DEPAR **1**

38 CFR Part 51

RIN 2900-AR62

Payments Under State Home Care Agreements for Nursing Home Care

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs proposes to amend its State home per diem regulation to provide a new formula for calculating the prevailing rate VA would pay a State home that enters into a State home care agreement to provide nursing home care to eligible veterans.

DATES: Comments must be received on or before **[Insert date 60 days after date of publication in the FEDERAL REGISTER]**.

ADDRESSES: Comments must be submitted through www.regulations.gov. Except as provided below, comments received before the close of the comment period will be available at www.regulations.gov for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on the following website as soon as possible after they have been received: https://www.regulations.gov. VA will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm the individual. VA encourages individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments. Any public comment received after the comment period's closing date is considered late and will not be considered in the final rulemaking.

FOR FURTHER INFORMATION CONTACT: Lisa Minor, National Director, Facilities Based Care, Geriatrics and Extended Care, 12GEC, Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue N.W., Washington, DC 20420, (202) 632-8320. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

I. Background

The State homes program is the largest provider of long-term care for our Nation's veterans with more than 162 State homes across all 50 states and Puerto Rico, totaling over 30,000 beds. They provide skilled nursing care, domiciliary care, and adult day health care (ADHC) to both veterans and non-veterans. Each State home is owned, operated, and managed by each State's government. In order to qualify for VA per diem payments, a State home facility must be formally recognized and certified by VA as meeting the requirements and standards (e.g., quality of life, quality of care, physical environment, etc.) necessary to receive such payments. After certification, VA reviews each State home annually to ensure continued compliance with VA's requirements and standards.

As it pertains to nursing home care, VA pays State homes a per diem for each eligible veteran who receives nursing home care from a State home. There are two types of per diem rates that VA may pay a State home for providing nursing home care: a basic rate for veterans who meet the State nursing home per diem eligibility criteria or a prevailing rate for certain veterans with service-connected disabilities for whom the State provides nursing home care pursuant to a State home care agreement (SHCA).

This rulemaking proposes changes that would affect the prevailing rate for nursing home care, not the basic rate.

II. Authority

VA has authority to pay State homes for providing nursing home care to eligible veterans under title 38 of the United States Code (U.S.C.), sections 1741 through 1745. Section 1745(a) sets forth VA's ability to enter into contracts or agreements with State homes to pay for nursing home care provided to eligible veterans within such homes. Section 1745(a)(2) further states that the payments by VA to State homes under such contracts or agreements shall be based on a formula, developed by the Secretary in consultation with the State home, to adequately reimburse the State home for the care.

Current § 51.41 of title 38 of the Code of Federal Regulations (CFR) implements VA's authority under section 1745 to enter into contracts or agreements with State homes for nursing home care provided to eligible veterans. Paragraph (a) provides that VA and State homes may enter into both contracts and agreements, but each veteran's care will be paid through only one of these two instruments. We are not proposing any changes to paragraph (a) in this rulemaking. Paragraph (b) addresses payment to State homes by VA when the State home provides care under a contract. We are not proposing any changes to paragraph (b) in this rulemaking. Paragraph (c) addresses payment to State homes by VA when the State home provides care under a SHCA. Specifically, paragraph (c) provides the formula for calculating the prevailing rate. We are proposing changes to paragraph (c) in this rulemaking by:

- Listing the current steps used to calculate the prevailing rate in subparagraphs and labeling them.
- Establishing a baseline fiscal year from the current prevailing rate and the Market Basket rate.

- Adding an additional step of applying the Market Basket rate to track with increased costs in a new subparagraph.
- Revising the note.
- Making a few technical corrections (i.e., grammatic changes).

III. Current § 51.41(c)(1): Formula Used to Calculate Prevailing Rates

Currently, the prevailing rate is specific to each State home and is published each year on VA's website. Veterans Affairs, *Geriatrics and Extended Care*, https://www.va.gov/geriatrics/pages/State_Veterans_Home_Program_per_diem.asp, last updated October 6, 2022. The prevailing rate is based on Centers for Medicare and Medicaid Services (CMS) case-mix levels. A case-mix is a classification system; the distribution of patients into categories reflecting differences in severity of illness or resource consumption. Centers for Medicare and Medicaid Services, *Glossary,* https://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English, last modified May 14, 2006. VA began using two CMS case-mix data sets in 2013: Resource Utilization Groups (RUG), which applies to metropolitan areas, and Skilled Nursing Facility Prospective Payment System (SNF-PPS), which applies to rural areas. See 77 FR 72738 (December 6, 2012).

Current § 51.41(c)(1) outlines the formula for calculating payments. The first step is to determine whether the RUG or SNF-PPS case-mix level applies. The next step is to compute the daily rate for each State home by following this formula:

- Multiply the labor component by the State home wage index for each of the applicable case-mix levels.
- Add to that amount the non-labor component.
- Divide the sum of the results of these calculations by the number of applicable case-mix levels.

- Add to this quotient the amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, then multiplied by 12, then divided by the number of days in the year.

The current note to § 51.41(c)(1) further explains, in pertinent part, that the amount calculated under this formula reflects the prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-VA nursing home.

IV. Changes to the CMS Case-mix Classification System

In July 2018, CMS finalized a new case-mix classification system, the Patient Driven Payment Model (PDPM), which replaced the RUG and SNF-PPS case-mix classification systems. It became effective on October 1, 2019. Centers for Medicare and Medicaid Services, *Patient Driven Payment Model Overview*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM, last modified July 29, 2022. As a result of changes by CMS to their case-mix classification systems (RUG and SNF-PPS), VA is now revising its payment formula in § 51.41(c)(1).

Consistent with the requirement in 38 U.S.C. 1745(a)(2) to consult with State homes in developing the payment formula for nursing home care provided through SHCAs, VA consulted with the National Association of State Veterans Homes (NASVH) in June of 2019 on whether VA should adopt CMS's PDPM formula, or if not, what formula should be utilized. VA, (2019), *Prevailing Rate Consultation State Home Per Diem (SHPD)*. Denver, CO. VA and NASVH agreed that it would not be appropriate to use the PDPM formula. Primarily, VA will not adopt the PDPM formula because this formula is focused on incentivizing providers to take on new patients, which is not an issue VA faces with State homes that provide nursing home care. An additional reason is that the PDPM model is specific to the needs of CMS facilities, rather than State homes. For example, under Medicare, CMS only pays for the first 100 days of skilled nursing home care. After which, the patient's care must be paid for by another source (i.e., private, insurance, Medicaid), or the patient is discharged. This does not apply to State homes. In many cases, State homes provide nursing home care to our veterans for the remainder of their lives.

Further, 31 percent of the State homes that provide nursing home care to eligible veterans are not subject to the CMS PDPM formula as they are not certified by CMS and do not receive CMS payments. After consultation with NASVH, VA determined to instead propose revising the current formula as explained further below.

V. Changes to the Prevailing Rate

We propose to keep the current formula described in § 51.41(c)(1) to create a baseline rate and then add, at the end, a provision for using the CMS Skilled Nursing Facilities (SNF) Market Basket increase to account for annual increases that will reflect price inflation facing providers in the provision of medical services. The CMS SNF Market Basket increase rates are published in the *Federal Register* on an annual basis. In 2023, the CMS SNF Market Basket rate increase was 5.1% percent. See 87 FR 47502 (August 3, 2022).

The CMS SNF Market Basket is a fixed-weight index. Generally, a market basket is a group of products designed to track the performance of a specific market segment and determine inflation levels. Thus, the CMS SNF Market Basket increase measures the price changes of a permanent mix of goods and services used by nursing homes between two set dates. They are used to update payments and cost limits in the various CMS payment systems and reflect price inflation facing providers in the provision of medical services. Centers for Medicare and Medicaid Services, *Market Basket Definitions and General Information*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf.

VA believes that the CMS SNF Market Basket rate would more accurately reflect actual costs than would an alternate method such as a component of the Consumer Price Index (CPI). The CMS SNF Market Basket rate is adjusted annually based on price changes in goods and services specifically identified as being utilized in nursing home care, while other measures such as the CPI reflect price changes in goods and services in the general medical services field.

VI. Rates for Fiscal Year (FY) 2020 through 2023

CMS's new payment model PDPM became effective in FY 2020. Therefore, we established an agreement with CMS to obtain average market basket data needed to continue providing an annual per diem rate until this rulemaking is finalized. Thus, for FY 2020 through 2023, we have and will continue to use the average market basket data provided by CMS to calculate the per diem rate that we are currently using.

VII. Rates for FY 2024

We plan to use our new formula in FY 2024. In determining the baseline for this formula, we would use the rate for FY 2023 because we anticipate this rulemaking to be finalized and effective on or before October 1, 2023, which is the first day of FY 2024. If that changes due to delays in the rulemaking process, we will ensure that we receive the necessary CMS data to continue our current formula until the rule becomes effective, and we will ensure the correct FY used for the baseline is appropriately and accurately referenced in the amended regulation.

VIII. Regulation Text Changes to § 51.41(c)

First, we propose a nonsubstantive revision of changing the title of § 51.41(c) from “*Payments under State home care agreements*.” to “*Payments for nursing home care under State home care agreements*.” This change clarifies that subparagraph (c) only applies to State nursing homes.

We also propose to revise § 51.41(c) by making the term “agreements” in State home care agreements singular to ensure consistency with 38 U.S.C. 1745, and with revisions of 38 CFR part 51. 83 FR 61250 (November 28, 2018). Thus, we would revise the sentence that currently states, “State home care agreements under this section will provide for payments at the rate determined by the following formula” to instead state “A State home care agreement for nursing home care under this section will provide for payments at the rate determined by the following formula.”

We also propose to reorganize § 51.41(c)(1) by breaking apart the steps of the formula and putting them into a list for easier readability. The steps will be listed in proposed § 51.41(c)(1)(i) through (ii).

Section 51.41(c)(1)(i) would require that one would determine which case-mix applies, the RUG or SNF-PPS. We also propose to change the name of the case-mix level used for rural areas in § 51.41(c)(1)(i). Currently, it states Skilled Nursing Prospective Payment System. We propose to change it to Skilled Nursing Facility Prospective Payment System. The word “facility” was evidently left off through an inadvertent oversight since the rulemaking that placed this name in the regulation did not explain an intended deviation from the proper title. By making this correction, the name will align with the name that CMS uses.

Proposed § 51.41(c)(1)(ii) would require that one compute the daily rate for each State home, using the formula described above. The formula would be listed in proposed paragraphs (c)(1)(ii)(A) through (E). As previously explained, paragraphs (c)(1)(ii)(A) through (D) are substantively identical to the current formula, but merely listed out for ease of readability.

Proposed paragraph (c)(1)(ii)(E) would include the new calculation to the formula and would provide that one would multiply the current per diem baseline by the CMS SNF Market Basket increase in effect as of the fiscal year in which the final rule becomes effective to obtain the reference total per diem baseline rate from which subsequent fiscal year per diem rates will be calculated. For calculation of SNF per diem rates for subsequent fiscal years VA will apply the CMS SNF Market Basket increase to the total per diem baseline each year.

Lastly, we propose to amend the note in § 51.41(c) by clarifying that the first sentence is applicable to State homes. Additionally, we propose to add a sentence stating that the amount calculated under the new formula applies to both new and existing facilities with SHCAs.

IX. Technical and Grammatic Corrections to Part 51

We also propose to correct technical errors in 38 CFR 51.70 and 51.300. Section 51.70(n) erroneously refers to § 51.110(d)(2)(ii); however, the reference should be to § 51.110(e)(2)(ii). Therefore, we propose to revise § 51.70(n) by removing "51.110(d)(2)(ii)" and in its place inserting "51.110(e)(2)(ii)".

Section 51.110(d) refers to Version 2.0 of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set. The reference should be Version 3.0 as noted in § 51.110(b)(1). The prior amendment stated the change and explained the rationale. 77 FR 26183 (May 3, 2012). We propose to correct this inadvertent oversight by changing “Version 2.0” to “Version 3.0” in § 51.110(d).

Section 51.300(d)(3) refers to paragraphs (a)(2)(i) through (vii) of this section. However, the reference should be to paragraphs (d)(2)(i) through (vii), which lists the circumstances requiring the documentation to which paragraph (d)(3) refers. We propose to revise § 51.300(d)(3) by removing “(a)(2)(i) through (vii)”, and in its place inserting “(d)(2)(i) through (vii)”.

Executive Orders 12866 and13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is not a significant regulatory action under Executive Order 12866.

VA’s impact analysis can be found as a supporting document at https://www.regulations.gov, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its Regulatory Impact Analysis (RIA) are available on VA’s website at https://www.va.gov/orpm/, by following the link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601-612). The rulemaking would revise the formula VA uses to calculate the per diem it pays State homes for nursing home care of certain veterans. The effect of the rule would be to change VA payments to State homes. Therefore, this rule only affects veterans and State homes.

All State homes are owned, operated, and managed by State governments, except for a small number operated by entities under contract with State governments. Neither these contractors nor State governments are small entities as defined in 5 U.S.C. 601. State homes subject to this proposed rulemaking are State homes that are currently under a State home care agreement, those that enter into a new agreement, and any facility that begins an agreement for the first time. The effect of the rule would impose no direct costs on the State homes. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, or tribal governments, or on the private sector.

Paperwork Reduction Act

Although this action relates to provisions constituting collections of information at 38 CFR 51.41, under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521), no new or proposed revised collections of information would be associated with this proposed rule. The information collection requirements for § 51.41(e) are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control numbers 2900-0091 and 2900-0160.

List of Subjects in 38 CFR Part 51

Administrative practice and procedure; Claims; Adult Day Health Care; Domiciliary, Dental health; Government contracts; Grant programs-health; Grant programs-veterans; Health care; Health facilities; Health professions; Health records; Mental health programs; Nursing homes; Reporting and recordkeeping requirements; Travel and transportation expenses; Veterans.

Signing Authority:

Denis McDonough, Secretary of Veterans Affairs, approved this document on December 13, 2022, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulation Development Coordinator

Office of Regulation Policy & Management,

Office of General Counsel,

Department of Veterans Affairs.

For the reasons described in the preamble, Department of Veterans Affairs proposes to amend 38 CFR part 51 as follows:

PART 51 – PER DIEM FOR NURSING HOME, DOMICILIARY, OR ADULT DAY HEALTH CARE OF VETERANS IN STATE HOMES

1. The authority citation for part 51 continues to read as follows:

Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1743, 1745, and as follows.

* * * * *

2. In § 51.41 revise the introductory text of paragraph (c) and paragraph (c)(1) and the Note under paragraph (c)(1) to read as follows:

<u>§ 51.41 Contracts and State home care agreements for certain veterans with service-connected disabilities.</u>

* * * * *

(c) *Payments for nursing home care under State home care agreements*.

(1) State homes must sign an agreement to receive payment from VA for providing care to certain eligible veterans under a State home care agreement. A State home care agreement for nursing home care under this section will provide for payments at the rate determined by the following formula.

(i) Determine whether the Resource Utilization Groups (RUG) or Skilled Nursing Facility Prospective Payment System (SNF-PPS) applies.

For State Homes in a metropolitan statistical area, use the published fiscal year Centers for Medicare and Medicaid Services (CMS) RUG case-mix levels for the applicable metropolitan statistical area.

For State Homes in a rural area, use the published fiscal year CMS SNF-PPS case-mix levels for the applicable rural area.

(ii) Compute the daily rate for each State home, using the following formula in the order described:

(A) Multiply the labor component by the State home wage index for each of the applicable case-mix levels.

(B) Add to that amount the non-labor component.

(C) Divide the sum of the results of these calculations by the number of applicable case-mix levels.

(D) Add to this quotient the amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, then multiplied by 12, then divided by the number of days in the year. The resulting sum is the per diem baseline rate for the State home.

(E) Multiply the per diem baseline rate from the previous year by the CMS Skilled Nursing Facilities (SNF) Market Basket increase in effect as of [Date 30 days after date of publication of Final Rule in the FEDERAL REGISTER]. The sum establishes the reference total per diem baseline rate from which subsequent fiscal year per diem rates will be calculated. For calculation of SNF per diem rates for subsequent fiscal years VA will apply the CMS SNF Market Basket increase to the total per diem each year.

NOTE TO PARAGRAPH (c)(1): The amount calculated under this formula reflects the prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a State home. The amount calculated under this formula applies to both new and existing facilities with State home care agreements.

Further, the formula for establishing these rates includes CMS information that is published in the *Federal Register* every year and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.

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§ 51.70 [Amended]

3. In § 51.70(n), removing the term “51.110(d)(2)(ii)”, and adding in its place, the term “51.110(e)(2)(ii)”.

§ 51.110 [Amended]

4. In § 51.110(d), removing the term “Version 2.0”, and adding in its place, the term “Version 3.0”.

§ 51.300 [Amended]

5. In § 51.300(d)(3), removing the term “(a)(2)(i) through (vii)”, and adding in its place, the term “(d)(2)(i) through (vii)”.

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