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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:	April 30, 2019
SUBJECT:	Summary of the Proposed SNF PPS Rule for FY 2020
ROUTE TO:	CEO, Administrator, CFO, Therapy Director, DON

Introduction

On April 25, 2019, The Centers for Medicare and Medicaid Services (CMS) published the Proposed Fiscal Year 2020 Payment and Policy Changes for Medicare Skilled Nursing Facilities (CMS-1718-P). The proposed 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 proposal, CMS customarily publishes the final rule in early August. It governs the fiscal year that begins on Oct. 1, 2020.

In the rule, CMS proposes to increase aggregate Medicare payments to Skilled Nursing Facilities (SNFs) by 2.5 percent and to redefine group therapy to consist of two to six patients. The rule makes no substantive changes to the Patient Driven Payment Model (PDPM) reimbursement methodology that is set to replace RUGs in October of this year but does propose to add two new QRP measures, tweaks the specifications for calculating the Discharge to Community measure, increases the data used for QRP measures to include all payer sources, adopts several standardized patient assessment data elements starting Oct. 1, 2020, and makes several other changes and clarifications. This memo provides a summary of the proposed changes.

PDPM

In last year's rule, CMS finalized the Patient Driven Payment Model (PDPM) and established that it will replace RUG-IV as the basis for Medicare Part A reimbursement on Oct. 1, 2019. In this year's rule, CMS proposes no major changes to the structure or implementation schedule for the new methodology

other than to the definition of Group Therapy (discussed below). CMS has provided a number of resources and issued several clarifications since finalizing the PDPM methodology in last year's SNF PPS rule. A comprehensive CMS slide set detailing the PDPM methodology is available here and a series of FAQs (4/17/19 update) can be downloaded by clicking here. The dedicated CMS PDPM site with these and other resources is accessible here.

Structurally, PDPM:

- Separates the amount of therapy from payment by no longer relying on minutes of therapy provided to a resident to classify that resident into a payment category;
- Imposes 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;
- Establishes 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;
- Incorporates a variable, per-diem payment adjustment for the PT, OT, and NTA components, resulting in a decreasing daily payment as a resident's stay progresses; and
- Reduces required PPS assessments to the 5-Day Scheduled PPS 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-IV category that determines the per-day payment under the current methodology, payment under the PDPM model will be the sum of five separate, case-mix adjusted components plus a non-case-mix component. For each component CMS will establish a base rate. Each base rate will be 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 below, CMS proposes to use the following base rates for the five PDPM components in FY 2020:

Urban

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$61.16	$56.93	$22.83	$106.64	$80.45	$95.48

Rural

Rate component	PT	OT	SLP	Nursing	NTA	Non-case-mix
Per Diem Amount	$69.72	$64.03	$28.76	$101.88	$76.86	$97.25

RUG-IV to PDPM Budget Neutrality

Apart from adjusting the rates for inflation through the market basket index, federal legislation requires PDPM to be implemented in a budget neutral manner. To maintain budget neutrality CMS applies budget neutrality multipliers that impact case mix weights. The proposed case mix weights for each of the four case mix adjusted components along with the associated dollar amounts, are shown in the tables below. Note that case mix weights differ from the weights published in last year's rule.

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	$93.57	1.49	$84.83	0.68	$15.52	ES3	4.06	$432.96	3.24	$260.66
B	1.70	$103.97	1.63	$92.80	1.82	$41.55	ES2	3.07	$327.38	2.53	$203.54
C	1.88	$114.98	1.69	$96.21	2.67	$60.96	ES1	2.93	$312.46	1.84	$148.03
D	1.92	$117.43	1.53	$87.10	1.46	$33.33	HDE2	2.40	$255.94	1.33	$107.00
E	1.42	$86.85	1.41	$80.27	2.34	$53.42	HDE1	1.99	$212.21	0.96	$77.23
F	1.61	$98.47	1.60	$91.09	2.98	$68.03	HBC2	2.24	$238.87	0.72	$57.92
G	1.67	$102.14	1.64	$93.37	2.04	$46.57	HBC1	1.86	$198.35	-	-
H	1.16	$70.95	1.15	$65.47	2.86	$65.29	LDE2	2.08	$221.81	-	-
I	1.13	$69.11	1.18	$67.18	3.53	$80.59	LDE1	1.73	$184.49	-	-
J	1.42	$86.85	1.45	$82.55	2.99	$68.26	LBC2	1.72	$183.42	-	-
K	1.52	$92.96	1.54	$87.67	3.70	$84.47	LBC1	1.43	$152.50	-	-
L	1.09	$66.66	1.11	$63.19	4.21	$96.11	CDE2	1.87	$199.42	-	-
M	1.27	$77.67	1.30	$74.01	-	-	CDE1	1.62	$172.76	-	-
N	1.48	$90.52	1.50	$85.40	-	-	CBC2	1.55	$165.29	-	-
O	1.55	$94.80	1.55	$88.24	-	-	CA2	1.09	$116.24	-	-
P	1.08	$66.05	1.09	$62.05	-	-	CBC1	1.34	$142.90	-	-
Q	-	-	-	-	-	-	CA1	0.94	$100.24	-	-
R	-	-	-	-	-	-	BAB2	1.04	$110.91	-	-
S	-	-	-	-	-	-	BAB1	0.99	$105.57	-	-
T	-	-	-	-	-	-	PDE2	1.57	$167.42	-	-
U	-	-	-	-	-	-	PDE1	1.47	$156.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	$130.10	-	-
W	-	-	-	-	-	-	PA2	0.71	$75.71	-	-
X	-	-	-	-	-	-	PBC1	1.13	$120.50	-	-
Y	-	-	-	-	-	-	PA1	0.66	$70.38	-	-

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	$106.67	1.49	$95.40	0.68	$19.56	ES3	4.06	$413.63	3.24	$249.03
B	1.70	$118.52	1.63	$104.37	1.82	$52.34	ES2	3.07	$312.77	2.53	$194.46
C	1.88	$131.07	1.69	$108.21	2.67	$76.79	ES1	2.93	$298.51	1.84	$141.42
D	1.92	$133.86	1.53	$97.97	1.46	$41.99	HDE2	2.40	$244.51	1.33	$102.22
E	1.42	$99.00	1.41	$90.28	2.34	$67.30	HDE1	1.99	$202.74	0.96	$73.79
F	1.61	$112.25	1.60	$102.45	2.98	$85.70	HBC2	2.24	$228.21	0.72	$55.34
G	1.67	$116.43	1.64	$105.01	2.04	$58.67	HBC1	1.86	$189.50	-	-
H	1.16	$80.88	1.15	$73.63	2.86	$82.25	LDE2	2.08	$211.91	-	-
I	1.13	$78.78	1.18	$75.56	3.53	$101.52	LDE1	1.73	$176.25	-	-
J	1.42	$99.00	1.45	$92.84	2.99	$85.99	LBC2	1.72	$175.23	-	-
K	1.52	$105.97	1.54	$98.61	3.70	$106.41	LBC1	1.43	$145.69	-	-
L	1.09	$75.99	1.11	$71.07	4.21	$121.08	CDE2	1.87	$190.52	-	-
M	1.27	$88.54	1.30	$83.24	-	-	CDE1	1.62	$165.05	-	-
N	1.48	$103.19	1.50	$96.05	-	-	CBC2	1.55	$157.91	-	-
O	1.55	$108.07	1.55	$99.25	-	-	CA2	1.09	$111.05	-	-
P	1.08	$75.30	1.09	$69.79	-	-	CBC1	1.34	$136.52	-	-
Q	-	-	-	-	-	-	CA1	0.94	$95.77	-	-
R	-	-	-	-	-	-	BAB2	1.04	$105.96	-	-
S	-	-	-	-	-	-	BAB1	0.99	$100.86	-	-
T	-	-	-	-	-	-	PDE2	1.57	$159.95	-	-
U	-	-	-	-	-	-	PDE1	1.47	$149.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	$124.29	-	-
W	-	-	-	-	-	-	PA2	0.71	$72.33	-	-
X	-	-	-	-	-	-	PBC1	1.13	$115.12	-	-
Y	-	-	-	-	-	-	PA1	0.66	$67.24	-	-

Group Therapy Definition

CMS is proposing to define SNF Part A Group Therapy as "a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities." CMS points out that this would standardize the definition currently used in Inpatient Rehabilitation Facility (IRF) setting, forwarding their effort to increase consistency across Post Acute Care settings. CMS indicates this definition would offer therapists in the SNF "more clinical flexibility when determining the appropriate number for a group, without compromising the therapist's ability to manage the group and the patient's ability to interact effectively and benefit from group therapy." Currently, Group Therapy for SNF Part A residents is defined as "4 residents performing same or similar activities, regardless of payer source." Medicare Part B residents have always been the exception to this rule, as Medicare Part B requires coding Group Therapy when 2 or more residents are treated together for any reason.

Despite the change, CMS reaffirms that it continues to believe that individual therapy is the preferred mode of therapy provision which offers the most tailored service for patients. Note that the redefinition of group therapy does not alter the combined 25 percent limit on concurrent and group therapy for each discipline of therapy provided finalized in last year's rule.

Assessment Terminology Clarifications

CMS also proposes several revisions to regulatory language governing assessments to reflect the PDPM assessment schedule. The rule replaces the phrase "patient assessments" in section 413.343(b) and "the 5-day assessment in section 409.30 with the phrase, "an initial patient assessment" and clarifies that taking grace days into consideration, an initial patient assessment must be completed no later than on the 8th day of posthospital SNF care. CMS would memorialize the discretionary nature of the Interim Payment Assessment by revising section 413.343(b) by replacing the phrase "such other assessments that are necessary to account for changes in patient care needs" with the following: "such other interim payment assessments as the SNF determines are necessary to account for changes in patient care needs." CMS believes their language "makes clear that the SNF's responsibility in this context would include recognizing those situations that warrant a decision to complete an IPA in order to account appropriately for a change in patient status."

ICD-10 Updates

The proposed rule would ensure SNFs have updated ICD-10 code information by developing a sub-regulatory process for communicating non-substantive changes to the list of ICD-10 codes used to classify patients. This would consist of posting non-substantive changes to the CMS PDPM web site while using the formal rule-making process for substantive changes to ICD-10 codes.

Rate Update

CMS proposes to increase Medicare payments to SNFs in FY 2020 by 2.5 percent resulting in an aggregate increase of $887 million. While this is good news, an individual provider's Part A Medicare revenue for the coming year will be determined primarily by the contours of PDPM, not the inflation adjustment and wage index update, as may have been the case in prior years.

The formula for the estimated increase starts with a 3.0 percent Market Basket Increase (MBI) and reduces it by 0.5 percentage points to reflect the mandated Multifactor Productivity Adjustment (MPA) for a net 2.5 percent increase. The SNF MBI reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF market basket. The unadjusted 3.0 percent increase is based on the IHS Global Insight, Inc. (IGI) first quarter 2019 forecast of the FY 2014-based SNF market basket with historical data through the fourth quarter of 2018.

A Market Basket Forecast Error Adjustment (MBFE), a mechanism to reconcile the projected to the actual MBI from two years' prior, is not applied because the difference between projected and actual 2018 increase is less than the established threshold where an adjustment is required.

For purposes of the MBFE calculation for FY 2018 (the most recently available FY for which there is final data), the estimated increase in the market basket index of 2.6 percentage points matched the actual increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the FY 2020 market basket percentage will be not adjusted to account for the 2018 forecast error.

With the net 2.5 percent increase, overall Medicare Part A payments are set to increase. However, providers should note and budget for the ongoing impact of "sequestration" (2 percent cut to Medicare payments) and be aware of the potential impact that their VBP score may have on their rate. In the current year, VBP multipliers range from .9803 to 1.0165 and are applied to the daily rate that the home would otherwise be paid. VBP multipliers for FY 2020 are likely to be distributed in the summer. In addition, homes that fail to meet the required threshold for reporting complete information for QRP measure calculation will face an additional 2 percent reduction of their Part A rate.

Wage index

In the proposed rule FY 2020, CMS ascribes **70.8 percent of the rate as labor-related and 29.2 percent as non-labor**. This means that a regional wage index will be applied to 70.8 percent of the rate in FY 2020. The current wage index methodology will not change under PDPM: once all components are case mix adjusted and combined and any variable per diem adjustment factor is applied, 70.8 percent of the resulting rate will be adjusted by the regional wage index.

For most regions, the proposed wage index adjustment is a bit lower than in the current year, with the Glens Falls region seeing the largest drop (-8.6 percent) followed by the Syracuse region (-2.4 percent). The New York City index dips by 1.1 percent while non-urban areas decline by 0.8 percent. The Utica region increases by 3.3 percent.

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. However the agency is specifically seeking stakeholder comments rates regarding the appropriateness of using the hospital index. The proposed rule for Inpatient Prospective Payment System would make some changes to increase the wage index to certain rural hospitals. It is unclear at this time what, if any, impact this might have on the application of the hospital wage index to SNF rates in future years.

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 are 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. As in previous years, CMS is specifically requesting 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.

SNF Value-Based Purchasing (VBP)

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 will be 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	Performance Period	Baseline Period
FY 2020 (10/1/19 – 9/30/20)	0.80218	0.83721	FY 2018	FY 2016
FY 2021 (10/1/20 – 9/30/21)	0.79476	0.83212	FY 2019	FY 2017
FY 2022 (10/1/21 – 9/30/22)	0.79476 (est.)	0.83212 (est.)	FY 2020	FY 2018

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.

In the FY 2020 SNF PPS proposed rule, CMS proposes to change the name of the SNFPPR to the "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge" measure, retaining the same acronym. The intent is to clearly differentiate the SNF VBP potentially preventable readmission measure from the SNF Quality Reporting Program potentially preventable readmission measure, thereby reducing stakeholder confusion.

The proposed rule also includes an update to the public reporting requirements to ensure that CMS publishes accurate performance information for low-volume SNFs. Under current policy, SNFs with less than 25 eligible stays during the baseline period for a fiscal year are only scored on achievement and do not have improvement information to display on Nursing Home Compare. In addition, SNFs with less than 25 eligible stays during a performance period are assigned a SNF performance score for that program year that results in a value-based incentive payment that restores the 2 percentage point reduction. In these cases, CMS does not believe it would be appropriate to suppress the SNF's information entirely on Nursing Home Compare, but wants to ensure the reliability of posted data.

Accordingly, CMS proposes to suppress the SNF information available to display as follows:

- If a SNF has less than 25 eligible stays during the baseline period for a program year, neither its baseline risk-standardized readmission rate (RSRR) nor its improvement score would be posted, but the performance period RSRR, achievement score and total performance score would be if the SNF had sufficient data during the performance period.
- If a SNF has less than 25 eligible stays during the performance period for a program year and receives an assigned SNF performance score as a result, the assigned SNF performance score would be reported but the performance period RSRR, the achievement score and improvement score would not be displayed.
- If a SNF has zero eligible cases during the performance period for a program year, CMS would not display any information for that SNF.

CMS estimates that 16 percent of SNFs will have fewer than 25 eligible stays during the performance period and 16 percent of SNFs will have fewer than 25 stays in the baseline period for FY 2020.

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 provided during a calendar year until the following March 31st.

Based on small numbers of facilities submitting Phase One correction information between Oct. 1, 2018 and March 31, 2019 and concerns about the effect of the March 31st deadline on finalizing SNF VBP payment calculations, CMS is proposing a 30-day deadline for Phase One review and correction requests.

SNF Quality Reporting Program (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.
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).

Short name	Measure name & data source
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

The IMPACT Act requires CMS to implement quality measures related to transferring health information and care preferences of an individual to the individual, family caregiver(s), and providers of services when the person transitions from a post-acute care (PAC) provider to another applicable setting, including a different PAC provider, a hospital or the individual's home. To this end, CMS proposes to adopt the following two new quality measures in FY 2020 to assess how health information is shared:

1. ***Transfer of Health Information from the SNF to Another Provider:*** This process-based measure assesses whether a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred from his or her current PAC setting. The measure would be calculated as the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at the time of discharge.
2. ***Transfer of Health Information from the SNF to the Patient:*** This process-based measure assesses whether a current reconciled medication list was provided to the patient, family, or caregiver when the patient was discharged from a PAC setting to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home with home health services, or a hospice. The measure would be based on the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the resident, family, or caregiver at the time of discharge.

CMS proposes to finalize these measures by Oct. 1, 2019, collect data beginning Oct. 1, 2020, and use the measures in the FY 2022 SNF QRP.

In addition to the two measure proposals, CMS is also proposing to update the specifications for the Discharge to Community (DTC) – PAC SNF QRP measure to exclude baseline nursing facility (NF) residents from the measure beginning with the FY 2020 SNF QRP. The DTC measure reports a SNF's risk-standardized rate of Medicare fee-for-service residents who are discharged to the community following a SNF stay, do not have an unplanned readmission to an acute care hospital or long term care hospital in the 31 days following community discharge, and who remain alive during the 31 days following community discharge. The rationale for the proposed change is that baseline NF residents are those that have resided in a NF prior to their SNF stay, and may not be expected to return to the community following their SNF stay. For this purpose, "baseline NF residents" would be defined as SNF residents who had a long-term NF stay in the 180 days preceding their hospitalization and SNF stay, with no intervening community discharge between the NF stay and hospitalization.

In addition, CMS proposes to adopt a number of standardized patient assessment data elements (SPADES) that assess:

- ***Cognitive function or mental status***, using data from the Brief Interview for Mental Status (BIMS), the Confusion Assessment Method (CAM) and the Patient Health Questionnaire—2 to 9;
- ***Special services, treatments and interventions*** including cancer treatment (chemotherapy, radiation); respiratory treatment (oxygen therapy, suctioning, tracheostomy care, non-invasive mechanical ventilator and invasive mechanical ventilator); intravenous (IV) medications; transfusions; dialysis; IV access; nutritional approach (parenteral/iv feeding, feeding tube, mechanically altered diet and therapeutic diet); and high risk drug classes: use and indication;
- ***Medical conditions and comorbidities***, most notably pain interference;

- ***Impairments in hearing and vision***; and
- ***Social determinants of health*** including race and ethnicity, preferred language and interpreter services, health literacy, transportation, or social isolation).

SNFs would be required to report these SPADEs via the MDS beginning with the FY 2022 SNF QRP. If finalized as proposed, SNFs would be required to report these data for SNF admissions and discharges occurring between Oct. 1, 2020 and Dec. 31, 2020 for the FY 2022 SNF QRP. Beginning with the FY 2023 SNF QRP, SNFs would report data for admissions and discharges that occur during the subsequent calendar year (for example, CY 2021 for the FY 2023 SNF QRP, CY 2022 for the FY 2024 SNF QRP). SPADES related to hearing, vision, race and ethnicity would only need to be submitted for admission since it is unlikely they would be different at discharge.

Finally, CMS is proposing to collect standardized patient assessment data and other data required to calculate quality measures under the QRP using the MDS on all patients, regardless of payer source. CMS believes that the most accurate representation of the quality provided in SNFs to Medicare residents would be best conveyed using data collected via the MDS on all SNF residents. This proposal, if adopted, would be effective beginning with the FY 2022 program year.

A fact sheet on the proposed rate is available here and the entire rule publication can be accessed here. If you have comments that you would like to be reflected on LeadingAge NY comments please share them with us by June 11 so that we may incorporate them into the association's comments and meet the June 18 CMS deadline for comment submission. Please e-mail Dan Heim (dheim@leadingageny.org) or Darius Kirstein (dkirstein@leadingageny.org) or contact us at 518-867-8383, with questions, comments and input.