Summary of Centers for Medicare and Medicaid Services (CMS) Final SNF Payment Rule for Federal Fiscal Year (FY) 2023

The final rule may be found in early publication form at this link. It will be published officially in the *Federal Register* soon. CMS's fact sheet on the rule is here.

CMS's description of the final rule:

> This final rule updates payment rates; forecast error adjustments; diagnosis code mappings; the Patient Driven Payment Model (PDPM) parity adjustment; the SNF Quality Reporting Program (QRP); and the SNF Value-Based Purchasing (VBP) Program. It also establishes a permanent cap policy to smooth the impact of year-to-year changes in SNF payments related to changes in the SNF wage index. We also announce the application of a risk adjustment for the SNF Readmission Measure for COVID-19 beginning in FY 2023. We are finalizing changes to the long-term care facility fire safety provisions referencing the National Fire Protection Association (NFPA)® Life Safety Code, and Director of Food and Nutrition Services requirements.

CMS estimated the increase in aggregate payments to SNFs resulting from the FY 2023 rate changes to be $904 million. They estimated the QRP changes to cost SNFs an additional $30.9 million and the VBP program to reduce aggregate payments by $185.55 million.

Patient-Driven Payment Model (PDPM) Rate Adjustments

CMS finalized a base market basket adjustment of 3.9%, which was 1.1 percentage points higher than the proposed 2.8%. They added a forecast error adjustment (from FY 2021) of 1.5%, the same as proposed, and a productivity adjustment of negative 0.3%, a tenth of a point less than proposed. These adjustments total 5.1%, compared with 3.9% in the proposed version. With the negative 2.3% parity adjustment that CMS finalized for FY 2023, the net rate increase is 2.7% (because of rounding).

Adjustment	Proposed	Final	Difference	Reason
Base market basket	2.8%	3.9%	1.1%	Updated inflation data
Forecast error	1.5%	1.5%	0	No change, 2021 data
Productivity	-0.4%	-0.3%	0.1%	Updated data
Parity	-4.6%	-2.3%	2.3%	Phased in
Total	-0.7%	2.7%	3.4%	

The following tables include the net 2.7% adjustment that incorporates the parity adjustment.

TABLE 3: FY 2023 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$66.06	$61.49	$24.66	$115.15	$86.88	$103.12

TABLE 4: FY 2023 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$75.30	$69.16	$31.07	$110.02	$83.00	$105.03

CMS finalized the proposed parity adjustment of -4.6% without change, based on their analysis of PDPM's impact on aggregate payments, factoring out COVID-19. CMS evaluated multiple ways of adjusting for COVID-19 and chose the option that yielded the smallest rate reduction. Remember that last year, CMS proposed a -5% parity adjustment.

TABLE 11: Adjustment Factors Based on Population and Data Period

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

The selected methodology compared actual results against a control period consisting of 12 months since PDPM's inception that had little or no COVID-19 (October 2019-March 2020, April-September 2021). The control-period methodology reduces spending by an estimated $1.5 billion, as opposed to $1.6 or $1.8 billion for the other approaches. CMS also decided to apply the parity adjustment equally across all components of PDPM instead of differentially by component.

Most importantly, CMS accepted the request from AHCA/NCAL and thousands of members to phase in the parity adjustment:

> However, we also recognize that the ongoing COVID-19 PHE provides a basis for taking a more cautious approach in order to mitigate the potential negative impacts on providers, such as the potential for facility closures or disproportionate impacts on rural and small facilities. Given this, we believe that it would be appropriate to implement a phased-in approach to recalibrating the PDPM parity adjustment. Therefore, after considering these comments, and in order to balance mitigating the financial impact on providers of recalibrating the PDPM parity adjustment with ensuring accurate Medicare Part A SNF payments, we are finalizing the proposed recalibration of the PDPM parity

adjustment with a 2-year phase-in period, resulting in a 2.3 percent reduction in FY 2023 ($780 million) and a 2.3 percent reduction in FY 2024.

In addition to reducing the negative impact on FY 2023 rates, this statement by CMS also locks in the -4.6% total parity adjustment. CMS could have chosen to recalculate the amount for FY 2024.

The wage indices for FY 2023 are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. CMS projected the labor share of the rate for applying the wage indices at 70.8% for FY 2023 vs. 70.4% for FY 2022. CMS finalized its proposal to cap negative swings in the wage indices permanently at 5% per year, starting with FY 2023.

CMS made no changes to the consolidated billing exclusions and finalized their proposed changes to PDPM mappings for certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. Detail on the now-finalized mapping changes can be found in the proposed rule.

Regulatory Changes

Although CMS largely has ignored the previous administration's July 18, 2019, proposed rule that would have relaxed certain aspects of the SNF Requirements of Participation (ROPs), two key items surprisingly turned up in the final payment rule. They deal with dietary managers and the Fire Safety Evaluation System (FSES). Both of the final changes are helpful.

In the proposed rule, CMS would have eliminated the existing certification/degree requirement for directors of food and nutrition services and would have allowed them to qualify with 2 or more years of experience in the position *or* completion of a food safety course (e.g., ServSafe). In the final version, CMS requires the dietary manager both to have the two years of experience *and* to complete the course, and to do so by October 1, 2023. The final rule also retains the requirement to meet any applicable state standards. Because of the October 1, 2023, deadline, this solution would appear to be a temporary fix.

Relative to the FSES, CMS proposed in 2019 to bring back the previous scoring methodology instead of the new methodology that shifted some buildings in existence in 2016 from compliance to non-compliance, requiring very costly renovations or building closure. CMS has allowed temporary waivers since then to circumvent this problem. In the final rule, they adopted the proposal to return to the previous scoring methodology, thereby eliminating the issue.

Quality Reporting Program

CMS finalized three additional QRP measures for FY 2024, one that was new in the proposed rule and two others that were adopted previously but delayed.

The new measure is Influenza Vaccination Coverage among Healthcare Personnel. CMS initially proposed to activate this measure for FY 2025, but moved it up. The data will come from

National Healthcare Safety Network (NHSN) reporting by SNFs plus census information from the MDS. A SNF will be required to submit a single influenza vaccination summary report at the conclusion of the reporting period, which starts October 1, 2022, and runs through March 31, 2023. The report will be due May 15. The data thresholds are 80% for MDS and 100% for NHSN.

The delayed measures are Transfer of Health (TOH) Information to the Provider and TOH Information to the Patient, both dealing with updated medication lists. CMS originally postponed requiring MDS data elements for these measures until two years after the Public Health Emergency ends. They now have decided to move the timing up to October 1, 2023, through MDS version 3.0 v1.18.161.

Value-Based Purchasing

CMS finalized their proposal to suppress VBP for payment purposes in FY 2023 as was the case in FY 2022. Most SNFs will receive a 1.2% payback from the 2% VBP rate deduction regardless of their individual re-hospitalization rates. CMS stated that the full VBP will return in FY 2024.

CMS also finalized a change for FY 2023 relative to the low-volume provider VBP exclusion, moving the standard to fewer than 25 eligible stays. These providers do not get a VBP deduction or payback. If the SNF has enough cases for the performance period but not the baseline period, they get achievement points but not improvement points.

CMS will share with providers their actual performance in FY 2023 via the normal feedback reports. The data also will be publicly available through the Provider Data Catalog. Some adjustments will be made to the data reporting to address the threshold change for VBP inclusion.

CMS created a new risk adjustment to the VBP re-hospitalization measure for COVID-19 patients. This adjustment will apply in FY 2023. The methodology includes variables for patients with COVID-19 during their original hospitalization and for those with a history of COVID-19.

CMS finalized their proposal to update the baseline period to FY 2019, instead of 2020, for the FY 2025 VBP.

TABLE 17: Final FY 2025 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79139	0.82912

Currently, VBP is based on a single measure, hospital readmissions. In the rule, CMS finalized three new measures that will be added to VBP in FY 2026 and 2027. This action is pursuant to authority Congress gave CMS late last year.

In the final rule, CMS adopted two new measures for FY 2026, Healthcare-Acquired Infections (HAI) Requiring Hospitalization and Total Nursing Hours per Resident Day. The HAI measure is based on SNF and hospital claims and does not require additional data reporting. The staffing

measure is the same as already used for the 5-Star Quality Rating System, taken from Payroll-Based Journal and MDS data. For both measures, CMS will use FY 2024 as the performance period and FY 2022 as the baseline period for the FY 2026 program year, then roll forward.

For FY 2027, CMS adopted the Discharge to Community measure. This measure is already in QRP. It is based on 2 years of fee-for-service claims. The baseline period for this measure will be FY 2021-2022, and the performance period will be FY 2024-2025.

The new measures will require CMS to change other aspects of VBP that are based on the current single-measure structure. To participate in VBP for FY 2026, SNFs will need the minimum number of cases for two of the three measures and for FY 2027, three of the four measures. CMS will change its scoring methodology to account for the additional measures. A SNF will be able to earn up to 10 points per measure for achievement and nine points per measure for improvement. The total for all 3 or 4 measures will be normalized to a 100-point scale. The conversion factor for determining the provider's payback amount was the subject of one of CMS's many RFIs in the proposed rule, so that piece is not final.

Requests for Information

In the proposed rule, CMS issued numerous RFIs on topics such as coding for isolation, additional QRP measures including the CoreQ satisfaction survey, adding staff turnover and COVID-19 vaccination rates to VBP, the exchange function for VBP, how to incorporate health equity into VBP, and minimum staffing standards for SNFs. In the final rule, CMS typically acknowledged receipt of comments and stated that they would study them for potential future rule-making.

Relative to the most noteworthy RFI - minimum staffing requirements - CMS said a little more:

> We appreciate the robust response we received on this RFI. As noted, staff levels in nursing homes have a substantial impact on the quality of care and outcomes residents experience. The input received will be used in conjunction with a new research study being conducted by CMS to determine the level and type of nursing home staffing needed to ensure safe and quality care. CMS intends to issue proposed rules on a minimum staffing level measure within one year. We will consider the feedback that we have received on this RFI for the upcoming rulemaking and changes to the LTC facility requirements for participation. This feedback from a wide range of interested parties will help to establish minimum staffing requirements that ensure all residents are provided safe, quality care, and that workers have the support they need to provide high-quality care.

Unlike the other RFIs that may or may not appear in rules, CMS restated the one-year timeframe for a proposed rule on minimum staffing. We believe the one year anniversary will be February 2023, although CMS's statement is somewhat ambiguous.