estimates a reduction in SNF spending of approximately $1.7 billion. Tables 24 and 25 in the rule provide the FY 2022 PDPM CMIs and case-mix adjusted rates if CMS applied the recalibration methodology described above in that year.

Parity Adjustment Update Options. CMS presents for discussion several potential phase-in strategies for a prospective PDPM parity adjustment update that would not affect prior payments, which could perhaps be proposed in future rulemaking:

- *Delayed Implementation Strategies*: Delay the reduction for some period of time, perhaps one or more years, but implement the full 5-percent reduction in a single year;
- *Phased Implementation Strategies*: Spread the reduction over some number of years, such as 2.5% for each of two years; and
- *Combination Strategies*: Both delay and phase in the reduction over more than a single year.

To assist stakeholders, CMS posted a file on its website (Skilled Nursing Facility PPS | CMS). Click on the link in the "Spotlight" box for PDPM case-mix utilization data at the case-mix group and PDPM component levels, including FY 2020 payments under both the prior case-mix system and PDPM.

Technical Updates to the ICD-10 Mapping to PDPM Case-mix Indices

The proposed 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 PT, OT, SPT and NTA components. The current PDPM ICD-10 code mappings are available at https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/SNFPPS/PDPM.

Changes in ICD-10 codes may affect the accuracy of patient classification (and payment) under the PDPM. Changes with limited effects, termed nonsubstantive, are handled through a sub-regulatory process, while substantive changes are addressed through notice and comment rulemaking. CMS proposes the following substantive changes to the PDPM ICD-10 code mappings and list for FY 2022.

Codes D57.42 and D57.44: Sickle-cell thalassemia zero and beta without crisis
- Original Mapping: Medical Management
- Revised Mapping: Return to Provider
- Rationale: Patients not in crisis are unlikely to require SNF care

Codes K20.81, K20.91, and K21.0: Esophageal diseases with bleeding
- Original Mapping: Return to Provider
- Revised Mapping: Medical Management
- Rationale: Added code specificity of bleeding is more likely to identify need for SNF care

Code M35.81: Multisystem inflammatory disease
- Original Mapping: Non-Surgical Orthopedic/Musculoskeletal
- Revised Mapping: Medical Management
- Rationale: Multisystem disease is not limited only to musculoskeletal system

Codes P92.821, P91.822, and P91.823: Neonatal cerebral infarction, sites specified
- Original Mapping: Return to Provider

- Revised Mapping: Acute Neurologic
- Rationale: Diagnoses can persist and be linked to later diagnoses that need SNF care

Code U07.0: Vaping disorder
- Original Mapping: Return to Provider
- Revised Mapping: Pulmonary
- Rationale: Intensive treatments (e.g., steroids) followed by SNF care required in some cases

Codes G93.1: Anoxic brain damage, not elsewhere classified
- Original Mapping: Return to Provider
- Revised Mapping: Acute Neurologic
- Rationale: CMS clinician review supports similarity to other codes in the revised mapping category

Consolidated Billing

Each year CMS reviews the requirement that SNFs submit consolidated medical bills for physical, occupational and speech-language therapy services for covered and non-covered Part A stays. In this rule, the agency again reviews the consolidated billing exclusions that allow separate billing under Part B for selected Part A "high-cost, low-probability" services that fall within these four categories:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services;
- Customized prosthetic devices; and
- Blood clotting factor items and services (as proposed by this rule).

CMS invites public comment on any additional Healthcare Common Procedure Coding System (HCPCS) codes for items in any of these categories that have been subject to medical advances, which, as a result, now warrant an exclusion under the SNF consolidated billing policy.

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 Oct. 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 HCPCS 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 agency projects minimal

impact on aggregate SNF payments. CMS is proposing a $0.02 reduction to the nursing and non-therapy ancillary federal per diem rates to make this provision budget neutral. To calculate the fiscal impact of this policy change, CMS used FY 2020 data – excluding COVID-19 cases and those using a PHE waiver, because these data best reflect the latest types of BCFs and utilization patterns, as well as because they are the only data reflecting SNF operations under PDPM.

Administrative Presumption

As in the last several years of rulemaking, this rule reviews the administrative presumption that is applied to SNF patients based on information collected during the patient's 5-day assessment. This policy reflects CMS's position that there is a strong likelihood that a beneficiary's clinical profile during the immediate post-hospital period is correlated with the level of care needed by the patient. Therefore, clinical information collected during the 5-day assessment is used to automatically deem a patient with qualifying clinical characteristics as meeting the SNF level of care definition. As finalized in the FY 2019 final rule, CMS will apply the administrative presumption policy to cases that contain these PDPM elements:

- **Nursing** – *One of these case-mix groups based on functional status and other conditions and needs*: Extensive Services, Special Care High, Special Care Low, or Clinically Complex;
- **PT and OT** -- *One of these categories based on condition and functional status*: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, or TO;
- **SLP** – *One of these categories based on condition and comorbidities*: SC, SE, SF, SH, SI, SJ, SK, or SL; and
- **NTA**: A NTA function score of 12 or more.

The rule also restates CMS' position that the administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that any services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. In addition, CMS stresses the importance of carefully monitoring for changes in each patient's condition to determine whether there is a continuing need for Part A SNF benefits after the 5-day assessment.

Swing Beds

CMS again clarifies that all rates and wage indexes for the SNF PPS also apply to all noncritical access hospital swing beds. Per the FY 2010 SNF PPS final rule, these rural hospitals must complete a Minimum Data Set (MDS) 3.0 swing-bed assessment. Information on the MDS for swing-bed rural hospitals is available on CMS' website.

SNF Quality Reporting Program (QRP)

The Affordable Care Act mandated that reporting of quality measures for SNFs begin no later than FY 2014. Failure to comply with SNF QRP requirements will result in a 2 percentage point reduction to the SNF's annual market-basket update. See proposed and finalized measures for FYs 2020—2023.

Proposed and Finalized Measures for the SNF QRP, FY 2020 – FY 2023

Measure	FY 2020	FY 2021	FY 2022	FY 2023
Application of Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X	X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Change in Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Medicare spending per beneficiary for post-acute care SNF QRP	X	X	X	X
Discharge to community –Post-acute care SNF	X	X	X	X
Potentially preventable 30-day post-discharge readmission measure for SNF QRP	X	X	X	X
Drug regimen review conducted with follow-up for identified issues	X	X	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X	X	X
Transfer of Information to Provider			X	X
Transfer of Information to Patient			X	X*
SNF Healthcare-Associated Infections Requiring Hospitalization				Y
COVID-19 Vaccination Coverage among Healthcare Personnel				Y

X = Finalized
Y = Proposed
** = Proposed modification*

FY 2022 Measurement Provisions

CMS proposes to adopt two new quality measures and adjust the denominator of one measure beginning with the FY 2023 SNF QRP. The agency also offers proposals regarding publicly reported data affected by the COVID-19 pandemic and related reporting exemptions, and solicits input on several cross-cutting quality topics.

Proposed Adoption of COVID-19 Vaccination among Health Care Personnel (HCP) Measure. CMS proposes to adopt this measure that calculates the percentage of HCP eligible to work in the SNF for at least one day during the reporting period who received a complete vaccination course. If finalized, SNFs would be required to submit data beginning Oct. 1, 2021.

The measure would exclude persons with contraindications to the COVID-19 vaccination as described by the Centers for Disease Control and Prevention (CDC). For the purposes of this measure, "health care personnel" is defined as:

- Employees (all persons receiving a direct paycheck from the reporting facility);
- Licensed independent practitioners affiliated with but not directly employed by the reporting facility (including post-residency fellows); and
- Adult students/trainees and volunteers.

Regardless of clinical responsibility or patient contact. Facilities may, but are not required to, include other contract personnel. Detailed specifications for this measure can be found of CDC's website.

To report this data, SNFs would use the CDC's National Healthcare Safety Network (NHSN) Healthcare Personnel Safety Component submission framework, which facilities currently use to report other COVID-19-related data; HCP and resident COVID-19 vaccination data reporting modules are currently available for voluntary reporting through NHSN. SNFs would submit data through NHSN for at least one week each month, and the CDC would calculate a summary measure of the data each quarter. If SNFs submit more than one week of data in a month, CDC would use the most recent week's data to calculate the rate. This quarterly rate would be publicly reported on the SNF *Care Compare* website.

The measure, which is also proposed for adoption in the QRPs for all other post-acute and acute care settings, is not endorsed by the National Quality Forum (NQF). In its preliminary recommendations, the NQF's Measure Applications Partnerships PAC-Long-term Care Workgroup did not support this measure for rulemaking, subject to potential for mitigation; the mitigating factors included well-documented evidence, finalized specifications, testing and NQF endorsement. CMS and CDC contend that because the measure is aligned with the Influenza Vaccination Coverage among HCP (NQF #0431), which is currently endorsed by NQF and used in several QRPs (but not the SNF QRP), and underwent some validity testing using NHSN data, it is sufficiently specified for inclusion in the SNF QRP.

Proposed Adoption of Healthcare-associated Infections (HAI) Requiring Hospitalization Measure. CMS proposes to adopt this outcome measure that uses Medicare fee-for-service claims data to estimate the risk-standardized rate of HAIs that are acquired during SNF care and result in hospitalization. Unlike HAI measures used in other QRPs that are defined around specific infections like central line-

associated blood stream infections, this measure would instead target all HAIs serious enough to require admission to an acute care hospital.

HAIs would be identified using the principal diagnosis code and the Present on Admission indicator on the hospital—not SNF—claim for hospitalizations beginning on day four after SNF admission and within three days after SNF discharge. The measure would exclude pre-existing infections, chronic infections, infections with long incubation periods, and HAIs ostensibly acquired from emergency department visits and observation stays. Measure rates would be risk adjusted based on patient characteristics including sex, age, prior hospitalization, comorbidities, and clinical conditions and treatments. Performance would be assessed as better, no different or worse than the national average.

CMS notes that measure testing demonstrated moderate reliability. The measure is not endorsed by the NQF; CMS states in the proposed rule that it intends to submit the measure for endorsement in the future. If finalized, the measure would be added to the SNF QRP beginning with the FY 2023 program year, and publicly displayed on the *Care Compare* website beginning April 2022 using FY 2019 data (as this is the most recent fiscal year of data not exempted due to the COVID-19 PHE). Because the measure is calculated using hospital claims, SNFs would not be required to submit any data to inform this measure.

Proposed Modification of Transfer of Health Information to the Patient (TOH-Patient) Measure. CMS proposes to exclude residents discharged to home under the care of a home health agency or to a hospice from the denominator of this measure, which was adopted in the FY 2020 SNF PPS final rule for use beginning with the FY 2022 SNF QRP. The measure evaluates whether a medication list is transferred to a patient or caregiver upon discharge from a post-acute care facility to a non-PAC setting. A similar measure, Transfer of Health Information to the Provider, assesses whether the medication list is transferred to a subsequent provider if the patient is discharged to another PAC setting. Patients discharged home under the care of a home health agency or to a hospice are included in both measures; to avoid double-counting these patients, CMS would exclude them from the TOH-Patient measure beginning with the FY 2023 SNF QRP.

Publicly Reported Data Affected by the COVID-19 Pandemic. SNF quality measures are publicly reported on the *Care Compare* website, which uses four quarters of data for Minimum Data Set (MDS) assessment-based measures and eight quarters for claims-based measures. However, due to the COVID-19 pandemic, CMS granted exceptions to reporting requirements for the fourth quarter of 2019 and the first two quarters of 2020; the agency also stated that it would not publicly report any SNF QRP data that might be greatly impacted by these exceptions.

CMS determined that temporarily freezing the data displayed on the *Care Compare* website with the October 2020 refresh values—that is, holding the data constant without subsequent update—would be the best approach. However, these data are

becoming increasingly out-of-date and thus less useful for consumers. Therefore, CMS proposes to calculate SNF QRP measures for the January 2022 refresh using three quarters of data for MDS assessment-based measures and six quarters for claims-based measures for the January 2022 through July 2023 refreshes. Normal reporting would resume for assessment-based measures for the April 2022 refresh and for claims-based measures for the October 2023 refresh.

Requests for Information (RFIs)

In addition to the various proposals regarding the SNF QRP, CMS uses the proposed rule to solicit feedback on various topics. The agency will not respond to comments on these RFIs in the final rule, and states that it may release additional RFIs to collect more information on these topics at a later date.

Future Measures for the SNF QRP. CMS seeks input on the importance, relevance, appropriateness, and applicability of the following measures and concepts for future years in the SNF QRP:

- Frailty;
- Patient-reported outcomes;
- Shared decision-making process;
- Appropriate pain assessment and pain management processes; and
- Health Equity

Digital Quality Measures (dQMs) and Fast Healthcare Interoperability Resource (FHIR). CMS is considering adopting the following standardized definition of dQMs in alignment across quality programs:

"Digital Quality Measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes a calculation that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources."

CMS also seeks feedback on the potential use of FHIR for dQMs within the SNF QRP and aligning with other quality programs. FHIR is a free and open source standards framework that establishes a common language and process for health information technology. CMS believes that using FHIR-based standards to exchange clinical information through application programming interfaces (APIs) would allow clinicians to digitally submit quality information one time that can then be used in many ways. The agency relates that it is currently evaluating the use of FHIR-based APIs to access patient assessment data collected and maintained through the Quality Improvement and Evaluation System (QIES) systems.

CMS states that it is considering the future development and staged implementation of a cohesive portfolio of dQMs across quality programs, agencies and private payers. This would require standardization of measures and data elements. In this RFI, CMS seeks feedback on the steps that would enable transformation of CMS' quality measurement enterprise to be fully digital.

Health Equity. CMS requests information on revising several agency programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patients. Specifically, CMS seeks recommendations for quality measures or measurement domains that address health equity as well as the collection of other standardized patient assessment data elements (SPADEs) that address gaps in health equity in the SNF QRP. In addition, CMS requests feedback on how the agency can promote health equity in outcomes among SNF residents by stratifying quality measure results by social risk factors and what challenges exist for effective capture, use, and exchange of health information including data on race, ethnicity and other social determinants of health.

SNF Value-based Purchasing (VBP) Program

The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019. The SNF VBP program applies to freestanding SNFs, SNFs affiliated with acute care facilities and all non-critical access, swing-bed rural hospitals. The SNF VBP program must tie a portion of SNF Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs or a "potentially avoidable readmission" measure. A pool of funding is created by reducing each SNF's Medicare per-diem payments by 2%. However, as finalized in the FY 2018 SNF PPS final rule, only 60% of the total pool is distributed back to SNFs as incentive payments, which is applied as a percentage increase to the Medicare per-diem rate. SNFs scoring at or below the 40th percentile of performance are not eligible for any incentive payment, and will receive the full 2%ercent reduction. Details on the finalized scoring methodology can be found in the FY 2018 SNF PPS final rule Regulatory Advisory.

In this rule, CMS proposes several temporary adjustments to the SNF VBP program to account for the effects of the COVID-19 public health emergency (PHE).

Proposed Measure Performance Suppression for FY 2022. CMS notes in the proposed rule that the agency recognizes the effects that the COVID-19 pandemic has had on SNF readmission rates, and that these effects are not uniform across the country. Therefore, the agency does not wish to penalize SNFs based on measure scores that have likely been distorted by the pandemic and are not reflective of the quality of care. In this rule, the agency proposes to adopt a policy for the duration of the PHE to allow itself to suppress SNF readmission measure data for use in the VBP program if the agency determines that the PHE has affected performance significantly; following this

policy, CMS proposes to suppress the all-cause hospital readmissions measure for the FY 2022 SNF VBP program year.

Under the proposed policy, CMS would calculate SNF readmission measure rates, but suppress the use of those rates to generate performance scores, rank SNFs, and calculate value-based incentive payment percentages. Instead, CMS would assign each eligible SNF a performance score of zero for the program year and then adjust the federal per diem rate by an identical value-based incentive payment amount equal to 60% of the total 2% reduction; in other words, all participating SNFs would still have their base payment rates reduced by the 2% withhold, and then would all get a 1.2% payback. SNFs with fewer than 25 eligible stays during the performance period would receive 100% of their two-percent withhold (i.e., a net-neutral payment incentive multiplier), as finalized in previous rulemaking. Performance would still be publicly reported, but CMS would add appropriate caveats noting the limitations of the data due to the PHE.

In addition, CMS proposes to adopt for the SNF VBP and hospital value-based purchasing programs a number of "Measure Suppression Factors" to guide the agency's determination of whether to propose measure data suppression for one or more program years that overlap with the PHE. These factors include:

- Significant deviation in national performance on the measure during the PHE for COVID-19;
- Clinical proximity of the measure's focus to the relevant disease (i.e. whether the disease would be expected to directly affect performance on the measure);
- Rapid or unprecedented changes in clinical guidelines or practice or the generally accepted scientific understanding of the nature of the disease;
- Significant national shortages or rapid or unprecedented changes in healthcare personnel, medical supplies, or patient case volumes or case mix.

CMS also invites comment on whether the agency should consider adopting a measure suppression policy that would apply in a future national PHE without having to go through the rulemaking process. Finally, CMS requests comment on whether the agency should, in future years, consider adopting a regional adjustment policy for measure suppression that could account for any disparate effects of a PHE.

Other SNF VBP Updates. CMS proposes a 90-day lookback period for risk adjustment in the FY 2023 program year performance period, which is based on FY 2021 data. Normally, CMS uses a 365-day lookback period; however, considering the excepted data and other effects from the COVID-19 PHE, the agency believes a shorter lookback period will result in the use of more recent claims and avoid combining data from before and during the PHE.

CMS also proposes to adjust the baseline period for the FY 2024 SNF VBP program. Normally, the performance period would be FY 2022 and the baseline period would be FY 2020. However, due to the PHE-related exceptions, CMS will not have a full year of data to calculate performance for FY 2020. Therefore, to ensure enough data are available to reliably calculate performance on the single readmissions measure used in the program, CMS proposes to use FY 2019 as the baseline period for the FY 2024 SNF VBP program.

Finally, CMS lists the estimated performance standards on the SNF 30-day all-cause readmission measure for the FY 2024 program year:

- Achievement threshold: 0.79270
- Benchmark: 0.83028

The agency will update the numerical values in the FY 2022 SNF PPS final rule.

Soliciting Input on Measures to Add to SNF VBP Program. The Consolidated Appropriations Act of 2021 allows the addition of up to nine quality measures to the SNF VBP program. CMS seeks input regarding which measures it should consider adding, including measures of functional status, patient safety, care coordination or patient experience.

Next Steps

AHA members are invited to an upcoming conference call, May 13 at 11 a.m. ET, to discuss this rule and provide input for our comment letter to CMS. Register here. Related materials and a recording of this call will be available at: www.aha.org/postacute in the SNF section.

The AHA urges all SNFs to submit comments to CMS by June 7. Comments may be submitted electronically at www.regulations.gov. Use reference code CMS-1718-P in your submission. You also may mail written comments to CMS.

Via regular mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via overnight or express mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org, with any quality-related questions.