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M E M O R A N D U M

TO: RHCF Members

FROM: Dan Heim, Executive Vice President
Darius Kirstein, Director of Financial Policy & Analysis

DATE: Aug. 25, 2020

SUBJECT: Summary of the Final SNF PPS Rule for FY 2021

ROUTE TO: CEO, Administrator, CFO, Therapy Director, DON

Introduction

October 1, 2020 marks the one year anniversary of the Patient Driven Payment Model (PDPM) that replaced the RUG-IV methodology as the basis for nursing home Medicare Part A rates. The new methodology shifted the focus of reimbursement away from the minutes of therapy provided, and towards resident characteristics shown to be predictive of care needs. While most Skilled Nursing Facilities (SNFs) had to dedicate resources to train staff, reconfigure systems and rethink operations, many homes in New York state were experiencing slightly higher Medicare reimbursement in the initial months of the new methodology prior to the onset of the COVID-19 health emergency.

In moving forward with the required publication of the SNF PPS Rule to update Medicare Part A payments, the Centers for Medicare and Medicaid Services (CMS) indicated that they were limiting the rulemaking to routine updates and did not propose any structural changes to PDPM. The final rule, which closely mirrors the proposed rule, applies an inflation adjustment to the component base rates, updates the wage index and recategorizes certain counties from one wage index region to another, makes changes to ICD-10 code mapping to improve how patients are classified into PDPM payment categories, and finalizes Value-Based Purchasing (VBP) performance periods and performance standards for upcoming program years. CMS is not making any other changes to the VBP measure, scoring, or payment policies at this point.

We provided highlights of the Final SNF Prospective Payment System (PPS) Rule for FY 2021 when it was first published. In this memo we provide additional detail and:

- list the final payment rates for individual PDPM components and wage adjustment information for Fiscal Year (FY) 2021 that begins Oct. 1, 2020;
- outline the PDPM payment structure and other Part A rate related adjustments;
- link to a file that provides rate tables and calculators for urban and non-urban counties;
- point to key PDPM resources from the Centers for Medicare and Medicaid Service (CMS); and,
- detail the updates to the SNF Quality Reporting Program (QRP) and Value Based Purchasing (VBP) program included in the Final Rule.

On August 5, 2020, the Centers for Medicare and Medicaid Services (CMS) published the Final Rule establishing fiscal year 2021 Medicare payment and policy changes for Skilled Nursing Facilities (*Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021, CMS-1737-F*). The rule is the annual vehicle used by CMS to update SNF Medicare Part A rates as well as policies governing the Quality Reporting Program (QRP) and Value Based Purchasing (VBP) program, both of which may impact a home's Part A rates. After reviewing comments received on the proposed rule issued in April, CMS made some minor changes and published the final rule in early August. It governs the fiscal year that begins on Oct. 1, 2020.

The 2.2 percent inflation adjustment adopted in the final rule is expected to increases aggregate Medicare payments to Skilled Nursing Facilities (SNFs) by $750 million in federal fiscal year 2020-21, although utilization fluctuations due to the pandemic make that a rough figure. Other than providing final rates, the rule makes no substantive changes to the Patient Driven Payment Model (PDPM) reimbursement methodology.

PDPM

CMS finalized the regulatory structure of PDPM two years ago and implemented it as the basis for Medicare Part A reimbursement on Oct. 1, 2019. In this year's rule, CMS made no changes to the structure of the methodology but did indicate that the agency would continue to monitor the impact of PDPM on both patient outcomes and program outlays. CMS has developed a presentation providing a comprehensive overview of the PDPM methodology that is available here and a series of FAQs (last updated 8/27/19) can be downloaded by clicking here. The dedicated CMS PDPM site with these and other resources including the PDPM Grouper is accessible here.

Structurally, PDPM:

- Divorced the amount of therapy a resident receives from the payment amount by no longer relying on minutes of therapy provided to a resident to classify that resident into a payment category;
- Imposed a combined 25 percent limit on group and concurrent therapy, by discipline, to ensure that at least 75 percent of therapy is provided on an individual basis;
- Established five individual rate components, each with its own discrete case-mix adjustment, and classifies each resident into the appropriate category for each of the components (Physical Therapy (PT), Occupational Therapy (OT), Speech/Language Pathology (SLP), nursing, and non-therapy ancillaries (NTA)) based primarily on that resident's clinical and functional characteristics;

- Incorporated a variable, per-diem payment adjustment for the PT, OT, and NTA components, resulting in a significantly higher rate in the first three days and gradually decreasing daily payments as a resident's stay progresses; and
- Reduced the required PPS assessments to the 5-Day Scheduled PPS Assessment (now referred to as the "Initial Medicare Assessment"), PPS Discharge Assessment with some additional items, and a new Interim Payment Assessment (IPA) used at the discretion of the home to change the resident classifications assigned by the 5-Day PPS Assessment when certain criteria are met.

Instead of a resident being assessed into a RUG category that determines the per-day payment under the RUG-IV methodology, payment under the PDPM model is the sum of five separate, case-mix adjusted components plus a non-case-mix component. For each component CMS has established a base rate. Each base rate is adjusted by the component-specific case-mix derived from resident characteristics deemed relevant to that component.

PDPM Base Rates

Based on the Market Basket Adjustments discussed in the Rate Updates section further in this memo, in FY 2021 CMS will use the base rates listed in the table below for the six components that make up the rate under PDPM. PDPM will maintain two separate sets of base rates as did RUG-IV: one for urban areas and one for rural areas.

Figure 1. 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
Figure 2. 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

In addition to adjusting the rates for inflation through the market basket index, federal legislation requires PDPM to be implemented in a budget neutral manner. This includes ensuring that any changes to the wage index are budget neutral as well. To accomplish this, CMS applies budget neutrality factors to the base rates. The final base rates are shown in figures 1 and 2. Compared to the prior year, each base rate has been increased by 2.2 percent and then slightly reduced to reflect a budget neutrality factor of .9992. A table listing case mix weights for each of the four case mix adjusted components along with the associated dollar amounts for each component-case mix combination are shown in the figures 3 and 4 below. **A 2021 PDPM Rate Calculator that also includes the rate tables in Excel format can be downloaded here.**

Group Therapy Definition

Prior year final rules changed the definition of SNF Part A Group Therapy to mean "a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities" and limited to 25 percent the combined concurrent and group therapy for each discipline of therapy provided under PDPM. This years rule makes no changes to group therapy requirements.

Figure 2. PDPM Case-Mix Adjusted Federal Rates and Associated Indexes – URBAN:

PDPM GROUP	PT/OT CMG	PT CMI	PT RATE	OT CMI	OT RATE	SLP CMG	SLP CMI	SLP RATE	NURSING CMG	NURSING CMI	NURSING RATE	NTA CMG	NTA CMI	NTA RATE
A	TA	*1.53*	$ 94.92	*1.49*	$ 86.05	SA	*0.68*	$ 15.75	ES3	*4.06*	$ 439.13	NA	*3.24*	$ 264.38
B	TB	*1.70*	105.47	*1.63*	94.13	SB	*1.82*	42.15	ES2	*3.07*	332.05	NB	*2.53*	206.45
C	TC	*1.88*	116.64	*1.69*	97.60	SC	*2.67*	61.84	ES1	*2.93*	316.91	NC	*1.84*	150.14
D	TD	*1.92*	119.12	*1.53*	88.36	SD	*1.46*	33.81	HDE2	*2.40*	259.58	ND	*1.33*	108.53
E	TE	*1.42*	88.10	*1.41*	81.43	SE	*2.34*	54.19	HDE1	*1.99*	215.24	NE	*0.96*	78.34
F	TF	*1.61*	99.88	*1.60*	92.40	SF	*2.98*	69.02	HBC2	*2.24*	242.28	NF	*0.72*	58.75
G	TG	*1.67*	103.61	*1.64*	94.71	SG	*2.04*	47.25	HBC1	*1.86*	201.18			
H	TH	*1.16*	71.97	*1.15*	66.41	SH	*2.86*	66.24	LDE2	*2.08*	224.97			
I	TI	*1.13*	70.11	*1.18*	68.15	SI	*3.53*	81.75	LDE1	*1.73*	187.12			
J	TJ	*1.42*	88.10	*1.45*	83.74	SJ	*2.99*	69.25	LBC2	*1.72*	186.04			
K	TK	*1.52*	94.30	*1.54*	88.94	SK	*3.70*	85.69	LBC1	*1.43*	154.67			
L	TL	*1.09*	67.62	*1.11*	64.10	SL	*4.21*	97.50	CDE2	*1.87*	202.26			
M	TM	*1.27*	78.79	*1.30*	75.08				CDE1	*1.62*	175.22			
N	TN	*1.48*	91.82	*1.50*	86.63				CBC2	*1.55*	167.65			
O	TO	*1.55*	96.16	*1.55*	89.51				CA2	*1.09*	117.89			
P	TP	*1.08*	67.00	*1.09*	62.95				CBC1	*1.34*	144.93			
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			

Figure 3. PDPM Case-Mix Adjusted Federal Rates and Associated Indexes – RURAL:

PDPM GROUP	PT/OT CMG	PT CMI	PT RATE	OT CMI	OT RATE	SLP CMG	SLP CMI	SLP RATE	NURSING CMG	NURSING CMI	NURSING RATE	NTA CMG	NTA CMI	NTA RATE
A	TA	*1.53*	$ 108.20	*1.49*	$ 96.78	SA	*0.68*	$ 19.84	ES3	*4.06*	$ 419.56	NA	*3.24*	$ 252.59
B	TB	*1.70*	120.22	*1.63*	105.87	SB	*1.82*	53.11	ES2	*3.07*	317.25	NB	*2.53*	197.24
C	TC	*1.88*	132.95	*1.69*	109.77	SC	*2.67*	77.91	ES1	*2.93*	302.79	NC	*1.84*	143.45
D	TD	*1.92*	135.78	*1.53*	99.37	SD	*1.46*	42.60	HDE2	*2.40*	248.02	ND	*1.33*	103.69
E	TE	*1.42*	100.42	*1.41*	91.58	SE	*2.34*	68.28	HDE1	*1.99*	205.65	NE	*0.96*	74.84
F	TF	*1.61*	113.86	*1.60*	103.92	SF	*2.98*	86.96	HBC2	*2.24*	231.48	NF	*0.72*	56.13
G	TG	*1.67*	118.10	*1.64*	106.52	SG	*2.04*	59.53	HBC1	*1.86*	192.21			
H	TH	*1.16*	82.04	*1.15*	74.69	SH	*2.86*	83.45	LDE2	*2.08*	214.95			
I	TI	*1.13*	79.91	*1.18*	76.64	SI	*3.53*	103.01	LDE1	*1.73*	178.78			
J	TJ	*1.42*	100.42	*1.45*	94.18	SJ	*2.99*	87.25	LBC2	*1.72*	177.74			
K	TK	*1.52*	107.49	*1.54*	100.02	SK	*3.70*	107.97	LBC1	*1.43*	147.78			
L	TL	*1.09*	77.08	*1.11*	72.09	SL	*4.21*	122.85	CDE2	*1.87*	193.25			
M	TM	*1.27*	89.81	*1.30*	84.44				CDE1	*1.62*	167.41			
N	TN	*1.48*	104.67	*1.50*	97.43				CBC2	*1.55*	160.18			
O	TO	*1.55*	109.62	*1.55*	100.67				CA2	*1.09*	112.64			
P	TP	*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			

ICD-10 Updates

Last year's final rule established a sub-regulatory process for communicating non-substantive changes to the list of ICD-10 codes used to classify patients. Such changes are published on the CMS PDPM Web page here (bottom of page). Substantive changes continue to be proposed and finalized through the SNF PPS rulemaking process. Several technical updates to PDPM ICD-10 mapping were included in this year's rule and are detailed beginning on p. 39 of the final rule here.

Rate Update

CMS projects that the final rule will increase Medicare payments to SNFs in FY 2021 by 2.2 percent resulting in an aggregate increase of $750 million. However, an individual provider's Part A Medicare revenue for the coming year will be determined more by the PDPM categories of the population they serve and less by the market basket increase or changes in the wage index, as may have been the case in prior years.

The formula for the inflation adjustment starts with a Market Basket Increase (MBI) calculation which may be impacted by a forecast error adjustment as well as a potential Multifactor Productivity Adjustment (MPA). The SNF MBI reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF market basket while the Forecast Error Adjustment is a mechanism to reconcile the projected to the actual MBI from two years' prior when the gap between the two is greater than half of a percentage point. Because the 2019 MBI was set by Congress and not developed using the customary calculation, CMS determined that an adjustment was not appropriate. Similarly, CMS determined that the unique dynamics of the current economy argued against an MPA adjustment.

With the net 2.2 percent increase, overall Medicare Part A payments are set to increase. Providers should note that while "sequestration" (2 percent cut to Medicare payments) has been suspended for the remainder of the 2020 CY in response to COVID-19, it is expected to be reimposed in 2021. In addition, providers should be aware of the potential impact that their VBP score may have on their rate. VBP multipliers range from .98 to 1.02 and are applied to the daily rate that the home would otherwise be paid. Finally, homes that fail to meet the required threshold for reporting complete information for QRP measure calculation face an additional 2 percent reduction of their Part A rate.

Wage index

In the final rule for FY 2021, CMS ascribes 71.3 percent of the rate as labor-related and 28.7 percent as non-labor. This means that a regional wage index will be applied to 71.3 percent of the rate in FY 2021. The current wage index methodology does not change under PDPM: once all components are case mix adjusted and combined and any variable per diem adjustment factor is applied, 71.3 percent of the resulting rate will be adjusted by the regional wage index.

Several regions saw fairly large year-over-year changes to their final wage index. The index for Glens Falls dropped 3.7 percent Syracuse declined by 2.9 percent and Utica dipped by 2.1 percent. Rochester saw the largest increase of 5.4 percent, with NY City rising by 5 percent and Kingston by 4.8 percent. The wage index for non-urban counties increased by 1.75 percent. Only two counties in New York State are impacted by the nationwide realignment of certain wage index regions: Orange County is being shifted from the NY-NJ region into the newly named Poughkeepsie-Newburgh-Middletown region and facing a 5 percent decrease, while Putnam County is being moved into the NY-NJ region and seeing a 6.6 percent increase.

SNF rate setting continues to use the hospital wage index. While CMS acknowledges the potential benefit of developing a SNF wage index, it continues to maintain that the magnitude of the effort required to do so is beyond its capabilities at this time. The wage index list by county is provided as figure 5 below. It also appears on our PDPM Rate Calculator available here.

Figure 5. New York State FY 2021 Wage Indexes by County

County Name	CBSA Name	Urban/ Rural	FY 2021 INDEX	*CHANGE FROM 2020*
Albany	Albany-Schenectady-Troy, NY	Urban	0.8259	*0.2%*
Allegany	Non-Urban New York State	Rural	0.8595	*1.7%*
Bronx	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Broome	Binghamton, NY	Urban	0.8343	*-0.8%*
Cattaraugus	Non-Urban New York State	Rural	0.8595	*1.7%*
Cayuga	Non-Urban New York State	Rural	0.8595	*1.7%*
Chautauqua	Non-Urban New York State	Rural	0.8595	*1.7%*
Chemung	Elmira, NY	Urban	0.871	*1.6%*
Chenango	Non-Urban New York State	Rural	0.8595	*1.7%*
Clinton	Non-Urban New York State	Rural	0.8595	*1.7%*
Columbia	Non-Urban New York State	Rural	0.8595	*1.7%*
Cortland	Non-Urban New York State	Rural	0.8595	*1.7%*
Delaware	Non-Urban New York State	Rural	0.8595	*1.7%*
Dutchess	Poughkeepsie-Newburgh-Middletown, NY	Urban	1.2046	*-4.0%*
Erie	Buffalo-Cheektowaga, NY	Urban	1.0442	*-0.4%*
Essex	Non-Urban New York State	Rural	0.8595	*1.7%*
Franklin	Non-Urban New York State	Rural	0.8595	*1.7%*
Fulton	Non-Urban New York State	Rural	0.8595	*1.7%*
Genesee	Non-Urban New York State	Rural	0.8595	*1.7%*
Greene	Non-Urban New York State	Rural	0.8595	*1.7%*
Hamilton	Non-Urban New York State	Rural	0.8595	*1.7%*
Herkimer	Utica-Rome, NY	Urban	0.9026	*-2.1%*
Jefferson	Watertown-Fort Drum, NY (Jefferson)	Urban	0.8876	*-2.6%*
Kings	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Lewis	Non-Urban New York State	Rural	0.8595	*1.7%*
Livingston	Rochester, NY	Urban	0.8922	*5.4%*
Madison	Syracuse, NY	Urban	0.9859	*-2.9%*
Monroe	Rochester, NY	Urban	0.8922	*5.4%*
Montgomery	Non-Urban New York State	Rural	0.8595	*1.7%*
Nassau	Nassau County-Suffolk County, NY	Urban	1.3088	*1.7%*
New York	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Niagara	Buffalo-Cheektowaga, NY	Urban	1.0442	*-0.4%*
Oneida	Utica-Rome, NY	Urban	0.9026	*-2.1%*
Onondaga	Syracuse, NY	Urban	0.9859	*-2.9%*
Ontario	Rochester, NY	Urban	0.8922	*5.4%*
Orange	Poughkeepsie-Newburgh-Middletown, NY	Urban	1.2108	*-5.0%*
Orleans	Rochester, NY	Urban	0.8922	*5.4%*
Oswego	Syracuse, NY	Urban	0.9859	*-2.9%*
Otsego	Non-Urban New York State	Rural	0.8595	*1.7%*

County Name	CBSA Name	Urban/ Rural	FY 2021 INDEX	*CHANGE FROM 2020*
Putnam	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*6.6%*
Queens	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Rensselaer	Albany-Schenectady-Troy, NY	Urban	0.8259	*0.2%*
Richmond	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Rockland	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Saratoga	Albany-Schenectady-Troy, NY	Urban	0.8259	*0.2%*
Schenectady	Albany-Schenectady-Troy, NY	Urban	0.8259	*0.2%*
Schoharie	Albany-Schenectady-Troy, NY	Urban	0.8259	*0.2%*
Schuyler	Non-Urban New York State	Rural	0.8595	*1.7%*
Seneca	Non-Urban New York State	Rural	0.8595	*1.7%*
St. Lawrence	Non-Urban New York State	Rural	0.8595	*1.7%*
Steuben	Non-Urban New York State	Rural	0.8595	*1.7%*
Suffolk	Nassau County-Suffolk County, NY	Urban	1.3088	*1.7%*
Sullivan	Non-Urban New York State	Rural	0.8595	*1.7%*
Tioga	Binghamton, NY	Urban	0.8343	*-0.8%*
Tompkins	Ithaca, NY	Urban	0.9547	*4.2%*
Ulster	Kingston, NY	Urban	0.9306	*4.8%*
Warren	Glens Falls, NY	Urban	0.774	*-3.7%*
Washington	Glens Falls, NY	Urban	0.774	*-3.7%*
Wayne	Rochester, NY	Urban	0.8922	*5.4%*
Westchester	New York-Jersey City-White Plains, NY-NJ	Urban	1.3384	*5.0%*
Wyoming	Non-Urban New York State	Rural	0.8595	*1.7%*
Yates	Rochester, NY	Urban	0.8922	*5.4%*

Note: Yellow shading indicates counties impacted by geographic realignment

Consolidated Billing

PDPM does not alter consolidated billing. Under consolidated billing, the SNF is financially responsible for covering all services provided to the Medicare beneficiary in a Part A stay, unless the service is specifically excluded from consolidated billing. In general, the following services continue to be excluded from consolidated billing:

- Physician's professional services;
- Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- Erythropoietin for certain dialysis patients;
- Certain chemotherapy drugs;
- Certain chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.

CMS provides a specific listing of excluded services by Health Care Common Procedure Codes (HCPCs) that providers can use to determine if a specific service is excluded. In the proposed rule CMS specifically requested stakeholder input on excluding services that fall into the four specified categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) within which CMS has the authority to designate additional, individual services for exclusion. While acknowledging that they received a number of comments regarding COVD The final rule does not make any new additions to the exclusion list

Rate Tables and Calculations for FY 2020

Unlike prior years when payment for every day of a Part A stay was based on selecting one of 66 RUG-specific categories, individual components that comprise the rate under PDPM have their own set of case mix adjustments. To calculate a PDPM rate, the resident must be assigned a PT/OT case mix group as well as case mix groups for Speech Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA). These individually case-mix adjusted components are summed along with a fixed non-case-mix component to arrive at a sub-total.

That subtotal is further adjusted by a variable per-diem adjustment that impacts the PT, OT and NTA components based on the day of stay. The adjustment triples the NTA rate for the first three days of a stay, while the PT and OT adjustment decreases the PT and OT component of the rate by two percent starting on day 21 and decreasing by an additional two percent every seven days.

Once the rate is calculated and the variable per-diem adjustment is applied, 71.3 percent of the figure is adjusted by the regional wage index governing the facility's county. The final step is to multiply this entire result by the facility-specific Value Based Purchasing (VBP) Incentive Payment Multiplier for the appropriate year. Please note that homes subject to a Quality Reporting Program (QRP) penalty may face a further two percent decrease.

A listing of the rates, case mix weights, and wage indexes along with a calculator that automates the rate calculation allowing the user to see the moving pieces and calculation sequence is available here.

SNF Value-Based Purchasing (VBP)

In the FY 2021 SNF PPS final rule, CMS:

- Finalized updates to the SNF VBP Program regulation text at 42 CFR § 413.338 to ensure it reflects previously finalized policies;
- Announced performance periods and performance standards for the FY 2023 program year;
- Updated the 30-day Phase One Review and Correction deadline for the baseline period quality measure quarterly report; and
- Made no changes to the measures, SNF VBP scoring policies, or payment policies.

The SNF VBP Program, required by the Protecting Access to Medicare Act of 2014, began rewarding SNFs with incentive payments based on their quality measure performance on Oct. 1, 2018. The program currently scores SNFs on an all-cause measure of hospital readmissions, and in the future, will transition to a measure of potentially preventable hospital readmissions. As required by law, the program reduces

SNFs' Medicare payments by two percentage points and redistributes approximately 60 percent of those funds as incentive payments to SNFs based on each facility's rehospitalization rate and level of improvement.

CMS adopted the SNF 30-Day All-Cause Readmission Measure (SNFRM) as the all-cause, all-condition readmission measure that is used in the first stages of the SNF VBP Program. Each facility receives a SNF VBP Performance score (0 to 100) and ranking which is calculated based on that SNF's performance on the SNFRM during the performance period and the baseline period. Each SNF's VBP performance score is equal to the higher of its achievement score or improvement score. SNFs are awarded points for achievement on a 0-100-point scale and improvement on a 0-90-point scale, based on how their performance compares to national benchmarks and thresholds. The table below shows the performance standards for the upcoming three years of the SNF VBP:

SNF VBP Program Performance Standards SNF 30-Day All-Cause Readmission Measure (SNFRM)

Program Year	Achievement Threshold	Benchmark Period	Performance Period	Baseline
FY 2021 (10/1/20 – 9/30/21)	0.79476	0.83212	FY 2019	FY 2017
FY 2022 (10/1/21 – 9/30/22)	0.79025	0.82917	FY 2020	FY 2018
FY 2023 (10/1/22 – 9/30/23)	0.79270	0.83028	FY 2021	FY 2019

In the FY 2017 SNF PPS final rule, CMS finalized the "Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure" (SNFPPR) that will be used for the SNF VBP Program instead of the SNFRM as soon as it is feasible. This claims-based measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to a hospital. CMS later changed the name of the SNFPPR to the "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge" measure to distinguish it from the SNF Quality Reporting Program potentially preventable readmission measure.

CMS previously adopted a two-phase review and corrections process for SNFs' quality measure data and performance information that are displayed on *Nursing Home Compare*. Under this policy, CMS accepts corrections to the quality measure data used to calculate the measure rates included in any SNF's quarterly confidential feedback report and provides SNFs with an annual confidential feedback report containing the performance information that will be made public. CMS has detailed the process for requesting Phase One corrections and finalized a policy for accepting Phase One corrections to any quarterly report within 30 days. The final FY 2021 rule also applies this 30-day Phase One Review and Correction deadline to the baseline period quality measure report that CMS typically issues in December.

In a March 27, 2020 memo, CMS said it was invoking the SNF VBP Extraordinary Circumstances Exception Policy and excluding qualifying claims from the SNFRM calculation for the period Jan. 1 – June 30, 2020. In our comments on the proposed FY 2021 rule, we recommended that CMS carefully consider and address in future rulemaking how it will approach calculations and payment adjustments under the SNF VBP for time periods when the performance period or baseline period are impacted by the COVID-19 pandemic. CMS did not substantively address this issue in the final FY 2021 rule.

SNF Quality Reporting Program (QRP)

The final SNF PPS rule for FY 2021 made no changes to the SNF QRP. The SNF QRP is authorized by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. It applies to freestanding and hospital-based SNFs, as well as non-critical access hospital (CAH) swing-bed rural hospitals. Under the SNF QRP, SNFs that fail to submit the required quality data to CMS are subject to a 2 percentage point reduction from the applicable fiscal year's annual market basket percentage update to the Medicare Part A SNF rates.

The 11 QRP measures that are currently adopted for use in the SNF QRP for FY 2021, are as follows:

Quality Measures for the FY 2021 SNF QRP

Short name	Measure name & data source
Resident Assessment Instrument Minimum Data Set (MDS)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Short name	**Measure name & data source**
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).
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).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

The SNF Provider Preview Reports have been updated and are now available. The data contained within the Preview Reports is based on quality data submitted by SNFs between Q1 2019 – Q4 2019 (1/01/19 – 12/31/19) (for assessment-based measures) and Q4 2017 and Q3 2019 (10/01/17 – 9/30/19) (for claims-based measures). The data reflects what will be published on *Nursing Home Compare* during the Oct. 2020 refresh of the website. Providers have until **Aug. 30, 2020** to review their performance data. Corrections to the underlying data will not be allowed during this time; however, SNFs can request CMS review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate.

Beginning with the Oct. 2020 refresh, CMS will publicly display on the *Nursing Home Compare* website six new measures. SNF performance data for these measures will be included for the first time on this preview report:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury,
- Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC SNF QRP,
- Application of IRF Functional Outcome Measure: Change in Self-Care (NQF #2633),
- Application of IRF Functional Outcome Measure: Change in Mobility (NQF #2634),
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score (NQF #2635), and
- Application of IRF Functional Outcome Measure: Discharge Mobility Score (NQF #2636)

Conclusion

A fact sheet on the final rule is available here and the entire rule publication can be accessed at: https://www.federalregister.gov/documents/2020/08/05/2020-16900/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities. Please e-mail Dan Heim (dheim@leadingageny.org) or Darius Kirstein (dkirstein@leadingageny.org) or contact us at 518-867-8383, with questions.