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BROAD RIVER REHAB

SNF PPS FY 2022 Proposed Rule

The Facts Beyond the Headlines

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Agenda

FY 2022 Proposed Rule

- FY 2022 Proposed Updates to the SNF Payment Rates
- Wage Index Adjustments
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- Administrative Level of Care Presumption of Coverage
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- Skilled Nursing Facility Quality Reporting Program (SNF QRP) update
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- Financial Impact

FY 2022 Proposed Updates to the SNF Payment Rates

- **1. Market Basket Update**
  - Every year CMS updates the PPS rate based on changes in the Market Basket (the overall cost of goods and services that contribute to expenditures required to run and maintain a nursing facility). This is then adjusted by a forecast error adjustment and multi-factor productivity adjustment as applicable. For Fy2022 market basket updates, CMS has proposed using FY 2018 as the base comparison year.
  - For FY 2022, CMS proposed to update the Market Basket by 2.3%.
  - This has been adjusted down to 1.5% due to a 0.8% forecast error adjustment (0.5% threshold).

Index	Forecasted FY 2020 Increase*	Actual FY 2020 Increase**	FY 2020 Difference
SNF	2.8	2.0	-0.8

  - Finally, the FY 2022 Market Basket update has been adjusted to **1.3%** due to a 0.2% Multi-Factor Productivity adjustment (the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity).
  - CMS indicates the overall economic impact will be $444 million in aggregate payments to SNFs for FY 2022.

FY 2022 Proposed Updates to the SNF Payment Rates

- **2. Exclusion of Blood Clotting Factor (BCF) from Consolidated Billing**
  - For FY 2022, CMS has proposed to add “blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders . . . and items and services related to the furnishing of such factors to the list of items and services excludable from the Part A SNF PPS per diem payment, effective for items and services furnished on or after October 1, 2021
  - This will affect the NTA and nursing base rates because BCF is a type of NTA and nursing resources are required to furnish this medication.
  - After a 5-part calculation to determine the effect that excluding BCF from consolidated billing will have on these two components CMS has determined:
    - an urban base rate deduction of $0.02, which would be applied as a $0.01 reduction to the proposed FY 2022 NTA base rate and a $0.01 reduction to the proposed FY 2022 nursing base rate.
    - a rural base rate deduction of $0.02, which would be applied as a $0.01 reduction to the proposed FY 2022 NTA base rates and a $0.01 reduction to the proposed FY 2022 nursing base rate.
  - This results in a total reduction in SNF spending of $1.2 million.

FY 2022 Proposed Updates to the SNF Payment Rates

FY 2021 Base Rates

TABLE 3: FY 2021 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$62.04	$57.75	$23.16	$108.16	$81.60	$96.85

TABLE 4: FY 2021 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$70.72	$64.95	$29.18	$103.34	$77.96	$98.64

FY 2022 Base Rates

TABLE 4: FY 2022 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$62.84	$58.49	$23.46	$109.55	$82.64	$98.10

TABLE 5: FY 2022 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$71.63	$65.79	$29.56	$104.66	$78.96	$99.91

FY 2022 Proposed Updates to the SNF Payment Rates

Urban Case Mix Adjusted Rates and Associated indexes

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

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	1.53	$96.15	1.49	$87.15	0.68	$15.95	ES3	4.06	$444.77	3.24	$267.75
B	1.70	$106.83	1.63	$95.34	1.82	$42.70	ES2	3.07	$336.32	2.53	$209.08
C	1.88	$118.14	1.69	$98.85	2.67	$62.64	ES1	2.93	$320.98	1.84	$152.06
D	1.92	$120.65	1.53	$89.49	1.46	$34.25	HDE2	2.40	$262.92	1.33	$109.91
E	1.42	$89.23	1.41	$82.47	2.34	$54.90	HDE1	1.99	$218.00	0.96	$79.33
F	1.61	$101.17	1.60	$93.58	2.98	$69.91	HBC2	2.24	$245.39	0.72	$59.50
G	1.67	$104.94	1.64	$95.92	2.04	$47.86	HBC1	1.86	$203.76	-	-
H	1.16	$72.89	1.15	$67.26	2.86	$67.10	LDE2	2.08	$227.86	-	-
I	1.13	$71.01	1.18	$69.02	3.53	$82.81	LDE1	1.73	$189.52	-	-
J	1.42	$89.23	1.45	$84.81	2.99	$70.15	LBC2	1.72	$188.43	-	-
K	1.52	$95.52	1.54	$90.07	3.7	$86.80	LBC1	1.43	$156.66	-	-
L	1.09	$68.50	1.11	$64.92	4.21	$98.77	CDE2	1.87	$204.86	-	-
M	1.27	$79.81	1.30	$76.04	-	-	CDE1	1.62	$177.47	-	-
N	1.48	$93.00	1.50	$87.74	-	-	CBC2	1.55	$169.80	-	-
O	1.55	$97.40	1.55	$90.66	-	-	CA2	1.09	$119.41	-	-
P	1.08	$67.87	1.09	$63.75	-	-	CBC1	1.34	$146.80	-	-
Q	-	-	-	-	-	-	CA1	0.94	$102.98	-	-
R	-	-	-	-	-	-	BAB2	1.04	$113.93	-	-
S	-	-	-	-	-	-	BAB1	0.99	$108.45	-	-
T	-	-	-	-	-	-	PDE2	1.57	$171.99	-	-
U	-	-	-	-	-	-	PDE1	1.47	$161.04	-	-
V	-	-	-	-	-	-	PBC2	1.22	$133.65	-	-
W	-	-	-	-	-	-	PA2	0.71	$77.78	-	-
X	-	-	-	-	-	-	PBC1	1.13	$123.79	-	-
Y	-	-	-	-	-	-	PA1	0.66	$72.30	-	-

FY 2022 Proposed Updates to the SNF Payment Rates

Rural Case Mix Adjusted Rates and Associated indexes

TABLE 7: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

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	1.53	$109.59	1.49	$98.03	0.68	$20.10	ES3	4.06	$424.92	3.24	$255.83
B	1.70	$121.77	1.63	$107.24	1.82	$53.80	ES2	3.07	$321.31	2.53	$199.77
C	1.88	$134.66	1.69	$111.19	2.67	$78.93	ES1	2.93	$306.65	1.84	$145.29
D	1.92	$137.53	1.53	$100.66	1.46	$43.16	HDE2	2.40	$251.18	1.33	$105.02
E	1.42	$101.71	1.41	$92.76	2.34	$69.17	HDE1	1.99	$208.27	0.96	$75.80
F	1.61	$115.32	1.60	$105.26	2.98	$88.09	HBC2	2.24	$234.44	0.72	$56.85
G	1.67	$119.62	1.64	$107.90	2.04	$60.30	HBC1	1.86	$194.67	-	-
H	1.16	$83.09	1.15	$75.66	2.86	$84.54	LDE2	2.08	$217.69	-	-
I	1.13	$80.94	1.18	$77.63	3.53	$104.35	LDE1	1.73	$181.06	-	-
J	1.42	$101.71	1.45	$95.40	2.99	$88.38	LBC2	1.72	$180.02	-	-
K	1.52	$108.88	1.54	$101.32	3.7	$109.37	LBC1	1.43	$149.66	-	-
L	1.09	$78.08	1.11	$73.03	4.21	$124.45	CDE2	1.87	$195.71	-	-
M	1.27	$90.97	1.30	$85.53	-	-	CDE1	1.62	$169.55	-	-
N	1.48	$106.01	1.50	$98.69	-	-	CBC2	1.55	$162.22	-	-
O	1.55	$111.03	1.55	$101.97	-	-	CA2	1.09	$114.08	-	-
P	1.08	$77.36	1.09	$71.71	-	-	CBC1	1.34	$140.24	-	-
Q	-	-	-	-	-	-	CA1	0.94	$98.38	-	-
R	-	-	-	-	-	-	BAB2	1.04	$108.85	-	-
S	-	-	-	-	-	-	BAB1	0.99	$103.61	-	-
T	-	-	-	-	-	-	PDE2	1.57	$164.32	-	-
U	-	-	-	-	-	-	PDE1	1.47	$153.85	-	-
V	-	-	-	-	-	-	PBC2	1.22	$127.69	-	-
W	-	-	-	-	-	-	PA2	0.71	$74.31	-	-
X	-	-	-	-	-	-	PBC1	1.13	$118.27	-	-
Y	-	-	-	-	-	-	PA1	0.66	$69.08	-	-

•Wage Index Adjustments

- **Wage Index**
  - CMS is required to adjust the Federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate.
  - Since the inception of the SNF PPS, CMS has used hospital inpatient wage data in developing a wage index to be applied to SNFs. CMS is proposing to continue this practice for FY 2022,
  - CMS continues to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS.
  - The proposed wage index data for FY 2022 can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex
  - In the FY 2021 final rule CMS finalized the use of revised OMB CBSA delineation that included a 1-year transition that applied a 5% cap on any decrease in a CBSA's wage index compared to its wage index for the prior FY, 2020.
  - This year the revised wage indexes relative to the FY 2021 revised OMB delineations will go into full effect.
  - The wage index adjusts the labor related portion of the case mix adjusted base rate.

•Wage Index Adjustments

- **Labor Related Share of the Rate**
  - CMS defines the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, CMS calculates a revised labor related share based on the relative importance of labor-related cost categories in the input price index. Effective for FY 2022, CMS is proposing to revise and update the labor-related share to reflect the relative importance of the proposed 2018-based SNF market basket cost categories that they believe are labor-intensive and vary with, or are influenced by, the local labor market. For the proposed 2018-based SNF market basket these are:
    - (1) Wages and Salaries (including allocated contract labor costs as described above);
    - (2) Employee Benefits (including allocated contract labor costs as described above);
    - (3) Professional fees: Labor-related;
    - (4) Administrative and Facilities Support Services;
    - (5) Installation, Maintenance, and Repair Services;
    - (6) All Other: Labor-Related Services; and
    - (7) a proportion of capital-related expenses.
    - CMS proposes to continue to include a proportion of capital-related expenses because a portion of these expenses are deemed to be labor-intensive and vary with, or are influenced by, the local labor market.

Wage Index Adjustments

Labor Related Portion of the Rate (Cont.)

The proposed FY 2022 SNF labor-related share is 1.2 percentage points lower than the FY 2021 SNF labor-related share (based on the 2014-based SNF market basket). The major reason for the lower labor-related share is due to the incorporation of the 2012 Benchmark I-O data, primarily stemming from a decrease in the All Other: Labor-related services and Professional Fees: Labor-related services cost weights, and a decrease in the Compensation cost weight as a result of incorporating the 2018 MCR data.

TABLE 21: FY 2021 and Proposed FY 2022 SNF Labor-Related Share

	Relative importance, labor-related share, FY 2021 20:2 forecast [1]	Proposed Relative importance, labor-related share, FY 2022 20:4 forecast [2]
Wages and salaries [3]	51.1	51.2
Employee benefits*	9.9	9.5
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 (.391)	2.9	3.0
Total	71.3	70.1

[1] Published in the **Federal Register** (85 FR 47605); 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.
[3] The Wages and Salaries and Employee Benefits cost weight reflect contract labor costs as described above.

Provider Name	State	FY 2020 CBSA	FY 2021 CBSA	CBSA Changed	FY 2020 Wage Index	FY 2021 Wage Index (Old OMB Delineation)	FY 2021 Wage Index (New OMB Delineation)	FY 2021 Wage Index (New OMB Delineation + 5% Cap)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	NJ	35614	35154	Yes	1.2745	1.2998	1.0623	1.2108

FY 2021 Rate Table

Day	PT	OT	SLP	NSG	NTA	Urban				1.2108	
HIPPS	TN/N		SH/H	CBC2/N	NC/C	Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR
1	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 450.42	$ 96.85	$ 684.20	$ 275.41	$ 959.61	$ 1,103.84	$ 1,103.84
2	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 450.42	$ 96.85	$ 684.20	$ 275.41	$ 959.61	$ 1,103.84	$ 1,103.84
3	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 450.42	$ 96.85	$ 684.20	$ 275.41	$ 959.61	$ 1,103.84	$ 1,103.84
4	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 150.14	$ 96.85	$ 470.10	$ 189.23	$ 659.33	$ 758.43	$ 1,017.49
5	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 150.14	$ 96.85	$ 470.10	$ 189.23	$ 659.33	$ 758.43	$ 965.68
6	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 150.14	$ 96.85	$ 470.10	$ 189.23	$ 659.33	$ 758.43	$ 931.14
7	$ 91.82	$ 86.63	$ 66.24	$ 167.65	$ 150.14	$ 96.85	$ 470.10	$ 189.23	$ 659.33	$ 758.43	$ 906.46

FY 2022 Proposed Rate Table

Day	PT	OT	SLP	NSG	NTA	Urban				1.0651	
HIPPS	TN/N		SH/H	CBC2/N	NC/C	Non-CM	Labor	N-Labor	U Rate	WI Rate	ADR
1	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 456.18	$ 98.10	$ 681.32	$ 290.60	$ 971.92	$ 1,016.27	$ 1,016.27
2	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 456.18	$ 98.10	$ 681.32	$ 290.60	$ 971.92	$ 1,016.27	$ 1,016.27
3	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 456.18	$ 98.10	$ 681.32	$ 290.60	$ 971.92	$ 1,016.27	$ 1,016.27
4	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 152.06	$ 98.10	$ 468.13	$ 199.67	$ 667.80	$ 698.28	$ 936.77
5	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 152.06	$ 98.10	$ 468.13	$ 199.67	$ 667.80	$ 698.28	$ 889.07
6	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 152.06	$ 98.10	$ 468.13	$ 199.67	$ 667.80	$ 698.28	$ 857.28
7	$ 93.00	$ 87.74	$ 67.10	$ 169.80	$ 152.06	$ 98.10	$ 468.13	$ 199.67	$ 667.80	$ 698.28	$ 834.56

• Methodology for Recalibrating the PDPM Parity Adjustment

- **Parity Adjustment**
  - CMS has determined, through budget neutrality analysis, that even absent COVID related cases in 2020, i.e., active COVID dx. and or use of the 3-day stay waiver, there was a 5.0% increase in aggregate spending under the PDPM for FY 2020 due to the shift in case mix utilization, compared to FY 2019.
  - CMS observed slight decreases in the average CMI for the PT and OT rate components for SNF populations as compared to what was expected, as well as significant increases in the average CMI for the SLP (22.6%), Nursing (16.8%), and NTA (5.6%) for FY 2020 populations as compared to what was expected, for FY 2020 SNF population. CMS sees these significant increases in the average case-mix for these components as primarily responsible for the inadvertent increase in spending under PDPM.

TABLE 23: Average Case-Mix Index, Expected and Actual, by Component

	Expected CMI (FY 2019 Estimate)	Actual CMI (FY 2020)	Actual CMI (FY 2020 without DR or COVID)
Component	Average CMI	Average CMI	Average CMI
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

• Methodology for Recalibrating the PDPM Parity Adjustment

- **Parity Adjustment (Cont.)**
  - Due to the indication of a 5.0% increase in spending for FY 2020 compared to FY 2019, CMS has proposed a path towards recalibration of the parity adjustment that was in initially implemented with the PDPM in FY 2020 based on 2017 and 2018 data (46%), in order to achieve budget neutrality equally across all PDPM case mix adjusted components in FY 2022 (37%). This would achieve a 5% reduction in SNF spending under PDPM or $1.7 billion.
  - To do this, each expected PDPM case mix index, based on 2017 and 2018 claims data, would be revised by the new parity adjustment factor of 37%. This equates to a 5% reduction in the proposed FY 22 case mix indexes.

Methodology for Recalibrating the PDPM Parity Adjustment

FY 2022 Urban Case Mix Adjusted Rates and Associated indexes including a parity adjustment

TABLE 24: Recalibrated PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

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	1.44	$90.49	1.40	$81.89	0.64	$15.01	ES3	3.82	$418.48	3.05	$252.05
B	1.60	$100.54	1.53	$89.49	1.71	$40.12	ES2	2.89	$316.60	2.38	$196.68
C	1.77	$111.23	1.59	$93.00	2.51	$58.88	ES1	2.76	$302.36	1.73	$142.97
D	1.81	$113.74	1.44	$84.23	1.37	$32.14	HDE2	2.26	$247.58	1.25	$103.30
E	1.34	$84.21	1.33	$77.79	2.2	$51.61	HDE1	1.87	$204.86	0.9	$74.38
F	1.52	$95.52	1.51	$88.32	2.80	$65.69	HBC2	2.11	$231.15	0.68	$56.20
G	1.57	$98.66	1.54	$90.07	1.92	$45.04	HBC1	1.75	$191.71	-	-
H	1.09	$68.50	1.08	$63.17	2.69	$63.11	LDE2	1.96	$214.72	-	-
I	1.06	$66.61	1.11	$64.92	3.32	$77.89	LDE1	1.63	$178.57	-	-
J	1.34	$84.21	1.36	$79.55	2.81	$65.92	LBC2	1.62	$177.47	-	-
K	1.43	$89.86	1.45	$84.81	3.48	$81.64	LBC1	1.35	$147.89	-	-
L	1.03	$64.73	1.04	$60.83	3.96	$92.90	CDE2	1.76	$192.81	-	-
M	1.20	$75.41	1.22	$71.36	-	-	CDE1	1.52	$166.52	-	-
N	1.39	$87.35	1.41	$82.47	-	-	CBC2	1.46	$159.94	-	-
O	1.46	$91.75	1.46	$85.40	-	-	CA2	1.03	$112.84	-	-
P	1.02	$64.10	1.03	$60.24	-	-	CBC1	1.26	$138.03	-	-
Q	-	-	-	-	-	-	CA1	0.88	$96.40	-	-
R	-	-	-	-	-	-	BAB2	0.98	$107.36	-	-
S	-	-	-	-	-	-	BAB1	0.93	$101.88	-	-
T	-	-	-	-	-	-	PDE2	1.48	$162.13	-	-
U	-	-	-	-	-	-	PDE1	1.38	$151.18	-	-
V	-	-	-	-	-	-	PBC2	1.15	$125.98	-	-
W	-	-	-	-	-	-	PA2	0.67	$73.40	-	-
X	-	-	-	-	-	-	PBC1	1.06	$116.12	-	-
Y	-	-	-	-	-	-	PA1	0.62	$67.92	-	-

Methodology for Recalibrating the PDPM Parity Adjustment

FY 2022 Rural Case Mix Adjusted Rates and Associated indexes including a parity adjustment

TABLE 25: Recalibrated PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

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	1.44	$103.15	1.40	$92.11	0.64	$18.92	ES3	3.82	$399.80	3.05	$240.83
B	1.60	$114.61	1.53	$100.66	1.71	$50.55	ES2	2.89	$302.47	2.38	$187.92
C	1.77	$126.79	1.59	$104.61	2.51	$74.20	ES1	2.76	$288.86	1.73	$136.60
D	1.81	$129.65	1.44	$94.74	1.37	$40.50	HDE2	2.26	$236.53	1.25	$98.70
E	1.34	$95.98	1.33	$87.50	2.2	$65.03	HDE1	1.87	$195.71	0.9	$71.06
F	1.52	$108.88	1.51	$99.34	2.8	$82.77	HBC2	2.11	$220.83	0.68	$53.69
G	1.57	$112.46	1.54	$101.32	1.92	$56.76	HBC1	1.75	$183.16	-	-
H	1.09	$78.08	1.08	$71.05	2.69	$79.52	LDE2	1.96	$205.13	-	-
I	1.06	$75.93	1.11	$73.03	3.32	$98.14	LDE1	1.63	$170.60	-	-
J	1.34	$95.98	1.36	$89.47	2.81	$83.06	LBC2	1.62	$169.55	-	-
K	1.43	$102.43	1.45	$95.40	3.48	$102.87	LBC1	1.35	$141.29	-	-
L	1.03	$73.78	1.04	$68.42	3.96	$117.06	CDE2	1.76	$184.20	-	-
M	1.20	$85.96	1.22	$80.26	-	-	CDE1	1.52	$159.08	-	-
N	1.39	$99.57	1.41	$92.76	-	-	CBC2	1.46	$152.80	-	-
O	1.46	$104.58	1.46	$96.05	-	-	CA2	1.03	$107.80	-	-
P	1.02	$73.06	1.03	$67.76	-	-	CBC1	1.26	$131.87	-	-
Q	-	-	-	-	-	-	CA1	0.88	$92.10	-	-
R	-	-	-	-	-	-	BAB2	0.98	$102.57	-	-
S	-	-	-	-	-	-	BAB1	0.93	$97.33	-	-
T	-	-	-	-	-	-	PDE2	1.48	$154.90	-	-
U	-	-	-	-	-	-	PDE1	1.38	$144.43	-	-
V	-	-	-	-	-	-	PBC2	1.15	$120.36	-	-
W	-	-	-	-	-	-	PA2	0.67	$70.12	-	-
X	-	-	-	-	-	-	PBC1	1.06	$110.94	-	-
Y	-	-	-	-	-	-	PA1	0.62	$64.89	-	-

Methodology for Recalibrating the PDPM Parity Adjustment

FY 2022 rate table with the parity adjustment added

FY 2022 PDPM (Parity)
Variable Perdiem Adjustment Rate Table

Day	PT	OT	SLP	NSG	NTA	N-Casemix Urban			Wage Index 1.0651	
HIPPS	TN/N		SH/H	CBC2/N	NC/C	Non-CM	Labor	U Rate	WI Rate	ADR
1	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 428.91	$ 98.10	$ 644.84	$ 919.88	$ 961.86	$ 961.86
2	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 428.91	$ 98.10	$ 644.84	$ 919.88	$ 961.86	$ 961.86
3	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 428.91	$ 98.10	$ 644.84	$ 919.88	$ 961.86	$ 961.86
4	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 142.97	$ 98.10	$ 444.39	$ 633.94	$ 662.87	$ 887.11
5	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 142.97	$ 98.10	$ 444.39	$ 633.94	$ 662.87	$ 842.26
6	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 142.97	$ 98.10	$ 444.39	$ 633.94	$ 662.87	$ 812.37
7	$ 87.35	$ 82.47	$ 63.11	$ 159.94	$ 142.97	$ 98.10	$ 444.39	$ 633.94	$ 662.87	$ 791.01

• Methodology for Recalibrating the PDPM Parity Adjustment

- **Parity Adjustment (Cont.)**
  - CMS has proposed 3 potential pathways to achieve parity in the PDPM rates.
  - **Delayed**
    - If this reduction was finalized in FY 2022 with a 1 year delayed implementation, this would mean that the full 5 percent reduction would be prospectively applied to the PDPM CMIs in FY 2023.
    - If the reduction was finalized in FY 2022 with a 2 year delayed implementation, then the reduction in the PDPM CMIs would be applied prospectively beginning in FY 2024.
  - **Phased**
    - With regard to a phased implementation strategy, this would mean that the amount of the reduction would be spread out over some number of years. Such an approach helps to mitigate the impact of the reduction in payments by applying only a portion of the reduction in a given year. For example, if CMS were to use a 2-year phased implementation approach to the 5 percent reduction discussed above, this would mean that the PDPM CMIs would be reduced by 2.5 percent in the first year of implementation and then reduced by the remaining 2.5 percent in the second and final year of implementation. So, for example, if this adjustment was finalized for FY 2022, then the PDPM CMIs would be reduced by 2.5 percent in FY 2022 and then reduced by an additional 2.5 percent in FY 2023.
    - CMS notes that the number of years for a phased implementation approach could be as little as 2 years but as long as necessary to appropriately mitigate the yearly impact of the reduction. For example, CMS could implement a 5-year phased approach for this reduction, which would apply a one percent reduction to the PDPM CMIs each year for 5 years.

• Methodology for Recalibrating the PDPM Parity Adjustment

- **Parity Adjustment (Cont.)**
  - **Combination Delayed/Phased**
    - CMS also notes that these mitigation strategies may be used in combination with each other. For example, CMS could finalize a 2 year phased approach with a 1 year delayed implementation. Using FY 2022 as the hypothetical year in which such an approach could be finalized, this would mean that there would be no reduction to the PDPM CMIs in FY 2022, a 2.5 percent reduction to the PDPM CMIs in FY 2023 and then a 2.5 percent reduction in the PDPM CMIs in FY 2024.
  - CMS finally indicates that, "We are considering these approaches as they may be warranted to mitigate potential negative impacts on providers resulting from implementation of such a reduction in the SNF PPS rates entirely within a single year in the event we determine that recalibrating the parity adjustment is necessary to achieve budget neutrality. <u>However, we believe that these alternatives would continue to reimburse in amounts that significantly exceed our intended policy in excess of the rates that would have been paid had we maintained the prior payment classification system rather than in a budget neutral manner as intended,</u> and as we stated above, we believe it is imperative that we act in a well-considered but appropriately expedient manner once excess payments are identified."

• Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage**
  - Annually CMS designates those specific classifiers under the case-mix classification system that represent the required SNF level of care. This designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial Medicare assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) of the 5-Day assessment.
  - This presumption recognizes the strong likelihood that those beneficiaries who are assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.
  - This 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.
  - CMS Pub 100-2 Ch. 8 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

• Administrative Level of Care Presumption of Coverage

- **Presumption of Coverage (Cont.)**
  - For services furnished on or after October 1, 2019, the following are the designated case-mix classifiers under the Patient Driven Payment Model (PDPM) relative to the administrative presumption of coverage:
    - **Nursing** groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
    - **PT and OT** groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
    - **SLP** groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
    - **NTA** component's uppermost (12+) comorbidity group.

Proposed changes in PDPM ICD-10 Code Mappings

- PDPM utilizes International Classification of Diseases, Version 10 (ICD-10) codes in several ways, including to assign patients to clinical categories used for categorization under several PDPM components, specifically the PT, OT, SLP and NTA components. The ICD-10 code mappings and lists used under PDPM are available on the PDPM Website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
- In response to stakeholder feedback and to improve consistency between the ICD-10 code mappings and current ICD-10 coding guidelines, CMS is proposing several changes to the PDPM ICD-10 code mappings affecting the areas **of sickle-cell disease, esophageal conditions, multisystem inflammatory syndrome, neonatal cerebral infarction, vaping-related disorder, and anoxic brain damage**.

Proposed Change

For this reason, we propose to change the assignment of D57.42 and D57.44 to "**Return to Provider".**

Sickle Cell Disease

On October 1, 2020 two ICD-10 codes representing types of sickle-cell disease; D57.42 "Sickle-cell thalassemia beta zero without crisis" and D57.44 "Sickle-cell thalassemia beta plus without crisis" took effect and were clinically mapped to the category of "Medical Management".

However, there are more specific codes to indicate why a patient with sickle-cell disease would require SNF care, and if the patient is not in crisis, this most likely indicates that SNF care is not required.

Proposed Change

Therefore, we propose to change the assignment of K20.81, K20.91, and K21.01 to **"Medical Management"** in order to promote more accurate clinical category assignment.

Esophageal Conditions

On October 1, 2020, three new ICD-10 codes representing types of esophageal conditions; K20.81 "Other esophagitis with bleeding", K20.91, "Esophagitis, unspecified with bleeding, and K21.01 "Gastro-esophageal reflux disease with esophagitis, with bleeding" took effect and were clinically mapped to "Return to Provider".

Upon review of these codes, we recognize that these codes represent these esophageal conditions with more specificity than originally considered because of the bleeding that is part of the conditions and that they would more likely be found in SNF patients.

Proposed Change

For this reason, we propose to change the assignment of M35.81 to **"Medical Management"** in order to promote more accurate clinical category assignment.

Multisystem Inflammatory Syndrome

In December 2020, the CDC announced several additions to the ICD-10 Classification related to COVID-19 that became effective on January 1, 2021. One such code, M35.81 "Multisystem inflammatory syndrome", was assigned to "Non-Surgical Orthopedic/Musculoskeletal".

However, Multisystem inflammatory syndrome can involve more than the musculoskeletal system. It can also involve the gastrointestinal tract, heart, central nervous system, and kidneys.

Proposed Change

Therefore, we propose to change the assignment of P91.821, P91.822, and P91.823 to **"Acute Neurologic"** in order to promote more accurate clinical category assignment.

Neonatal Cerebral Infarction

On October 1, 2020, three new ICD-10 codes representing types of neonatal cerebral infarction were classified as "Return to Provider." These codes were P91.821 "Neonatal cerebral infarction, right side of brain," P91.822, "Neonatal cerebral infarction, left side of brain," and P91.823, "Neonatal cerebral infarction, bilateral."

While a neonate is unlikely to be a Medicare beneficiary, this diagnosis could continue to be used later in life hence placing those with this condition in the acute neurologic category.

Proposed Change

For this reason, we propose to change the assignment of U07.0 to **"Pulmonary"** classification in order to promote more accurate clinical category assignment.

Vaping-Related Disorder

On April 1, 2020, U07.0, "Vaping-related disorder," took effect and was classified as a "Return to Provider" code because at the time, "Vaping-related disorder" was not considered a code that would be a primary diagnosis during a SNF stay. However, upon further review, we believe that many patients who exhibit this diagnosis require steroids, empiric antibiotics and oxygen for care which could carry over to the post-acute setting.

Proposed Change

Therefore, we propose to change the assignment of G93.1 "Anoxic brain damage, not elsewhere classified" to **"Acute Neurologic"**

Anoxic Brain Damage

The ICD-10 code, G93.1 was initially clinically mapped to "Return to provider" because "Anoxic brain damage, not elsewhere classified" was non-specific and did not fully describe a patient's deficits and may not have been an acute condition.

However, upon further review, our clinicians determined that although this may not be an acute condition, "Anoxic brain damage, not elsewhere classified" would still likely result in a need for SNF care and is similar to conditions such as "Compression of the brain", "Cerebral edema", and "encephalopathy", which are mapped into the "Acute Neurologic" category.

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

The SNF QRP is a pay-for-reporting program. SNFs that do not meet reporting requirements may be subject to a two-percentage point (2%) reduction in their annual update.

CMS is proposing to adopt two new measures and update the specifications for another measure.

In addition, CMS is proposing a modification to the public reporting of SNF quality measures as well as seeking comment on two Requests for Information (RFI).

SNF QRP

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information

HAI Technical Specifications

https://www.cms.gov/files/document/development-skilled-nursing-facility-snf-healthcare-associated-infections-hais-requiring.pdf

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

Current QRP Measures

TABLE 26: Quality Measures Currently Adopted for the FY 2022 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider*	Transfer of Health Information to the Provider Post-Acute Care (PAC).
TOH-Patient*	Transfer of Health Information to the Patient Post-Acute Care (PAC).
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) (NQF #3481).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

*In response to the public health emergency (PHE) for the Coronavirus Disease 2019 (COVID-19), CMS released an Interim Final Rule (85 FR 27595 through 27597) which delayed the compliance date for collection and reporting of the Transfer of Health Information measures for at least two full fiscal years after the end of the PHE.

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

Measures Under Consideration

TABLE 27: Future Measures and Measure Concepts Under Consideration for the SNF QRP

Assessment-Based Quality Measures and Measure Concepts
Frailty
Patient reported outcomes
Shared decision making process
Appropriate pain assessment and pain management processes
Health equity

Closing the Health Equity Gap - RFI

Consistent with Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, CMS is committed to addressing the significant and persistent inequities in health outcomes in the United States through improving data collection to better measure and analyze disparities across programs and policies. CMS is working to make healthcare quality more transparent to consumers and providers, enabling them to make better choices as well as promoting provider accountability around health equity.

We are seeking feedback in this RFI on ways to attain health equity for all patients through policy solutions. Our ongoing commitment to closing the health equity gap in SNFs has been demonstrated by the adoption of standardized patient assessment data elements (SPADEs) which include several social determinants of health (SDOH) that were finalized in the FY 2020 SNF PPS final rule for the SNF QRP (84 FR 38805 through 38817).

With this RFI, we are also seeking comment on the possibility of expanding measure development, and the collection of other SPADEs that address gaps in health equity in the SNF QRP.

Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring Hospitalization Measure

CMS is proposing the adoption of a new claims-based measure, SNF HAI, to the SNF QRP, beginning with the FY 2023 SNF QRP.

Typically, HAIs result from inadequate patient management following a medical intervention, such as surgery or device implementation, or poor adherence to protocol and antibiotic stewardship guidelines.

Several provider characteristics are also related to HAIs including staffing levels (for example, high turnover, low staff-to-resident ratios, etc.), facility structure characteristics (for example, national chain membership, high occupancy rates, etc.), and adoption or lack thereof of infection surveillance and prevention policies.

Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring Hospitalization Measure

The proposed SNF HAI measure uses Medicare fee-for-service (FFS) claims data to estimate the rate of HAIs that are acquired during SNF care and result in hospitalization.

Some of the HAIs identified in this measure include sepsis, urinary tract infection, and pneumonia.

The goal of the measure is to be able to assess those SNFs that have notably higher rates of HAIs that are acquired during SNF care and result in hospitalization, when compared to their peers and to the national average HAI rate. Implementation of the SNF HAI measure provides information about a facility's adeptness in infection prevention and management and encourages improved quality of care.

Dry Run Reports available in your CASPER Folder

HAI Performance Report

Provider	Facility ID	State	Performance Year	Data Collection Period	# of Stays	# of HAI Cases	Observed HAI Rate	Risk Adjusted HAI Rate	95% CI Lower Bound	95% CI Upper Bound	Comparative Performance Category	Observed National Average	# of Providers Better than National Average	# of Providers No Different than National Average	# of Providers Worse than National Average	# of Providers Too Small to Report
XXXXX	XXXXXXXXX	XX	FY2018	10/01/2017-09/30/2018	158	14	8.86%	7.25%	4.63%	10.35%	No Different than National Average	5.96%	294	12,185	770	1,790
XXXXX	XXXXXXXXX	XX	FY2019	10/01/2018-09/30/2019	170	18	10.59%	9.27%	6.02%	13.42%	Worse than National Average	5.68%	292	12,175	650	1,983

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure

CMS is proposing the adoption of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure beginning with the FY 2023 SNF QRP.

This measure would require SNFs to report on COVID-19 HCP vaccination in order to assess whether SNFs are taking steps to limit the spread of COVID-19 among their HCP, reduce the risk of transmission within their facilities and help sustain the ability of SNFs to continue serving their communities throughout the COVID-19 PHE and beyond. Under this proposal, SNFs would report the vaccination data through the Centers for Disease Control and Prevention National Healthcare Safety Network beginning October 1, 2021.

CMS is proposing to publicly report the COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the October 2022 Care Compare refresh or as soon as technically feasible using data collected for Q4 2021 (October 1, 2021 through December 31, 2021).

If finalized as proposed, a SNF's HCP COVID-19 vaccination coverage rate would be displayed based on one quarter of data. Provider preview reports would be distributed in July 2022.

Thereafter, HCP COVID-19 vaccination coverage rates would be displayed based on one quarter of data updated quarterly. Subsequent to this, one additional quarter of data would be added to the measure calculation during each advancing refresh, until the point four full quarters of data is reached. Thereafter, the measure would be reported using four rolling quarters of data.

Transfer of Health (TOH) Information to the Patient-PAC Quality Measure

CMS is proposing to update the denominator for the Transfer of Health (TOH) Information to the Patient‐Post Acute Care (PAC) quality measure.

Currently the measure denominators for both the TOH Information to the Patient-PAC and the TOH Information to the Provider-PAC measures include patients discharged home under the care of an organized home health service organization or hospice.

In order to avoid counting the patient in both TOH measures, CMS is proposing to remove this location from the definition of the denominator for the TOH Information Patient–PAC measure.

Public Reporting of Quality Measures with Fewer than Standard Numbers of Quarters Due to COVID-19 Public Health Emergency (PHE) Exemptions

In March 2020, due to the COVID-19 PHE, CMS granted an exception to the SNF QRP reporting requirements from Q1 2020 (January 1, 2020–March 31, 2020), and Q2 2020 (April 1, 2020–June 30, 2020).

CMS also stated that it would not publicly report any SNF QRP data that might be greatly impacted by the exceptions from Q1 and Q2 of 2020.

This exception affected the standard number of quarters that CMS currently uses to display SNF QRP data.

CMS is proposing to update the number of quarters used for public reporting to account for this exception.

Public Reporting of Quality Measures with Fewer than Standard Numbers of Quarters Due to COVID-19 Public Health Emergency (PHE) Exemptions

TABLE 29: Revised and Proposed Schedule for Refreshes Affected by COVID-19 PHE Exemptions for SNF MDS Assessment-based QMs

Quarter Refresh	MDS Assessment Quarters in Revised/Proposed Schedule for Care Compare (number of quarters)
October 2020	Q1 2019 – Q4 2019 (4)
January 2021	Q1 2019 – Q4 2019 (4)
April 2021	Q1 2019 – Q4 2019 (4)
July 2021	Q1 2019 – Q4 2019 (4)
October 2021	Q1 2019 – Q4 2019 (4)
January 2022	Q3 2020 – Q1 2021 (3)
April 2022	Q3 2020 – Q2 2021 (4)* *Normal reporting resumes with 4 quarters of data

Note: The shaded cells represent data held constant due to PHE related to COVID-19.

TABLE 30: Revised and Proposed Schedule for Refreshes Affected by COVID-19 PHE Exemptions for SNF Claims-based QMs

Quarter Refresh	Claims-based Quarters in Revised/Proposed Schedule for Care Compare (number of quarters)
October 2020	Q4 2017 – Q3 2019 (8)
January 2021	Q4 2017 – Q3 2019 (8)
April 2021	Q4 2017 – Q3 2019 (8)
July 2021	Q4 2017 – Q3 2019 (8)
October 2021	Q4 2017 – Q3 2019 (8)
January 2022	Q4 2018 – Q4 2019, Q3 2020 (6)
April 2022	Q4 2018 – Q4 2019, Q3 2020 (6)
July 2022	Q4 2018 – Q4 2019, Q3 2020 (6)
October 2022	Q4 2019, Q3 2020 – Q3 2021 (6)
January 2023	Q4 2019, Q3 2020 – Q3 2021 (6)
April 2023	Q4 2019, Q3 2020 – Q3 2021 (6)
July 2023	Q4 2019, Q3 2020 – Q3 2021 (6)
October 2023	Q4 2020 – Q3 2022 (8)* *Normal reporting resumes with 8 quarters of data

Note: The shaded cells represent data held constant due to PHE related to COVID-19.

TABLE 31: Proposed Schedule for Refreshes Affected by COVID-19 PHE Exemptions for the SNF HAI Measure

Quarter Refresh	Claims-based Quarters in Proposed Schedule for Care Compare (number of quarters)
April 2022	Q4 2018 – Q3 2019 (4)
July 2022	Q4 2018 – Q3 2019 (4)
October 2022	Q4 2020 - Q3 2021 (4) *Normal reporting resumes for claims-based measures refreshed annually

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs - RFI

CMS is working to further the mission to improve the quality of healthcare for beneficiaries through measurement, transparency, and public reporting of data.

The SNF QRP and CMS' other quality programs are foundational for contributing to improvements in health care, enhancing patient outcomes, and informing consumer choice.

We believe that advancing our work with use of the FHIR standard offers the potential for supporting quality improvement and reporting which will improving care for our beneficiaries.

We are seeking feedback on our future plans to define digital quality measures (dQMs) for the SNF QRP.

We also are seeking feedback on the potential use of FHIR for dQMs within the SNF QRP aligning where possible with other quality programs.

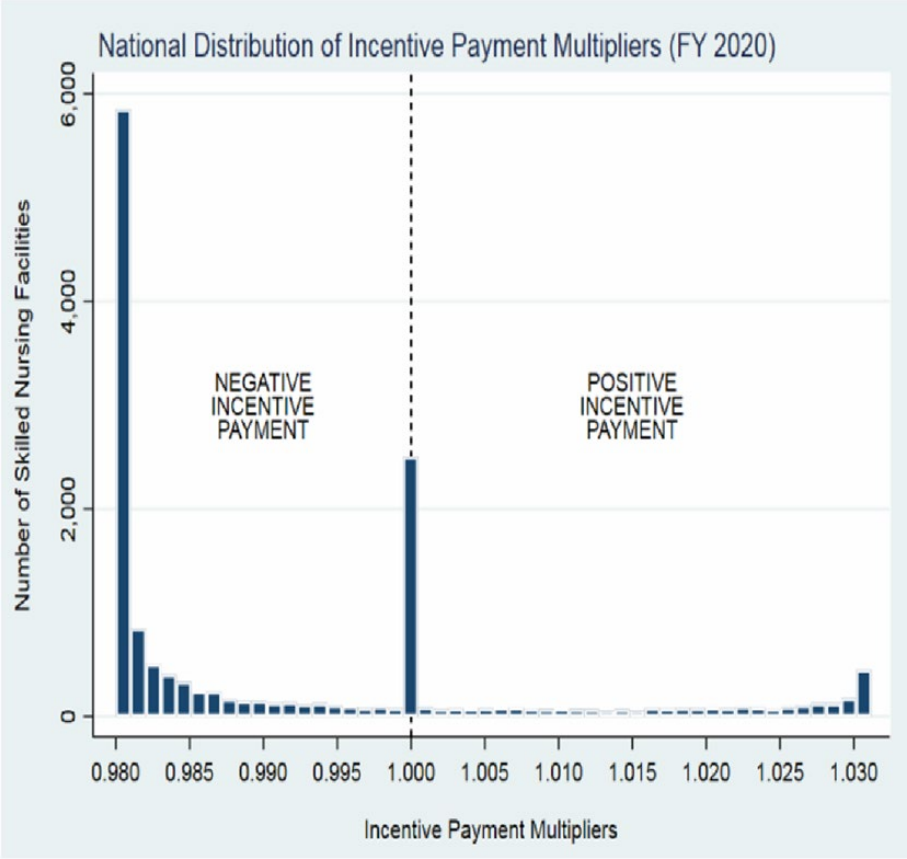
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing (Cont.)**
  - Currently the SNF VBP consists of a rehospitalization Measure, NQF 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/Measure
  - The SNFRM estimates the risk-standardized rate of all-cause, unplanned hospital readmissions for SNF Medicare FFS beneficiaries within 30 days of discharge from their prior proximal short-stay acute hospital discharge. This will be replaced by the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) which will be submitted to NQF for endorsement in the fall of 2021.
  - Nursing homes are currently measured by the specifications in NQF 2510 in a baseline and performance year. Individual nursing home performance is then utilized to determine an annual VBP incentive payment.
  - CMS withholds 2% of SNF payment and the individual facility performance compared to all other facilitates in the nation determines how much of that 2% the facility will earn back as a VBP incentive payment.
  - Individual facilities receive quarterly confidential feedback reports in CASPER and an annual update related to that year's incentive payment.

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

SNF VBP Performance Information	
Baseline Period Risk-Standardized Readmission Rate (RSRR)	20.499%
Performance Period RSRR	18.761%
Achievement Score	31.23180
Improvement Score	36.18483
Performance Score	36.18483
Program Rank	6,312
Incentive Payment Multiplier	0.9903466964

Your Incentive Payment Multiplier for FY 2020	
Starting October 1, 2019, your adjusted federal per diem rate will be multiplied by **0.9903466964**.	Your incentive payment multiplier is **net-negative**, meaning that your facility will earn back **less than** it would have in the absence of the SNF VBP Program.
Interpreting Incentive Payment Multipliers	
Incentive Payment Multiplier < 1	SNF receives less than the 2% withhold back (net-negative)
Incentive Payment Multiplier = 1	SNF receives the full 2% withhold (net-neutral)
Incentive Payment Multiplier > 1	SNF receives more than the 2% withhold back (net-positive)



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

- **Value Based Purchasing**
  - **FY 2022: Baseline FY 2018, Performance 4/1/19 through 12/31/19 and 7/1/20 through 9/30/20**

TABLE 15: Final FY 2022 SNF VBP Program Performance Standards*

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79025	0.82917

  - **FY 2023: Baseline FY 2019, Performance FY 2021**

TABLE 15: Final FY 2023 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79270	0.83028

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

- **Value Based Purchasing (Cont.)**
  - CMS has indicated that It is not their intention to penalize SNFs based on measure scores that they believe are distorted by the COVID-19 pandemic and are thus not reflective of the quality of care that the measure in the SNF VBP Program was designed to assess.
  - CMS is proposing to adopt a policy for the duration of the PHE for COVID-19 that would enable suppressing the use of SNF readmission measure data for purposes of scoring and payment adjustments in the SNF VBP Program if it is determined that circumstances caused by the PHE for COVID-19 have affected the measure and the resulting performance scores significantly.
  - Under this proposed policy, if CMS determines that the suppression of the SNF readmission measure is warranted for a SNF VBP program year, they will propose to calculate the SNF readmission measure rates for that program year but then suppress the use of those rates to generate performance scores, rank SNFs, and generate value-based incentive payment percentages based on those performance scores.

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

- **Value Based Purchasing (Cont.)**
  - CMS would instead assign each eligible SNF's performance score of zero for the program year to mitigate the effect that the distorted measure results would otherwise have on SNF's performance scores and incentive payment multipliers.
  - They would also reduce each eligible SNF's adjusted Federal per diem rate by the applicable percent (2 percent) and then further adjust the resulting amounts by a value-based incentive payment amount equal to 60 percent of the total 2% reduction resulting in a 1.2 percent payback for the FY 2022 program year. CMS sees this as the most equitable way to reduce the impact of the withhold in light of the proposal to award a performance score of zero to all SNFs.
  - Those SNFs subject to the Low-Volume Adjustment policy would receive 100 percent of their 2 percent withhold per the policy previously finalized in the FY 2020 SNF PPS final rule).
  - CMS would also provide each SNF with its SNF readmission measure rate in confidential feedback reports so that the SNF is aware of the observed changes to its measure rates.
  - CMS would also publicly report the FY 2022 SNF readmission measure rates with appropriate caveats noting the limitations of the data due to the PHE for COVID-19.

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

- **Value Based Purchasing (Cont.)**
  - CMS developed a number of Measure Suppression Factors that they believe should guide their determination of whether to propose to suppress the SNF readmission measure for one or more program years that overlap with the PHE for COVID-19.
    - (1) Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years.
    - (2) Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.
    - (3) Rapid or unprecedented changes in:
      - Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
      - The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.
    - (4) Significant national shortages or rapid or unprecedented changes in:
      - Healthcare personnel;
      - Medical supplies, equipment, or diagnostic tools or materials; or
      - Patient case volumes or facility-level case mix.
  - In this proposed rule, CMS is proposing to suppress the SNFRM for the FY 2022 SNF VBP Program Year under proposed Measure Suppression Factor: (4) Significant national shortages or rapid or unprecedented changes in: (iii) patient case volumes or facility-level case mix.

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

- **Value Based Purchasing (Cont.)**
  - In the FY 2021 SNF PPS final rule, CMS finalized the FY 2023 Program performance period as FY 2021 (October 1, 2020 – September 30, 2021) See slide 41.
  - The finalized risk adjustment model would account for certain risk-factors within 365 days prior to the discharge from the hospital to the SNF (a 365- day lookback period). Under the COVID-19 ECE, SNF qualifying claims for the period January 1, 2020 – June 30, 2020 are excepted from the calculation of the SNFRM; using FY 2021 data this results in at least 3 months of lookback being available for all SNF stays included in the measure without extending into or beyond June 30, 2020.
  - CMS is proposing instead a 90-day lookback period for risk adjustment in the FY 2023 performance period (FY 2021) only. Using a 90-day risk-adjustment period will allow CMS to use the most recent claims available for risk-adjustment, and an identical risk-adjustment lookback period for all stays included in the measure. It also allows CMS to avoid combining data from both prior to and during the COVID-19 PHE in the risk-adjustment lookback period, which would be necessary if they attempted to maintain a 12-month look-back period due to the COVID-19 ECE. Using a 90-day lookback period for risk adjustment will allow us to look back 90 days prior to the discharge from the hospital to the SNF for each SNF stay.
  - CMS is also considering similarly reducing the risk-adjustment lookback period for the applicable FY 2023 program baseline year which would align the risk-adjustment lookback period for the baseline and performance years in the FY 2023 program;

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

- **Value Based Purchasing (Cont.)**
  - CMS has updated the performance period for the FY 2022 SNF VBP Program to April 1, 2019 through December 31, 2019 and July 1, 2020 through September 30, 2020.
  - As the SNF VBP Program uses only a single measure calculated on 1 year of data and uses each year of data first as a performance period and then later on as a baseline period in the Program, the removal of 9 months of data in light of the COVID-19 PHE above will necessarily result in data being used more than once in the Program.
  - Therefore, to ensure enough data are available to reliably calculate the SNFRM, CMS is proposing FY 2019 data be used for the baseline period for the FY 2024 program year. CMS is also considering using FY 2021, which will also be the baseline period for the FY 2025 program year under our current policy. The performance period for FY 2024 VBP will remain FY 2022.
  - Based on this baseline period prosed for FY 2024, CMS estimates that the performance standards would have the numerical values noted in the table below. CMS notes that these values represent estimates based on the most recently available data and will update the numerical values in the FY 2022 SNF PPS final rule.

TABLE 32: Estimated FY 2024 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79270	0.83028

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

- **Value Based Purchasing (Cont.)**
  - On December 27, 2020, Congress enacted the Consolidated Appropriations Act, 2021 part of which contains amendments to, with respect to payments for services furnished on or after October 1, 2023, require the Secretary to apply the specified readmission measure and allow the Secretary to apply up to 9 additional measures determined appropriate.
  - In the proposed rule, CMS is seeking input from stakeholders regarding which measures should be considered to be added to the SNF VBP Program. CMS intends to use future rulemaking to address these new statutory requirements.
  - Currently, the SNF VBP Program includes only a single quality measure, the SNFRM, which CMS intends to transition to the SNFPPR measure as soon as practicable.
  - In considering which measures might be appropriate to add to the SNF VBP Program, CMS is considering additional clinical topics such as measures of functional status, patient safety, care coordination, and patient experience, as well as measures on those topics that are utilized in the SNF Quality Reporting Program (QRP).
  - CMS is also considering measures on clinical topics that are not included in the SNF QRP's measure set because they believe that other clinical topics would be helpful to our efforts to robustly assess the quality of care furnished by SNFs.

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

- **Value Based Purchasing (Cont.)**
  - In expanding the SNF VBP measure set, CMS is also considering measures that are already required for Long-Term Care Facilities (LTCFs), which include both SNFs and nursing facilities (NFs), to collect and report under other initiatives.
  - The vast majority of LTCF residents are also Medicare beneficiaries, regardless of whether they are in a Medicare Part A SNF stay. Therefore, CMS believes that expanding the SNF VBP measure set to assess the quality of care that SNFs provide to all residents of the facility, regardless of payer, would best represent the quality of care provided to all Medicare beneficiaries in the facility.
  - Table 31 on slides 48 and 49 include measures that CMS could add to the SNF VBP Program measure set, and they are seeking comment on those measures, including which of those measures would be best suited for the program. CMS also seeks public comment on any measures or measure concepts that are not listed in Table 31 that stakeholders believe CMS should consider for the SNF VBP Program.
  - In addition to the staffing measures listed in Table 31 that focus on nurse staffing hours per resident day and that are currently reported on the Nursing Home Care Compare website, CMS is also interested in measures that focus on staff turnover. CMS has been developing measures of staff turnover with the goal of making the information publicly available. CMS has indicated that they will be reporting rates of turnover in the future.

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

TABLE 31: Quality Measures Under Consideration for an Expanded Skilled Nursing Facility Value-Based Purchasing Program

Meaningful Measure Area	NQF	Quality Measure
Minimum Data Set		
Functional Outcomes	A2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients*
Functional Outcomes	A2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients*
Preventable Healthcare Harm	0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)**
Preventable Healthcare Harm	0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Ability to Move Independently Worsened (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)**
Transfer of Health Information and Interoperability	N/A	Transfer of Health Information to the Provider–Post Acute Care *
Medication Management	N/A	Percentage of Long-Stay Residents who got an Antipsychotic Medication**

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

Medicare Fee-For-Service Claims Based Measures		
Community Engagement	3481	Discharge to Community Measure-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Patient-focused Episode of Care	N/A	Medicare Spending per Beneficiary (MSPB)-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Healthcare-Associated Infections	N/A	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure~
Admissions and Readmissions to Hospitals	N/A	Number of hospitalizations per 1,000 long-stay resident days (Long Stay)**
Patient-Reported Outcome-Based Performance Measure		
Functional Outcomes	N/A	Patient-Reported Outcomes Measurement Information System [PROMIS]-PROMIS Global Health, Physical
Survey Questionnaire (similar to Consumer Assessment of Healthcare Providers and Systems (CAHPS))		
Patient's Experience of Care	2614	CoreQ: Short Stay Discharge Measure
Payroll Based Journal		
N/A	N/A	Nurse staffing hours per resident day: Registered Nurse (RN) hours per resident per day; Total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day**

Overall Financial Impact

- **Financial Impact**
  - CMS estimates that the aggregate impact of these proposals would be an increase of approximately $444 million in Part A payments to SNFs in FY 2022. This reflects a $445 million increase from the update to the payment rates and a $1.2 million decrease due to the proposed reduction to the SNF PPS rates to account for the recently excluded blood-clotting factors (and items and services related to the furnishing of such factors).
  - CMS notes that these impact numbers do not incorporate the SNFVBP reductions that are estimated to total $191.64 million in FY 2022. Nor do these numbers include any reductions to the rate based on QRP reporting penalties.
  - Based on the 60 percent payback percentage CMS estimates that they will redistribute approximately $324.5 million in value-based incentive payments to SNFs in FY 2022, which means that the SNF VBP Program is estimated to result in approximately $191.64 million in savings to the Medicare Program in FY 2022.
  - CMS believes the data submission for the COVID-19 Vaccination Coverage among HCP measure would cause SNFs to incur additional average burden of 12 hours per year for each SNF and a total annual burden of 180,936 hours for all SNFs. The estimated annual cost across all 15,078 SNFs in the U.S. for the submission of the COVID-19 Vaccination Coverage among HCP measure would be between $4,970,312 and $8,283,250.08, and an average of $6,625,872.

SNF PPS

Overall Financial Impact

TABLE 33: Impact to the SNF PPS for FY 2022

Provider Characteristics	# Providers	Update Wage Data	Total Change
Group			
Total	15,440	0.0%	1.3%
Urban	10,887	-0.1%	1.2%
Rural	4,553	0.4%	1.8%
Hospital-based urban	385	-0.2%	1.1%
Freestanding urban	10,502	-0.1%	1.2%
Hospital-based rural	451	0.3%	1.6%
Freestanding rural	4,102	0.4%	1.7%
Urban by region			
New England	742	-0.7%	0.6%
Middle Atlantic	1,447	-0.5%	0.8%
South Atlantic	1,820	0.4%	1.7%
East North Central	2,145	-0.2%	1.1%
East South Central	539	-0.4%	0.9%
West North Central	919	0.4%	1.7%
West South Central	1,342	-0.3%	1.0%
Mountain	536	0.1%	1.4%
Pacific	1,391	0.2%	1.5%
Outlying	6	0.4%	1.7%
Rural by region			
New England	129	-0.9%	0.4%
Middle Atlantic	245	0.5%	1.8%
South Atlantic	597	1.2%	2.5%
East North Central	909	0.5%	1.8%
East South Central	526	-0.1%	1.2%
West North Central	1,058	-0.3%	1.0%
West South Central	756	0.4%	1.7%
Mountain	222	0.5%	1.8%
Pacific	111	0.3%	1.6%
Ownership			
For profit	10,809	0.0%	1.3%
Non-profit	3,637	0.0%	1.3%
Government	994	0.2%	1.5%

Note: The Total column includes the proposed FY 2022 1.3 percent market basket increase factor. Additionally, we found no SNFs in rural outlying areas.

SNF VBP

Overall Financial Impact

TABLE 35: SNF VBP Program Estimated Impacts for FY 2022

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive multiplier	Percent of total payment after applying incentives
Group					
Total	15,026	19.90	1.4545	0.99426	100
Urban	10,845	19.94	1.1528	0.99379	85.29
Rural	4,181	19.81	2.2371	0.99547	14.71
Hospital-based urban*	284	19.68	1.1794	0.99383	1.79
Freestanding urban*	10,520	19.95	1.1423	0.99377	83.47
Hospital-based rural*	182	19.55	2.6050	0.99604	0.43
Freestanding rural*	3,803	19.81	2.1749	0.99538	14.12
Urban by region					
New England	744	20.10	0.8104	0.99326	5.38
Middle Atlantic	1,462	19.78	0.7155	0.99311	16.57
South Atlantic	1,874	20.00	0.6407	0.99299	17.01
East North Central	2,065	20.08	1.3950	0.99417	13.32
East South Central	555	20.08	0.9471	0.99347	3.53
West North Central	923	19.92	2.1104	0.99528	4.23
West South Central	1,312	20.11	1.6811	0.99461	7.48
Mountain	523	19.56	1.4090	0.99419	3.72
Pacific	1,381	19.67	0.9702	0.99351	14.05
Outlying	6	20.96	2.5766	0.9960	0.00
Rural by region					
New England	122	19.30	1.6896	0.99462	0.64
Middle Atlantic	210	19.53	1.1779	0.99383	0.90
South Atlantic	473	19.91	1.5144	0.99435	2.11
East North Central	895	19.69	1.8310	0.99484	3.35
East South Central	495	20.06	1.1139	0.99373	2.26
West North Central	1,006	19.77	3.5653	0.99753	1.99
West South Central	689	20.13	2.5430	0.99595	2.18
Mountain	199	19.43	2.5378	0.99594	0.66
Pacific	91	19.22	1.5856	0.99446	0.60
Outlying	1	19.37	5.1533	1.0000	0.00
Ownership					
Government	877	19.77	2.5149	0.9959	3.28
Profit	10,583	19.95	1.3693	0.9941	74.38
Non-Profit	3,566	19.81	1.4466	0.9943	22.33

* The group category which includes hospital-based/freestanding by urban/rural excludes 237 swing-bed SNFs.

Find Out More

ICD-10

End Stage Liver Disease	Possible diagnosis of end stage liver disease in Section I - Other Additional Active Diagnoses, at MDS item I8000. **(Possible NTA = 1 point)**
IV Fluids	Possible IV fluids for nutrition or hydration in section K - Swallowing/Nutritional Status, at MDS item K0510A1 or K0510A2. **(Possible Nursing Category = Special Care High)**
Wound	Possible wound of the following type has been identified, Arterial Ulcer, Diabetic Foot Ulcer, Severe Skin Burn or Condition, Stage 2, 3, or 4 pressure ulcer, Venous Ulcer, Open Lesion, Surgical Wound, Wound Infection and Open Lesion of the foot. Check triggers to identify specific type of wound
Radiation	Possible radiation post admit in section O - Special Treatments, Procedures, and Programs, at MDS item O0100B2. **(Possible NTA = 1 point)**
Chemotherapy	Possible chemotherapy post admit in section O - Special Treatments, Procedures, and Programs, at MDS item O0100A2. **(Possible Nursing Category = Clinically Complex)**
Asthma/COPD/Chronic Lung Disease	Possible diagnosis of asthma, COPD, and/or a chronic lung disease in Section I - Active Diagnoses, at MDS item I6200 **(Possible NTA = 2 points) (Possible Nursing Category = Special Care High when combined with MDS item J1100C shortness of breath or Trouble breathing when lying flat)**
Wound - Surgical	Possible surgical wound in section M - Skin Conditions, at MDS item M1040E **(Possible Nursing Category = Clinically Complex when combined with any selected skin treatments)**

Primary DX	SLP	Nursing	NTA	None

Anatomy
Conditions
Medication
PHI
Procedure
ALL

Page 1 of 5 DOB Encounter Date: 09/08/2019 MRN: H&P Date of Service: 9/9/2019 2:36 AM MD Hospitalist HPMC Hospitalist History and Physical Assessment/Plan: Principa
Problem: GI bleed Active Problems: Hypertension Hypothyroidism (acquired) Fecal occult blood test positive Dementia CKD stage 4 due to type 2 diabetes mellitus (HCC) Acut
cystitis with hematuria Cirrhosis (HCC) Hypoglycemia Acute-on-chronic kidney injury (HCC) Resolved Problems: * No resolved hospital problems. * is a 85 y.o. female with PMH:
stage IV kidney disease, cirrhosis with known esophageal varices, multiple AVMs and diverticulosis with prior GI bleed as reviewed in the EMR that presented to HPMC with Chie
Complaint Patient presents with Hypoglycemia Is being admitted with GI bleed 1. GI bleed with anemia: Hemoglobin 6.3, ordered to receive 1 unit packed red blood cells She is
known issue with GI bleeding secondary to AV malformations as well as multiple diverticuli Will transfuse, consult gastroenterology however I doubt that a colonoscopy or endoscop
would be beneficial 2. Hypoglycemia: She is received 2 doses of dextrose and continues to drop, she is not on antidiabetic agents, will place on dextrose infusion for now 3. Acut
kidney injury on chronic kidney disease: IV fluid hydration as above avoid nephrotoxic agents follow urine output renal function Continue bicarb 9/9/2019

--- End of Page 1 ---

Page 2 of 5 4. Acute cystitis: Received Keflex emergency department, follow urine cultures continue antibiotics 5. Bilateral lower extremity ulcerations present on admission: Left uppe
extremity skin tears will consult wound therapy for their assistance 6. Hypothyroidism unspecified: Synthroid Inpatient DVT prophylaxis: pneumatic compression device Anticipated
disposition: To Skilled Nursing Facility Estimated discharge: 2-3 days Chief Complaint: Chief Complaint Patient presents with Hypoglycemia HPI: is a 85 y.o. female with PMHx stage
IV kidney disease, cirrhosis with known esophageal varices, multiple AVMs and diverticulosis with prior GI bleed as reviewed in the EMR that presented to HPMC with Chief Complaint
Patient presents with Hypoglycemia 85-year-old Caucasian female with the above history as well as dementia who currently resides at Westchester Manor who is presenting with
altered mental status. Patient is not able to provide much information given mental status, at baseline. History is obtained from her daughter who is also present at bedside. Daughter
states that she knows her mom was more drowsy today and seemed confused. On EMS arrival she is found to be hypoglycemic blood glucose of 36. After glucose has improved she
is now back at her baseline mental status. Her daughter states that the patient is often confused and sometimes refuses to take her medications. She has not eaten very much today
but typically eats well. She is uncertain of any further complaints including fevers chills or further symptomatology On routine work-up she was found to be anemic and hemoglobin of
6.3 as well as evidence of urinary tract infection Fecal occult positive blood test She is last seen gastroenterology in July of this year for GI bleeding she underwent endoscopy and
colonoscopy, had multiple AVMs ablated Of note she also has bilateral leg wounds present on arrival, these are previously documented

--- End of Page 2 ---

Page 3 of 5 Allergies: Codeine; Influenza virus vaccines; Metrizamide; Other; Sulfasalazine; Amitriptyline; Indomethacin; Valsartan; and Ace inhibitors Medications: Updated Medicatio
List: acetaminophen (TYLENOL) 325 MG tablet Sig - Route: Take 650 mg by mouth every 6 (six) hours as needed - Oral Class: Historical Med allopurinol (ZYLOPRIM) 300 MG tablet

Find Out More

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QUESTIONS?