Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs); Updates to the Value-Based Purchasing Program for FY 2021 [CMS-1737-F]
Summary of Final Rule

On July 31, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating for fiscal year (FY) 2021 the Medicare skilled nursing facility (SNF) payment rates and the SNF Value-Based Purchasing Program (VBP). It will be published in the *Federal Register* on August 5, 2020. The final rule updates the federal per diem rates under the SNF Prospective Payment System (SNF PPS) by 2.2 percent; updates the wage areas with a transition that limits wage index reductions to 5 percent for FY 2021; modifies the ICD-10 code mappings for patient classification; and makes updates to the SNF VBP Program. No changes are made to the SNF Quality Reporting Program (SNF QRP) or to the Patient Driven Payment Model (PDPM) patient classification methodology.

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I. Background on the SNF PPS

CMS reviews relevant statutory and regulatory history, including the Protecting Access to Medicare Act (PAMA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. PAMA required the Secretary to establish a Value-Based Purchasing (VBP) Program for Medicare SNFs. The IMPACT Act required the Secretary to implement a quality reporting program for SNFs and requires SNFs to report standardized data for specified quality and resource use domains. CMS also notes that Section 1888(e)(4) of the Social Security Act (the Act) requires that the SNF PPS be updated annually and that certain elements be published in the *Federal Register* including the unadjusted federal per diem rates for covered SNF services, the applicable case-mix classification system, and the factors to be applied in making the area wage adjustment for these services.

Beginning in FY 2020, CMS implemented a new case-mix classification system to classify SNF patients under the SNF PPS, the PDPM (83 FR 39162). While the previous RUG-IV classification model primarily used the volume of therapy services provided to the patient as the basis for payment, PDPM classifies patients into payment groups based on specific, data-driven patient characteristics. CMS notes that it continues to monitor the impact of PDPM implementation on patient outcomes and program outlays. It hopes to release information on these issues in the future when more data are available.

In the proposed rule, CMS invited stakeholders to comment on any observations or information related to the impact of PDPM implementation on providers or on patient care. CMS does not indicate receipt of any such comments.

II. SNF PPS Rate Setting Methodology and FY 2021 Update

A summary of key data for the SNF PPS for FY 2021 is presented below with additional details provided in the subsequent sections.

Summary of Key Data under SNF PPS for FY 2021		
Market basket update factor		
Market basket increase		+2.2%
Forecast error adjustment for FY 2018		0.0%
Required multifactor productivity (MFP) adjustment		0.0%
Net MFP-adjusted update		**+2.2%**
Wage index budget neutrality adjustment		0.9992
Labor-related share		71.3%
Final FY 2021 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$62.04	$70.72
Occupational Therapy	$57.75	$64.95
Speech-Language Pathology	$23.16	$29.18
Nursing	$108.16	$103.34
Non-Therapy Ancillaries	$81.60	$77.96
Non-case mix adjusted	$96.85	$98.64

A. Federal Base Rates

CMS reviews the historical process used for setting the initial federal base rates, which were established for implementation of the SNF PPS beginning July 1, 1998. These rates have been updated for inflation and other factors through subsequent rulemaking and statutory requirements.

B. SNF Market Basket Update

CMS finalizes a market basket increase for FY 2021 of 2.2 percent based on the second quarter 2020 forecast from IHS Global Insight, Inc.(IGI), with historical data through the first quarter of

2020. The forecast addresses the percentage increase in the FY 2014-based SNF market basket index for routine, ancillary, and capital-related expenses.

The 2.2 percent final market basket forecast is substantially below the 2.7 percent included in the proposed rule, which was based on IGI's first quarter 2020 forecast, with historical data through fourth quarter 2019. CMS notes the lower forecast is primarily the result of slower growth in compensation for both health-related and other occupations, as labor markets are expected to be significantly impacted by the recession that began in February 2020.

No adjustment to the market basket update is made to account for forecast errors in previous market basket estimates. The most recent year for which actual data are available is FY 2019. The forecast FY 2019 market basket increase was 2.75 percent and the actual increase was 2.34 percent. The difference between the estimated and actual amount of change in the market basket index was 0.41 percent and does not exceed the previously adopted 0.5 percentage point threshold for making the adjustment. Moreover, CMS states that it would be inappropriate to apply a forecast error adjustment because the FY 2019 market basket update of 2.4 percent was set by statute (section 53111 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123)).

The final multifactor productivity (MFP) adjustment is 0.0, a notable change from the proposed rule, which included an adjustment of -0.4 percentage points. For the final rule, CMS uses the most recent available forecast for the 10-year moving average of changes in MFP for the period ending September 30, 2021. That forecast, from June 2020, is -0.1, which if subtracted from the market basket would result in a +0.1 percentage point addition to the SNF update factor. The statute does not allow for a positive MFP adjustment; therefore the final rule includes an adjustment of 0.0 percentage points. CMS notes that it is not using IGI's second quarter 2020 MFP forecast, which is usually would do for the final rule MFP as well as for the market basket forecast. That forecast would have resulted in an MFP adjustment for FY 2021 of -0.7 percentage points. The large difference in the second quarter and June MFP forecasts is atypical and due to the unprecedented economic uncertainty associated with the COVID-19 pandemic. (The MFP forecasts are available monthly, whereas the market basket forecast is only updated quarterly. The most recent market basket forecast available for the final rule is the second quarter 2020 forecast.)

Taking these elements together, the resulting final SNF market basket update equals 2.2 percent. CMS also applies a 2.0 percentage point reduction to the SNF market basket percentage changes for SNFs that do not satisfy the reporting requirements for the FY 2021 SNF QRP. CMS explains that this is derived by subtracting 2.0 percentage points from the MFP-adjusted market basket update of 2.2 percent resulting in a positive 0.2 percentage point update for FY 2021.

Using the final MFP-adjusted update, CMS finalizes FY 2021 unadjusted federal rates for each component of the payment for urban and rural areas. Tables 3 and 4 in the final rule, summarized in the table above, present the per diem rates for FY 2021. Under the PDPM case-mix classification system, the unadjusted federal per diem rates are divided into six components. Five of these are case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). The remaining component is a non-case-mix component, as existed under the previous RUG-IV

classification system. CMS further notes that elsewhere in final rule it adopts changes to the delineation of urban and rural areas for FY 2021. (See section IV.A of this summary.)

C. Case-Mix Adjustment

As noted earlier, CMS replaced its previous case-mix classification methodology, the RUG-IV model, with the PDPM effective October 1, 2019. The PDPM model was designed to classify patients into payment groups based on patient characteristics, rather than the volume of therapy services provided to patients, as done in the RUG-IV model. The FY 2021 payment rates reflect the use of the PDPM classification system from October 1, 2020 through September 30, 2021.

CMS lists the final case-mix adjusted PDPM payment rates for FY 2021, for urban and rural SNFs, in Tables 5 and 6 of the final rule (reproduced in an appendix to this summary); which reflects updated calculations from the proposed rule.

CMS notes that in future rulemaking it may reconsider the adjustments it made in the FY 2020 SNF PPS final rule to the case-mix weights used under PDPM to ensure budget neutrality in the implementation of the PDPM, and recalibrate these adjustments as appropriate.

D. Wage-Index Adjustment

The final rule continues application of the wage index adjustment to the labor-related portion of the federal rate using the pre-reclassified IPPS hospital wage data, without applying the occupational mix, the rural floor, or outmigration adjustments, as the basis for the SNF PPS wage index. For FY 2021, CMS uses updated wage data for hospital cost reporting periods in FY 2017. Responding to comments suggesting that SNF wage data be used instead, CMS notes that to use wage data from SNF cost reports would require audits that would burden SNFs and require a commitment of resources from CMS and the Medicare Administrative Contractors that is not feasible at this time.

Elsewhere in this final rule, CMS adopts revisions to the Office of Management and Budget (OMB) area delineations for purposes of the FY 2021 SNF wage index, and will apply a 5 percent cap on any decrease in a hospital's wage index for FY 2021 compared with its FY 2020 wage index. The wage index budget neutrality adjustment applies. (See section IV.A of this summary.)

CMS notes that that wage index tables are available exclusively through the CMS website, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. The final rule table shows, by county, the FY 2020 and FY 2021 wage area assignment as well as the FY 2021 wage index, including the application of the proposed 5 percent cap on decreased wage index values. The wage index adjustment is applied to the labor-related share. CMS uses a four-step process to trend forward the base year (2014) weights to FY 2021 price levels. This process includes computing the FY 2021 price index level for the total market basket and each cost category of the market basket. Based on this update, the final FY 2021 SNF labor-related share is 71.3 percent, compared with to a FY 2020 final labor-related share of 70.9 percent. Table 7 in the final rule summarizes the labor-related share for FY 2021 (based on the IGI

second quarter 2020 forecast) compared with FY 2020 for each of the cost categories.

In order to calculate the labor portion of the case-mix adjusted per diem rate, one would multiply the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies, and the non-case mix component rate, by the FY 2021 labor-related share percentage. CMS notes that in prior years, it has provided the labor and non-labor related shares of case-mix adjusted payments for urban and rural SNFs. Under PDPM, however, the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and thus would provide a large volume of possible combinations making it not feasible to provide tables similar to those that have existed in prior rulemaking. Instead, Tables 8, 9, and 10 of the final rule illustrate how payment will be calculated during FY 2021 under PDPM for a hypothetical 30-day SNF stay.

III. Additional Aspects of the SNF PPS

A. SNF Level of Care: Administrative Presumption

CMS continues to use an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the 5-day Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment. CMS notes that a beneficiary who does not qualify for the presumption is not automatically classified as either meeting or not meeting the level of care definition, but instead receives an individual determination on this point using the existing administrative criteria.

In the 2019 SNF PPS final rule, CMS finalized the designation of the following classifiers for purposes of applying the administrative presumption under the PDPM:

- The case-mix classifiers in the following nursing categories: Extensive Services, Special Care High, Special Care Low, and Clinically Complex;
- The following PT and OT classifiers: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- The following SLP classifiers: SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost comorbidity group (which is finalized as 12+).

CMS stresses that 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. For example, the presumption would not apply in a situation where the sole classifier that triggers the presumption is itself assigned through the receipt of services that are subsequently determined to be not reasonable and necessary. Further, CMS emphasizes careful monitoring is emphasized for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the ARD of the initial Medicare assessment.

B. Consolidated Billing

The consolidated billing requirements for SNFs are reviewed, including billing for physical therapy, occupational therapy, and speech-language pathology services that the resident receives

during a non-covered stay. CMS also reviews the specific exclusions from that requirement that remain separately billable, including several "high cost, low probability" services identified by Healthcare Common Procedure Coding System (HCPCS) codes, within four categories:

- Chemotherapy items;
- Chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

CMS further notes that the codes targeted for exclusion from consolidated billing represent events that could have significant financial impacts because their costs far exceed SNF PPS payments.

In the proposed rule, CMS invited commenters to identify specific HCPCS codes in any of the four service categories representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. These comments are discussed in the final rule; no new exclusions are finalized. Suggestions from commenters involved antiviral, antibiotic, and other expensive non-chemotherapy drugs; certain Part D-only oral chemotherapy drugs; and portable X-ray services. In the case of the non-chemotherapy drugs and portable X-ray services, CMS responds that the statute does not allow it to expand the exclusion categories to include these items. With respect to part D-only drugs, CMS points out that because these are not covered under Part B there is no basis for exclusion from consolidated billing.

C. Payment for SNF-level Swing-bed Services

CMS discusses the statutory requirement that critical access hospitals (CAHs) continue to be paid on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement while all non-CAH swing-bed rural hospitals continue to be paid under the SNF PPS. As discussed in the FY 2019 SNF PPS final rule, revisions were made to the swing-bed assessment to support implementation of PDPM. The latest changes in the MDS for swing-bed rural hospitals can be found at the SNF PPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.

In response to a comment suggesting that SNFs are disadvantaged by exemption of the swing-bed services of CAHs from the SNF PPS when both facilities are offering comparable services in an area, CMS reiterates that there was no differential until the Congress enacted the exemption as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554).

D. Changes to Regulatory Text

Changes are finalized to the regulatory text in two places as follows:

First, the regulatory text at §409.35(a) is modified to eliminate an outdated example that referenced outpatient therapy caps. Second, a minor technical correction is made to the regulation text in §413.114(c)(2) to remove an erroneous cross-reference and replace it with the correct cross-reference to the regulations on reasonable cost reimbursement at §413.53(a)(1).

IV. Other Issues

A. Changes to the SNF PPS Wage Index

CMS relies on OMB designations of Metropolitan and Micropolitan Statistical Areas[1] for purposes of establishing wage areas used for the SNF wage index, and in this rule, changes are adopted to wage index areas. Specifically, the FY 2021 SNF wage index reflects changes included in OMB Bulletin No. 18-04, issued on September 14, 2018. That bulletin is available at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf. Further, CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01—available on the web at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf—but it was not issued in time for development of the proposed rule. CMS plans to assess the changes in that latest bulletin and propose adoption of any updates in the FY 2022 SNF PPS proposed rule.

Adoption of the changes included in OMB Bulletin No 18-04 creates new Core Based Statistical Areas (CBSAs), changes 34 urban counties to rural, changes 47 rural counties to urban, and splits some existing CBSAs. Tables 11, 12, and 14 in the final rule detail these substantive changes; Table 13 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index.

CMS reports that adoption of the changes in OMB Bulletin No. 18-04 lowers the wage index for 42 percent of SNFs with just over 2 percent of SNFs experiencing a decrease of more than 5 percent; 54 percent of SNFs have higher area wage index values after adopting the revised OMB delineations. One example offered is that SNFs currently located in CBSA 35614 (New York-Jersey City-White Plains, NY-NJ) are now assigned to new CBSA 35154 (New Brunswick-Lakewood, NJ) resulting in a nearly 17 percent decrease in the wage index.

To mitigate the negative impact of these changes in the wage index, CMS adopts its proposal to provide for a 5 percent cap on decreases in any SNF's wage index for FY 2021 when compared to FY 2020. The cap provides a transition to the new wage index areas; no cap will be applied beginning in FY 2022. Readers are referred to the wage index table (link provided in section II.D above) which shows the wage index for the area for FY 2021.[2]

A final wage index budget neutrality adjustment of 0.9992 is applied to the unadjusted federal per diem rates for FY 2021 so that the changes in the wage index – including the proposed 5 percent cap on decreases – do not effect aggregate payments to SNFs. To calculate the budget neutrality adjustment, CMS estimates aggregate SNF PPS payments using the FY 2020 wage

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[1] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. Under previously adopted policies, CMS treats these as rural areas for purposes of the hospital and SNF wage indexes.

[2] The final rule refers readers to wage index Table A, which at the time this summary was prepared is not included at the link provided. The one table provided includes the FY 2021 wage index, by county, and shows the previous and current wage area assignment for the county.

index values and FY 2019 SNF PPS claims data and then aggregate payments using the FY 2021 wage index values (including the cap) and the same utilization data. The ratio of the amount based on the FY 2020 index to the amount estimated using the 2021 index is the budget neutrality adjustment to be applied to the unadjusted federal per diem rates for FY 2021.

Responding to a comment from the Medicare Payment Advisory Commission, CMS disagrees with the suggestion that the 5 percent cap also be applied to increases in the wage index. It believes that the purpose of the transition policy is to mitigate the negative impacts of the changes to wage areas, not curtail the positive effects. It views increases in the wage index as a sign that providers in that area are currently being paid less than their reported wage data suggests is appropriate.

With respect to other comments supporting a longer transition period, CMS believes that its now finalized policy appropriately balances mitigation of negative effects of changes in the wage areas with the importance of payment accuracy.

B. Technical Updates to PDPM ICD-10 Mappings

The PDPM utilizes ICD-10 codes to assign patients to clinical categories in the physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) components and to assign certain comorbidities for classification under the SLP and non-therapy ancillary (NTA) components. The ICD-10 mappings and lists used under the PDPM are available on the PDPM website at https://www.cms.gov/MEdicare/Medicare-Fee-for-Service-Payment/SNFPPS?PDPM.html.

In the FY 2020 SNF PPS final rule (84 FR 38750), CMS outlined the process it will use to update any ICD-10 code mappings and lists used under PDPM, as well as the SNF GROUPER software and other products related to patient classification and billing. Beginning with the FY 2020 updates, nonsubstantive changes to the ICD-10 codes were updated through a subregulatory process and substantive revisions proposed and finalized through notice and comment rulemaking.

- Nonsubstantive changes are changes that are necessary to maintain consistency with the most current ICD-10 medical code data set.
- Substantive changes are changes that goes beyond the intention of maintaining consistency with the most current ICD-10 medical code data set.

CMS notes that changes to the assignment of a code to a comorbidity or other changes that amount to a change in policy would be a substantive change. An example of a substantive change would be the separation of an ICD-10 code for a particular condition into two or more codes when one code represents a condition that is predictive of the costs of care in a SNF and one which is not predictive of the costs of care.

CMS proposed several changes to the PDPM ICD-10 code mappings and lists on the SNF PDPM website. Highlights of the changes to the PDPM ICD-10 code mappings, including modifications to the proposals, are summarized below. The final rule provides more specific details.

Mapping Certain Cancers with a Major Procedure. CMS finalizes the addition of certain cancer codes to the surgical clinical category "May be Eligible for the Non-Orthopedic Surgery Category" or "May be Eligible for One of the Two Orthopedic Surgery Category" when a major procedure is identified on the MDS.

CMS does not agree with a commenter's suggestion to add Z48.29 "aftercare following other organ transplant" to the list of surgical options and notes that Z48.29 is not a valid code because it requires an additional digit. CMS notes that ICD-10 coding guidance states that a code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character if applicable.[3] CMS also does not agree with another suggestion to add Z48.89 "encounter for other specified surgical aftercare" because this code provides inadequate information about the type of surgery performed.

CMS agrees with a commenter that it is appropriate to include ICD-10 code C410 "Malignant neoplasms of skull and face" in the "May be Eligible for One of the Two Orthopedic Surgery Categories". CMS notes that both orthopedic and non-orthopedic surgeries are possible in cases involving neoplasms of facial bones and that non-orthopedic surgery is more common. The current PDPM grouper design only allows a code to be either orthopedic or non-orthopedic and classification in the orthopedic surgery group results in a higher per diem rate than the non-orthopedic group. CMS plans to monitor the use of the orthopedic classification.

CMS agrees with a commenter's suggestion to add additional secondary malignant (metastatic) ICD-10 codes to the surgical clinical options but it does not agree with the suggestion to add these codes to the SLP comorbidities list. CMS acknowledges that SLP treatment can help patients adjust to the changes in their mouth after surgery, chemotherapy, or radiation but it does not think that secondary codes related to respiratory and digestive organs generally need SLP treatment.

COVID-19. Multiple commenters requested that CMS evaluate the cost of personal protective equipment, staff time, and resources associated with caring for COVID-19 patients; several commenters requested CMS add an NTA category for pandemic/epidemic type infection that would allow for timely reimbursement and allow adding new ICD-10-CM codes for COVID-19 to the code mappings. A commenter suggested CMS add the COVID-19 diagnosis code U07.1 to the NTA comorbidities mapping list and another commenter suggested the use of ICD-19 code U07.2 (suspected COVID-19) as an alternative method to document treatment for COVID-19, to eliminate delays where a patient is being treated for COVID-19 but testing is limited.

In response, CMS refers readers to the COVID-19 coding guidelines established by the CDC;[4] CDC has not yet adopted the use of code U07.2. CMS notes that it currently does not have enough post-April data to estimate the costs of COVID-19 in the NTA component and may consider this in future rulemaking. Additional suggestions by commenters, including substantive

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[3] https://www.cms.gov/Medicare/Coding/ICD10?Dpwnloads/2020-Coding-Guidelines.pdf.

[4] https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf?fbclid=IwAR06h6zP8KkehNzjEqlpGvACzMBhP26Khp9WG1JqbfLUQpYOt_LCqwGVHxU

changes to the ICD-10 code mappings and lists, are outside the scope of this rulemaking and might be considered in future rulemaking.

Comments outside the scope of this rulemaking. Several commenters suggested additional changes to the ICD-10 code mappings and comorbidity lists that were outside the scope of this rulemaking. CMS will consider these suggestions in the future as appropriate.

C. SNF Value-Based Purchasing Program

The SNF VBP Program began implementation for discharges beginning in FY 2019. Measures for the program were adopted in the FY 2016 and 2017 SNF PPS final rules. These rules also gave an overview of statutory requirements, finalized a performance scoring methodology, and addressed other topics. In the FY 2018 final rule, CMS adopted additional requirements for the SNF VBP Program, and codified policies in regulations at §413.338, In the FY 2019 final rule, more policies were adopted including a scoring adjustment for low-volume facilities.

The measures that have been adopted are the SNF 30-Day All-Cause Readmission Measure (SNFRM) and the Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge (previously named the SNF 30-Day Potentially Preventable Readmission Measure, or (SNFPPR). As required by statute, CMS intends to replace the SNFRM with the SNF Potentially Preventable Readmissions after Hospital Discharge measure as soon as is practicable. Toward that end, CMS intends to submit the Potentially Preventable Readmissions after Hospital Discharge measure it to the National Quality Forum (NQF) for review during the fall 2021 cycle, and will assess transition timing for the measure replacement after NQF endorsement review is complete. More information on the SNF VBP Program can be found on the CMS web page https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.html.

1. Change in Measure Name -- Technical Change to Regulatory Text

In a purely technical change, CMS corrects the definition of "SNF Readmission Measure" under 42 CFR 413.338(a)(11) to refer to the SNF Potentially Preventable Readmissions after Hospital Discharge measure. The name of the measures was changed in the FY 2020 SNF PPS final rule.

2. Performance Standards, and Performance and Baseline Periods

Under previous established policy, the performance period for the FY 2023 SNF VBP program year will be FY 2021, and the baseline period will be FY 2019. No changes to the policy for annually updating these periods were proposed. No changes were proposed to the previously adopted numerical performance standards (achievement level or benchmark) for FY 2021 or to the policy authorizing CMS to make corrections to the numerical values if there is an error that affects the achievement threshold or benchmark (83 FR 39276 through 39277).

CMS finalizes its proposal to codify its previously adopted policy regarding corrections by amending the definition of "Performance standards" at §413.338(a)(9) to state that beginning with the performance standards that apply to FY 2021, if CMS discovers an error in the performance standard calculations subsequent to publishing their numerical values for a fiscal year, it will

update the numerical values to correct the error. If CMS subsequently discovers one or more other errors with respect to the same fiscal year, CMS will not further update the numerical values for that fiscal year.

The final numerical performance standards for FY 2023 for the SNF 30-Day All-Cause Readmission Measure (NQF #2510) are shown in Table 15 of the final rule and consist of an achievement threshold of 0.79270 and a benchmark of 0.83028.

3. SNF VBP Performance Scoring

No changes are made to the SNF VBP Program performance scoring methodology.

4. SNF Value-Based Incentive Payments

Readers are referred to the FY 2018 SNF PPS final rule (82 FR 36616-36621) for a description of the exchange function methodology adopted for the SNF VBP Program under which CMS calculates the incentive payment adjustments from the performance scores. In general, the SNF VBP Program takes 2.0 percent of the payments that would be made to SNFs and redistributes 60 percent of this total based on VBP performance measures. The other 40 percent is savings to the Medicare program.

No changes are made to this methodology.

CMS' analysis of historical data shows that the SNF VBP Program incentive payment multipliers appear relatively consistent over time. Therefore, it believes that the FY 2020 payment results represent the best estimate of facility performance in FY 2021. The SNF VBP Program Facility Performance data for FY 2020 is available at https://data.medicare.gov/Nursing-Home-Compare/FY-2020-SNF-VBP-Facility-Performance/284v-j9fz.

5. Public Reporting of SNF VBP Scores and Ranking

CMS previously finalized a policy under which it will publish measure performance information on the SNF VBP Program on *Nursing Home Compare* after SNFs have an opportunity to review and submit corrections. In the FY 2020 SNF PPS final rule, CMS modified the circumstances under which data on a SNF's performance will be suppressed from public display Specifically, CMS will suppress the SNF information available to display as follows:

- If a SNF has fewer than 25 eligible stays during the baseline period for a fiscal year but has 25 or more eligible stays during the performance period for that fiscal year, CMS will not publicly report the SNF's baseline period SNF readmission measure rate and improvement score for that fiscal year;
- If a SNF is a low-volume SNF with respect to a fiscal year, and therefore receives an assigned SNF performance score, the assigned score will not be displayed and the SNF;s performance period SNF readmission measure rate, achievement score and improvement score will not be displayed for the fiscal year.
- No information will be publicly reported for a SNF with zero eligible cases during a performance period.

In this rule, CMS codifies this policy (without changes) at §413.338(e)(3)(i), (ii), and (iii).

Further, §413.338(e)(3) is amended to reflect that SNF performance information will be publicly reported on the *Nursing Home Compare* website *or a successor website*. CMS announced plans for a website transition in January 2020 (https://www.cms.gov/blog/making-it-easier-compare-providers-and-care-settingsmedicaregov under which data from provider-specific sites will be merged into a "Medicare Care Compare" website. (The January announcement referred to 'later this year,' and the final rule provides no insight on a timeline.) CMS intends to communicate further with stakeholders and obtain feedback from them on this transition in the future.

6. Update to Phase One Review and Correction Deadline

In the FY 2020 SNF PPS final rule, CMS adopted a 30-day deadline for Phase One correction requests; the 30-day period begins on the date when CMS issues the June report which includes the measure rate and the underlying claims information used to calculate the measure rate. A SNF has 30 days from that date to submit a correction request if it believes any of that information is inaccurate. A SNF may also submit a correction request for any claims in which it discovers an error prior to the issuance of the June report.

In this rule, CMS finalizes its proposal to also apply the 30-day deadline to the baseline period quality measure report that it typically issues in December. This will begin with baseline period quality measure quarterly reports issued on or after October 1, 2020. SNFs will therefore have 30 days following issuance of the baseline or performance period reports to review the underlying claims and measure rate information and submit a correction request. CMS notes that although the baseline period information reports are typically issued in December, and the performance period information reports in June, the issuance dates could vary. A significant delay or shift in the dates of the reports will be communicated to SNFs through memos, emails, notices on the CMS SNF VBP website and other routine communications. The policy is codified §413.338(e)(1).

CMS notes that under this policy SNFs are not precluded from submitting correction requests prior to receipt of their quarterly report if they believe that an error has occurred, after reviewing data from earlier quarterly reports.

7. Impact Analysis of SNF VBP Program

CMS estimates that the total reduction in payments required under the statute for the SNF VBP Program (i.e., the 2.0 percent withhold) will total $528.6 million for FY 2021. The low-volume adjustment is estimated to return $11.9 million to SNFs in FY 2021, increasing the payback percentage from 60 percent to 62.25 percent and reducing the federal savings to $199.5 million.

In Table 17 of the final rule, reproduced below, CMS displays the estimated effects in FY 2021 of the SNF VBP Program by types of providers and location. The estimates are based on historical data (2016 base year and 2018 performance year.) Mean standardized readmission rates, and therefore performance scores and incentive multipliers, vary in particular by region.

TABLE 17: SNF VBP Program Estimated Impacts for FY 2021

Characteristic	Number of facilities	Mean SNFRM Risk-Standardized Readmission Rate (%)	Mean performance score	Mean incentive multiplier	Percent of total SNF Medicare Part A FFS payment after applying incentives
Group					
Total	15,201	19.67	27.7397	0.99251	100.00
Urban	10,893	19.72	26.6713	0.99205	84.98
Rural	4,308	19.55	30.4412	0.99367	15.02
Hospital-based urban*	307	19.30	34.4100	0.99645	1.88
Freestanding urban*	10,545	19.73	26.4063	0.99191	83.07
Hospital-based rural*	208	19.15	38.7270	0.99781	0.49
Freestanding rural*	3,888	19.56	29.9215	0.99346	14.36
Urban by region					
New England	752	19.76	25.4730	0.99151	5.48
Middle Atlantic	1,468	19.47	29.2070	0.99355	16.07
South Atlantic	1,864	19.84	25.2768	0.99150	17.29
East North Central	2,087	19.82	24.5481	0.99085	13.66
East South Central	542	19.85	25.2002	0.99120	3.56
West North Central	927	19.72	27.2973	0.99194	4.10
West South Central	1,324	20.05	23.3211	0.98996	7.49
Mountain	527	19.11	34.3344	0.99643	3.68
Pacific	1,396	19.50	30.1656	0.99406	13.65
Outlying	6	20.16	17.5878	0.98708	0.00
Rural by region					
New England	129	19.13	32.5091	0.99497	0.67
Middle Atlantic	210	19.24	31.5817	0.99419	0.91
South Atlantic	493	19.72	27.3343	0.99248	2.22
East North Central	909	19.45	29.3109	0.99361	3.44
East South Central	515	19.81	26.1659	0.99182	2.33
West North Central	1,040	19.41	34.5946	0.99503	1.98
West South Central	708	20.02	25.6838	0.99105	2.21
Mountain	208	18.97	40.1353	0.99883	0.66
Pacific	95	18.53	43.9844	1.00106	0.60
Outlying	1	18.78	30.7950	0.98659	0.00

Characteristic	Number of facilities	Mean SNFRM Risk-Standardized Readmission Rate (%)	Mean performance score	Mean incentive multiplier	Percent of total SNF Medicare Part A FFS payment after applying incentives
Ownership					
Government	948	19.37	33.8732	0.99539	3.48
Profit	10,656	19.76	26.2134	0.99171	74.39
Non-Profit	3,597	19.48	30.6447	0.99414	22.13

* The group category which includes hospital-based/freestanding by urban/rural excludes 253 swing-bed SNFs.

V. Economic Analyses

CMS estimates that under the final rule, in FY 2021 SNFs will experience an increase of about $750 million in payments compared with FY 2020. This results from the SNF market basket update to the payment rates. CMS notes that this total does not incorporate the SNF VBP reductions and the proposed low-volume adjustment, which it estimates will reduce aggregate payments to SNFs by an estimated $200 million.

Table 16 of the final rule (reproduced below) shows the estimated impact of various elements of the final rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the market basket update and the updates to the wage index data and the OMB delineations, which are both implemented in a budget neutral manner. In general, CMS estimates that because of the wage index changes, payment rates for SNFs in rural areas as well as hospital-based urban SNFs would grow by more than the 2.2 percent overall increase.

TABLE 16: Impact to the SNF PPS for FY 2021

Provider Characteristics	# Providers	Update Wage Data	Update OMB Delineation	Total Change
Group				
Total	15,078	0.0%	0.0%	2.2%
Urban	10,951	0.0%	0.0%	2.2%
Rural	4,127	0.1%	0.1%	2.4%
Hospital-based urban	380	0.3%	0.1%	2.6%
Freestanding urban	10,571	0.0%	0.0%	2.2%
Hospital-based rural	245	0.1%	0.1%	2.4%
Freestanding rural	3,882	0.1%	0.1%	2.4%
	-			
Urban by region	-			
New England	775	-1.1%	-0.1%	1.0%
Middle Atlantic	1,470	0.9%	0.1%	3.2%
South Atlantic	1,868	-0.1%	-0.1%	2.0%
East North Central	2,118	0.0%	-0.1%	2.1%
East South Central	536	-0.3%	-0.1%	1.8%
West North Central	921	-0.7%	-0.1%	1.3%
West South Central	1,323	-0.1%	0.0%	2.1%
Mountain	527	-0.7%	0.0%	1.5%
Pacific	1,407	0.0%	0.1%	2.2%
Outlying	6	0.0%	-0.1%	2.1%

Provider Characteristics	# Providers	Update Wage Data	Update OMB Delineation	Total Change
	-			
Rural by region	-			
New England	126	0.1%	-0.1%	2.3%
Middle Atlantic	194	0.6%	-0.1%	2.8%
South Atlantic	462	-0.1%	0.2%	2.3%
East North Central	908	0.5%	0.1%	2.8%
East South Central	452	-0.2%	0.1%	2.1%
West North Central	1,020	-0.2%	0.1%	2.1%
West South Central	666	-0.1%	0.1%	2.2%
Mountain	207	-0.2%	-0.1%	1.9%
Pacific	92	1.0%	-0.1%	3.1%
	-			
Ownership	-			
For profit	10,729	0.0%	0.0%	2.2%
Non-profit	3,469	0.0%	0.0%	2.2%
Government	880	0.1%	0.1%	2.3%

Notes: The Total column includes the FY 2021 2.2 percent market basket increase factor.
No SNFs in were found in rural outlying areas.

Appendix: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes

CMS notes that under PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim in order to bill for covered SNF services. The first character of the HIPPS code represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group "TA", then the first character in the patient's HIPPS code would be an A. Similarly, if the patient is classified into the SLP group "SB", then the second character in the patient's HIPPS code would be a B. The third character represents the Nursing group into which the patient classifies. The fourth character represents the NTA group into which the patient classifies. Finally, the fifth character represents the assessment used to generate the HIPPS code.

Tables 5 and 6 in the final rule (recreated below) show the case-mix adjusted federal rates and associated indexes for PDPM groups for urban and rural SNFs, respectively. (Effects of the SNF VBP program are not included.) In each table, Column 1 represents the character in the HIPPS code associated with a given PDPM component. Columns 2 and 3 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant PT group. Columns 4 and 5 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant OT group. Columns 6 and 7 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant SLP group. Column 8 provides the nursing case-mix group (CMG) that is connected with a given PDPM HIPPS character. For example, if the patient qualified for the nursing group CBC1, then the third character in the patient's HIPPS code would be a "P." Columns 9 and 10 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant nursing group. Finally, columns 11 and 12 provide the case-mix index and associated case-mix adjusted component rate, respectively, for the relevant NTA group.

TABLE 5: 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	$94.92	1.49	$86.05	0.68	$15.75	ES3	4.06	$439.13	3.24	$264.38
B	1.70	$105.47	1.63	$94.13	1.82	$42.15	ES2	3.07	$332.05	2.53	$206.45
C	1.88	$116.64	1.69	$97.60	2.67	$61.84	ES1	2.93	$316.91	1.84	$150.14
D	1.92	$119.12	1.53	$88.36	1.46	$33.81	HDE2	2.40	$259.58	1.33	$108.53
E	1.42	$88.10	1.41	$81.43	2.34	$54.19	HDE1	1.99	$215.24	0.96	$78.34
F	1.61	$99.88	1.60	$92.40	2.98	$69.02	HBC2	2.24	$242.28	0.72	$58.75
G	1.67	$103.61	1.64	$94.71	2.04	$47.25	HBC1	1.86	$201.18	-	-
H	1.16	$71.97	1.15	$66.41	2.86	$66.24	LDE2	2.08	$224.97	-	-
I	1.13	$70.11	1.18	$68.15	3.53	$81.75	LDE1	1.73	$187.12	-	-
J	1.42	$88.10	1.45	$83.74	2.99	$69.25	LBC2	1.72	$186.04	-	-
K	1.52	$94.30	1.54	$88.94	3.7	$85.69	LBC1	1.43	$154.67	-	-
L	1.09	$67.62	1.11	$64.10	4.21	$97.50	CDE2	1.87	$202.26	-	-
M	1.27	$78.79	1.30	$75.08	-	-	CDE1	1.62	$175.22	-	-
N	1.48	$91.82	1.50	$86.63	-	-	CBC2	1.55	$167.65	-	-
O	1.55	$96.16	1.55	$89.51	-	-	CA2	1.09	$117.89	-	-
P	1.08	$67.00	1.09	$62.95	-	-	CBC1	1.34	$144.93	-	-

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
Q	-	-	-	-	-	-	CA1	0.94	$101.67	-	-
R	-	-	-	-	-	-	BAB2	1.04	$112.49	-	-
S	-	-	-	-	-	-	BAB1	0.99	$107.08	-	-
T	-	-	-	-	-	-	PDE2	1.57	$169.81	-	-
U	-	-	-	-	-	-	PDE1	1.47	$159.00	-	-
V	-	-	-	-	-	-	PBC2	1.22	$131.96	-	-
W	-	-	-	-	-	-	PA2	0.71	$76.79	-	-
X	-	-	-	-	-	-	PBC1	1.13	$122.22	-	-
Y	-	-	-	-	-	-	PA1	0.66	$71.39	-	-

TABLE 6: 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	$108.20	1.49	$96.78	0.68	$19.84	ES3	4.06	$419.56	3.24	$252.59
B	1.70	$120.22	1.63	$105.87	1.82	$53.11	ES2	3.07	$317.25	2.53	$197.24
C	1.88	$132.95	1.69	$109.77	2.67	$77.91	ES1	2.93	$302.79	1.84	$143.45
D	1.92	$135.78	1.53	$99.37	1.46	$42.60	HDE2	2.40	$248.02	1.33	$103.69
E	1.42	$100.42	1.41	$91.58	2.34	$68.28	HDE1	1.99	$205.65	0.96	$74.84
F	1.61	$113.86	1.60	$103.92	2.98	$86.96	HBC2	2.24	$231.48	0.72	$56.13
G	1.67	$118.10	1.64	$106.52	2.04	$59.53	HBC1	1.86	$192.21	-	-
H	1.16	$82.04	1.15	$74.69	2.86	$83.45	LDE2	2.08	$214.95	-	-
I	1.13	$79.91	1.18	$76.64	3.53	$103.01	LDE1	1.73	$178.78	-	-
J	1.42	$100.42	1.45	$94.18	2.99	$87.25	LBC2	1.72	$177.74	-	-
K	1.52	$107.49	1.54	$100.02	3.7	$107.97	LBC1	1.43	$147.78	-	-
L	1.09	$77.08	1.11	$72.09	4.21	$122.85	CDE2	1.87	$193.25	-	-
M	1.27	$89.81	1.30	$84.44	-	-	CDE1	1.62	$167.41	-	-
N	1.48	$104.67	1.50	$97.43	-	-	CBC2	1.55	$160.18	-	-
O	1.55	$109.62	1.55	$100.67	-	-	CA2	1.09	$112.64	-	-
P	1.08	$76.38	1.09	$70.80	-	-	CBC1	1.34	$138.48	-	-
Q	-	-	-	-	-	-	CA1	0.94	$97.14	-	-
R	-	-	-	-	-	-	BAB2	1.04	$107.47	-	-
S	-	-	-	-	-	-	BAB1	0.99	$102.31	-	-
T	-	-	-	-	-	-	PDE2	1.57	$162.24	-	-
U	-	-	-	-	-	-	PDE1	1.47	$151.91	-	-
V	-	-	-	-	-	-	PBC2	1.22	$126.07	-	-
W	-	-	-	-	-	-	PA2	0.71	$73.37	-	-
X	-	-	-	-	-	-	PBC1	1.13	$116.77	-	-
Y	-	-	-	-	-	-	PA1	0.66	$68.20	-	-