Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

APRIL 2021

FFY 2022 SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE (CMS-1746-P)

On April 8, the Centers for Medicare & Medicaid Services (CMS) posted the unpublished version of the federal fiscal year (FFY) 2022 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) proposed rule effective Oct. 1, 2021 through Sept. 30, 2022. After accounting for all payment and budget neutrality factors, CMS proposed 1.3% update to SNF PPS payment rates. Comments are due June 7.

Market Basket (*Federal Register (FR) pp. 19957-19959*): CMS proposed a 2.3% market basket update, a multifactor productivity (MFP) reduction of 0.2 percentage points, and a 0.8 percent reduction to adjust for a market basket forecast error in FFY 2020. The payment rate for SNFs that fail to submit required quality data will decrease by two percentage points.

CMS requested comments on the continued use of the forecast error adjustment (finalized in the Aug. 4, 2003 FFY 2004 IPPS final rule). Specifically, should CMS either eliminate the forecast error adjustment, or raise the threshold for the forecast error from 0.5% to 1.0%.

Unadjusted Federal Per Diem Rates (*FR pp. 19959-19961*): The proposed FFY 2022 SNF per diem rates under the Patient-Driven Payment Model (PDPM) are below (Tables 4 and 5 in the proposed rule, *p. 19961*). These rates apply to hospital-based and freestanding SNFs, as well as to payments made for non-Critical Access Hospital swing-bed services.

Case-Mix Rate Component	Proposed FFY 2022	Final FFY 2021
Urban		
Non-Therapy Ancillary	$82.64	$81.60
Nursing	$109.55	$108.16
Occupational Therapy	$58.49	$57.75
Physical Therapy	$62.84	$62.04
Speech Language Pathology	$23.46	$23.16
Non-Case-Mix	$98.10	$96.85
Rural		
Non-Therapy Ancillary	$78.96	$77.96
Nursing	$104.66	$103.34
Occupational Therapy	$65.79	$64.95
Physical Therapy	$71.63	$70.72
Speech Language Pathology	$29.56	$29.18
Non-Case-Mix	$99.91	$98.64

CMS adjusts federal per diem rates by the SNF market basket update, wage index budget neutrality factor, and urban and rural status as defined by the Office of Management and Budget

(OMB) delineations in OMB Bulletin No. 18-04.[1] CMS must also adjust per diem base rates per the Consolidated Appropriations Act of 2021 that added blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders to the list of items and services excludable from the Part A SNF PPS per diem payment effective Oct. 1, 2021. The estimated base rate reduction specific to blood clotting factors is in Table 3 of the proposed rule (*p. 19961*).

Consolidated Billing (*FR pp. 19967-19968*): The Consolidated Appropriations Act of 2021 established new categories of excluded codes to add to the SNF consolidated billing policy effective Oct. 1, 2021. The consolidated billing policy includes a list of expensive and rare services that are separately billable under Part B when furnished to a Part A SNF patient. Specifically, the Consolidated Appropriations Act excluded certain blood clotting factors used to treat patients with hemophilia and other bleeding disorders (along with related items and services), including the following healthcare common procedure coding system (HCPCS) codes: J7170, J7175, J7177-J7183, J7185-J7190, J7192-J7195, J7198-J7203, J7205 and J7207-J7211.

Any services that are unbundled from consolidated billing, and thus become separately payable under Part B, must come with a corresponding proportional reduction to aggregate SNF payments under Part A. Therefore, CMS proposed a proportional reduction of $0.02 to the unadjusted urban and rural rates to reflect the new blood clotting factor exclusions.

CMS also requested comments identifying medical advances that might meet criteria for exclusion from SNF consolidated billing in the following service categories: chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors.

Case-Mix Index Updates (*FR pp. 19961-19963*): CMS did not propose any material changes to the design of the PDPM case-mix system. Proposed FFY 2022 payment rates reflect the use of the PDPM case-mix classification system from Oct. 1, 2021 through Sept. 30, 2022. Tables 6 (*p. 19962*) and 7 (*p. 19963*) display the proposed PDPM case-mix adjusted federal rates and associated indexes for urban and rural SNFs, respectively.

Patient-Driven Payment Model (*FR pp. 19984-19990*): The PDPM utilizes International Classification of Diseases, Version 10 (ICD-10) codes to assign patients to clinical categories under several PDPM components including physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP) and non-therapy ancillary (NTA).[2] ICD-10 medical code datasets are updated annually, and CMS outlined their process for maintaining and updating the ICD-10 code mappings and lists in the FFY 2020 SNF PPS final rule. For FFY 2022, CMS proposed several changes to the PDPM ICD-19 code mappings and lists. The proposed changes are on *pp. 89-91*.

Additionally, CMS proposed a recalibration of the PDPM parity adjustment. CMS finalized the PDPM in a budget neutral manner, meaning the transition to the PDPM was not intended to result in an increase or decrease in aggregate Medicare SNF payments. Using FFY 2020 data,

[1] OMB Bulletin No. 18-04. Available at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.
[2] The ICD-10 code mappings and lists used under PDPM are available at https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/SNFPPS/PDPM.

CMS found significant differences between expected and actual SNF PPS payments and case-mix utilization under the PDPM. CMS stated the FFY 2020 parity adjustment may have inadvertently triggered a significant increase in overall payment levels under the SNF PPS (SNF payments were 5%, or $1.7 billion more in FFY 2020 than they otherwise would have been). However, CMS acknowledged that using FFY 2020 SNF utilization data to recalibrate the PDPM parity adjustment may lead to further inaccuracies due to the impact of COVID-19 on SNF utilization.

Given these issues, CMS requested feedback on a potential methodology to recalibrate the PDPM parity adjustment that accounts for the impact of COVID-19 without compromising the accuracy of the adjustment. Tables 24 (Urban, *pp. 19988-19989*) and 25 (*Rural, p. 19989*) display the FFY 2022 PDPM case-mix indexes and case-mix adjusted rates under CMS' proposed recalibration methodology. CMS also requested comments on whether it should delay or phase-in necessary adjustments to provide payment stability.

Wage Index (*FR pp. 19963-19965*): CMS proposed continued use of the pre-reclassified inpatient prospective payment system (IPPS) hospital wage data as the basis for the SNF PPS wage index. CMS excludes IPPS occupational mix, rural floor, and outmigration adjustments when calculating the SNF PPS wage index.

CBSA	Proposed FFY 2022	Final FFY 2021
Bloomington	0.9138	0.9114
Cape Girardeau	0.8300	0.8019
Carbondale	0.8197	0.8184
Champaign-Urbana	0.8699	0.8655
Chicago-Naperville-Evanston	1.0392	1.0442
Danville	0.9427	0.9032
Decatur	0.8371	0.8326
Elgin	1.0254	1.0559
Kankakee	0.8934	0.9068
Lake County	1.0069	1.0192
Peoria	0.8475	0.8644
Rock Island	0.8391	0.8520
Rockford	0.9922	0.9693
St. Louis	0.9595	0.9317
Springfield	0.9156	0.9256
Rural	0.8404	0.8297

CMS proposed a FFY 2022 labor-related share of 70.1%, down from 71.3% in FFY 2021.

SNF Value-Based Purchasing Program (*FR pp. 20006-20015*): CMS proposed adopting a policy for the SNF Value-Based Purchasing (VBP) program for the duration of the COVID-19 public health emergency. This policy would allow CMS to suppress the use of SNF readmission measure data for scoring and payment adjustments if CMS determines that COVID-19 significantly affected the measure and resulting performance scores. While CMS would still calculate SNF readmission rates, it would not use those rates to generate performance scores, rank SNFs, or generate value-based incentive payment percentages. Instead, CMS would give each eligible SNF a performance score of zero for the affected program year; reduce each

eligible SNF's adjusted federal per diem rate by 2%; and award each participating SNF 60% of that 2% withhold, resulting in a 1.2% payback. SNFs subject to the Low-Volume Adjustment policy would recoup 100% of the withhold. SNFs with fewer than 25 eligible stays during the performance period would receive a net-neutral payment incentive adjustment. Additionally, CMS would report SNF readmission measure rates with appropriate caveats noting limitations of the data due to COVID-19. If finalized, CMS proposed implementing this policy to suppress the SNF VBP readmission measure for the FFY 2022 program year.

CMS also proposed using FFY 2019 rather than FFY 2020 as the baseline period for the FFY 2024 program year because data from the first six months of 2020 are excepted from the calculation of the SNF VBP readmission measure due to COVID-19. Because of this exception, there is not enough information to accurately calculate SNF VBP performance.

Finally, CMS is considering additional measures for the SNF VBP, and requested comments on potential measures outlined in Table 31 (*p. 20005*).

SNF Quality Reporting Program (QRP) (*FR pp. 19990-19998*): Table 26 (*pp. 19990-19991*) lists the 13 measures currently adopted for the FFY 2022 SNF QRP.

COVID-19 Vaccination Coverage among Healthcare Personnel: For the FFY 2023 SNF QRP, CMS proposed adopting COVID-19 Vaccination Coverage among Healthcare Personnel (COVID-19 HCP). This proposed measure supports CMS' Meaningful Measures framework under the "Promote Effective Prevention and Treatment of Chronic Disease" quality priority. COVID-19 HCP is a process measure developed with the Centers for Disease Control and Prevention (CDC) to track COVID-19 vaccination coverage among HCP. The National Quality Forum (NQF) has not endorsed this measure; however, CMS justified collecting the measure before securing an NQF endorsement given the ongoing COVID-19 public health emergency (PHE).

While the SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital swing-bed rural hospitals, CMS stated it believes it is necessary to include all HCP within the facility in the measure denominator because all HCP would have access to and may interact with SNF residents. Therefore, the COVID-19 HCP numerator is the cumulative number of HCP eligible to work in a facility for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. The denominator is the number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC.[3] SNFs would submit COVID-19 HCP data for at least one week per month, with CMS calculating a summary measure for each quarter.

If finalized, SNFs would begin submitting COVID-19 HCP data Oct. 1, 2021 for the FFY 2023 SNF QRP program year; CMS would begin publicly reporting the COVID-HCP measure with the October 2022 *Care Compare* refresh.

[3] Centers for Disease Control and Prevention. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, Appendix B. Available at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinicalconsiderations.html#Appendix-B.

SNFs would submit data for COVID-19 HCP through the CDC/National Healthcare Safety Network (NHSN) web-based surveillance system using the COVID-19 vaccination data-reporting module in the NHSN Healthcare Personnel Safety Component.

SNF Healthcare-Associated Infections Requiring Hospitalization: CMS proposed adopting the Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring Hospitalization Quality measure beginning with the FFY 2023 SNF QRP. SNF HAI estimates the risk-standardized rate of HAIs acquired during SNF care that result in hospitalization using Medicare fee-for-service claims data. The numerator is the estimated number of SNF stays predicted to have an HAI that results in hospitalization. The denominator is the expected number of SNF stays with the measure outcome. Both the numerator and denominator are risk-adjusted. If finalized, CMS would publicly report SNF HAI using four quarters of claims data beginning with the October 2022 *Care Compare* refresh. As the SNF HAI measure is claims-based, SNFs would not be responsible for submitting data. This measure is not NQF endorsed.

Transfer of Health Information to the Patient-Post-Acute Care: CMS proposed updating the denominator for the Transfer of Health (TOH) Information to the Patient-Post-Acute Care (PAC) measure (TOH-Patient). TOH-Patient is a process-based measure that assesses the timely transfer of a patient's medication list. CMS proposed excluding patients discharged home under the care of an organized home health service organization or hospice from the denominator. Instead, the TOH-Patient denominator will only include discharges to a private home/apartment, board and care home, assisted living, group home, or transitional living.

Future SNF QRP Measure Input: CMS requested input on assessment-based quality measures and concepts under consideration for future SNF QRP program years, including: frailty; patient reported outcomes; shared decision-making process; appropriate pain assessment and pain management processes; and health equity.

Public Reporting of SNF QRP Measures Impacted by COVID-19 Exemptions (*FR pp. 20003-20005*): CMS granted Medicare providers several exemptions from reporting quality data early in the COVID-19 PHE. Table 28 (*p. 20003*) details the original schedules for *Care Compare* refreshes affected by COVID-19 PHE exemptions. CMS also froze publicly displayed quality data, holding data constant on *Care Compare* with the October 2020 refresh. These quality data will quickly become outdated; therefore, CMS proposed to refresh the data moving forward under a scenario entitled the COVID-19 Affected Reporting (CAR) Scenario. Under the CAR scenario, CMS would begin displaying data that are more recent in January 2022 (Q1 2019 through Q4 2019 for assessment-based measures, Q4 2017 through Q3 2019 for claims-based measures). Table 29 (*p. 20005*) summarizes the frozen data schedule and the proposed CAR schedule for assessment-based measures. Table 30 (*p. 20005*) summarizes the frozen data schedule and the proposed CAR schedule for claims-based measures.

Request for Information on Closing the Health Equity Gap (*FR pp. 20000-20001*): CMS requested comments regarding the revision of measure development, and the collection of additional standardized patient assessment data elements (SPADEs) that address gaps in health equity in the SNF QRP. Specifically, CMS requested comments on:

- Recommendations for quality measures, or measurement domains, that address health equity;
- Guidance on additional items, including SPADEs, that could be used to assess health equity in the care of SNF residents;
- Recommendations for how CMS can promote health equity outcomes among SNF residents;
- Methods used by providers in employing data to reduce disparities and improve patient outcomes, including source(s) of data; and
- Existing challenges providers encounter when attempting to effectively capture, use, and exchange health information, including data on race, ethnicity, and other social determinants of health, to support care delivery and decision-making.

Request for Information on Fast Healthcare Interoperability Resources (FHIR) and QRPs (*FR pp. 19998-20000*): CMS requested feedback on plans to define digital quality measures (dQMs) for the SNF QRP, as well as the potential use of FHIR for dQMs within the SNF QRP in an effort to align with other quality programs. FHIR is a free and open source standards framework created by the Health Level Seven International (HL7®) that establishes a common language and process for health information technology.

The standardized dQM definition CMS may adopt is as follows: 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(s). Data sources for dQMs may include, but are not limited to, administrative systems, electronically submitted clinical assessment data, electronic health records (EHRs), and health information exchanges.

Additionally, CMS is evaluating the use of FHIR-based application programming interfaces (APIs) to access assessment data collected and maintained through the Quality Improvement and Evaluation System QIES) and Internet QIES (iQIES) health information systems, and is working with healthcare standards organizations to assure that their evolving standards fully support CMS' assessment instrument content. Additionally, as more SNFs adopt EHRs, CMS is evaluating using FHIR interfaces (APIs) for accessing patient data directly from SNF EHRs.

Thus, CMS is considering the development and staged implementation of a cohesive portfolio of dQMs across CMS quality programs, agencies, and private payers. This portfolio would require, where possible, alignment of: (1) measure concepts and specifications including narrative statements, measure logic, and value sets, and (2) the individual data elements used to build these measure specifications and calculate the measures. Required data elements would be limited to standardized, interoperable elements as possible.

CMS envisions these changes as ongoing to allow for continuous refinement. CMS expects movement toward increased interoperability would include conformance with standards and health IT module updates, future adoption of technologies incorporated within the Office of the National Coordinator (ONC) Health IT Certification Program, and may also include standards adopted by ONC (e.g., to enable standards-based APIs). Coordination would build on the principles outlined in the U.S. Department of Health and Human Services' (HHS) National Health

Quality Roadmap,[4] focusing on safety, timeliness, efficiency, effectiveness, equitability, and patient centeredness.

CMS requested comments on these plans, including:

- What EHR/IT systems do you use, and do you participate in a health information exchange (HIE)?
- How do you currently share information with other providers?
- In what ways could CMS incentivize or reward innovative uses of health IT that could reduce burden for post-acute care settings?
- What additional resources or tools would post-acute care settings and health IT vendors find helpful to support the testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?
- Are vendors interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?

Contact:
Cassie Yarbrough, Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:

Centers for Medicare & Medicaid Services. Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022. April 15, 2021. Available from: https://www.federalregister.gov/public-inspection/2021-07556/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities. Accessed April 14, 2021.

Centers for Medicare & Medicaid Services. CMS-1746-P Wage Index Tables for FY 2022 – Proposed. Skilled Nursing Facility PPS Wage Index. Available from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex. Accessed April 14, 2021.

[4] Department of Health and Human Services. National Health Quality Roadmap. May 15, 2020. Available at: https://www.hhs.gov/sites/default/files/national-health-quality-roadmap.pdf.