Medicare Skilled Nursing Facility Prospective Payment System

Payment Rule Brief — FINAL RULE
Program Year: FFY 2021

Overview and Resources

On July 31, 2020, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2021 final payment rule for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) SNF payment rates and policies.

A copy of the final rule *Federal Register* (FR) and other resources related to the SNF PPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

An online version of the final rule is available at https://www.federalregister.gov/documents/2020/08/05/2020-16900/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

Program changes adopted by CMS will be effective for discharges on or after October 1, 2020, unless otherwise noted. CMS estimates the overall economic impact of this final payment rate update to be an increase of $750 million in aggregate payments to SNFs in FFY 2021 over FFY 2020 with a reduction of $199.54 million due to the SNF Value-Based Purchasing Program (VBP).

Note: Text in italics is extracted from the *Federal Register.*

SNF Payment Rates

Federal Register pages 47596-47603, 47618-47619

Incorporating the adopted updates with the effect of a budget neutrality adjustment, the tables below show the finalized urban and rural SNF federal per-diem payment rates for FFY 2021 compared to the rates currently in effect. These rates apply to hospital-based and freestanding SNFs, as well as to payments made for non-Critical Access Hospital (CAH) swing-bed services:

<table>
<tr><th colspan="2" rowspan="3">Case-Mix Rate Component</th><th colspan="3">Urban SNFs</th></tr>
<tr><th colspan="2">PDPM</th><th rowspan="2">Percent Change</th></tr>
<tr><th>Final FFY 2020</th><th>Final FFY 2021</th></tr>
<tr><td rowspan="2">Nursing</td><td>Nursing</td><td>$105.92</td><td>$108.16 (as proposed)</td><td rowspan="6">+2.1%</td></tr>
<tr><td>Non-Therapy Ancillary (NTA)</td><td>$79.91</td><td>$81.60 (as proposed)</td></tr>
<tr><td rowspan="3">Therapy</td><td>Physical Therapy (PT)</td><td>$60.75</td><td>$62.04 (as proposed)</td></tr>
<tr><td>Occupational Therapy (OT)</td><td>$56.55</td><td>$57.75 (as proposed)</td></tr>
<tr><td>Speech Language Pathology (SLP)</td><td>$22.68</td><td>$23.16 (as proposed)</td></tr>
<tr><td colspan="2">Non-Case-Mix</td><td>$94.84</td><td>$96.85 (as proposed)</td></tr>
</table>

Unadjusted Case-Mix Rate Component		**Rural SNFs**		
		PDPM		**Percent Change**
		Final FFY 2020	Final FFY 2021	
Nursing	**Nursing**	**$101.20**	**$103.34** (as proposed)	**+2.1%**
	Non-Therapy Ancillary (NTA)	**$76.34**	**$77.96** (as proposed)	
Therapy	**Physical Therapy (PT)**	**$69.25**	**$70.72** (as proposed)	
	Occupational Therapy (OT)	**$63.60**	**$64.95** (as proposed)	
	Speech Language Pathology (SLP)	**$28.57**	**$29.18** (proposed at $29.17)	
Non-Case-Mix		**$96.59**	**$98.64** (proposed at $98.63)	

The table below provides details of the final updates to the SNF payment rates for FFY 2021:

	SNF Rate Final Updates and Budget Neutrality Adjustment
Marketbasket Update	**+2.2%** (proposed at +2.7%)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.0 percentage points** (proposed at -0.4 ppt)
Wage Index/Labor-Related Share Budget Neutrality (including 5% Wage Index Reduction Cap Budget Neutrality)	**0.9992** (proposed at 0.9986 for WI/LS and 0.9996 for 5% cap)
Overall Rate Change	***+2.1%***

Wage Index, Labor-Related Share, and Revised CBSA Delineations

Federal Register pages 47603-47605, 47610-47619

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the SNF rates that CMS considers to be labor-related. The labor-related share for FFY 2021 is finalized at 71.3% compared to 70.9% in FFY 2020.

CMS is adopting a wage index and labor-related share budget neutrality factor of 0.9992 for FFY 2021 to ensure that aggregate payments made under the SNF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

For FFY 2021, CMS finalized its update the Core-Based Statistical Areas (CBSA) for all providers based on the delineations published in the Office of Budget and Management (OMB) Bulletin No. 18-04 released on September 14, 2018. Included in this bulletin are new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs which are split apart or otherwise changed. CMS believes that these delineations better represent current rural and urban areas. As a result, provider wage indexes change depending on which CBSA they are assigned to. In order to alleviate significant losses in revenue, CMS is adopting a 1-year transition period. Adopted delineations will be effective beginning October 1, 2020 and

include a 5% cap on the reduction of a provider's wage index for FFY 2021 compared to its wage index for FFY 2020, with the full reduction of a provider's wage index beginning in FFY 2022. This transition will be budget neutral and is taken into account in the wage index and labor share budget neutrality factor of 0.9992.

A complete list of the wage indexes adopted for payment in FFY 2021, including new CBSA designations as well as the wage index if the provider was affected by the 5% cap, is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. OMB Bulletin 18-04 can be found at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.

The March 6, 2020 OMB Bulletin 20-01 was not issued in time for integration into the rule. This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf. For FFY 2022, CMS intends to propose any updates from this OMB bulletin to further update CBSA delineation.

Case-Mix Adjustment

Federal Register pages 47600-47603

CMS uses a classification system to adjust payments to account for the relative resource utilization of different types of patients. The case-mix components of the Patient Driven Payment Model (PDPM) address costs associated with an individual's specific needs and characteristics, while the non-case-mix component addresses consistent costs that are incurred for all residents, such as room and board and various capital-related expenses.

The PDPM classifies each resident into five components (PT, OT, OLP, Nursing, NTA) and provides a single payment based on the sum of these individual characteristics. The payment for each component is calculated by multiplying the CMI for the resident's group by the component federal base payment rate and then by the specific day in the variable per diem adjustment schedule noted below. These payments are added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate.

The FFY 2021 finalized CMI updates for each component may be found on pages 47602-47603 of the *Federal Register*.

Under the PDPM, CMS uses a variable per diem adjustment to the PT, OT, and NTA components to account for changes in resource utilization over a stay, as detailed below. There are no such adjustments to the SLP and nursing components as resource use tends to remain relatively constant for these components over the course of a SNF stay.

Variable Per-Diem Adjustment Factors and Schedule – PT and OT	
Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Variable Per-Diem Adjustment Factors and Schedule – NTA	
Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

CMS uses a five-day SNF PPS scheduled assessment to classify a resident under the SNF PDPM for the entirety of his or her Part A SNF stay. Facilities will have the option to reclassify residents as appropriate from the initial 5-day classification using an Interim Payment Assessment (IPA) in order to address potential changes in clinical status. The assessment reference date (ARD) for the IPA will be the date the facility chooses to complete the IPA and payment based on the IPA will begin the same day as the ARD. Furthermore, the IPA will not be susceptible to assessment penalties.

SNF PPS Assessment Schedule under PDPM		
Medicare Minimum Data Set (MDS) assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
Initial Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless IPA is completed)
Interim Payment Assessment (IPA)	Date IPA is completed	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

Since the PDPM policy includes variable per diem adjustments CMS implemented an interrupted stay policy. This policy discourages a SNF from discharging a resident and then readmitting the resident shortly thereafter to reset the resident's variable per diem adjustment schedule to maximize payment rates for that resident. CMS' interrupted stay policy is as follows:

- In cases where a resident is discharged from a SNF and returns to the same SNF by 12:00am at the end of the third day of the interruption window (defined below); the resident's stay would be treated as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule; or
- In cases where the resident's absence from the SNF exceeds the 3-day interruption window, or in any case where the resident is readmitted to a different SNF, the readmissions would be treated as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1. The only relevant factors in determining if the interrupted stay policy would apply are the number of days between the residents discharge from a SNF and subsequent readmission to a SNF, and whether the resident is readmitted back to the same SNF or a different SNF.

CMS defines the interruption window as the 3-day period starting with the calendar day of discharge and additionally including the 2 immediately following calendar days.

SNF Value-Based Purchasing Program

Federal Register pages 47605, 47624-47627

Background: For FFYs 2019 and beyond, CMS is required by the Protecting Access to Medicare Act of 2014 (PAMA) to utilize a VBP (Value-Based Purchasing) program for SNFs under which value-based incentive payments are made to the SNFs. CMS withholds 2% of SNFs' fee-for-service Part A Medicare payments to fund

the program. CMS redistributes between 50% and 70% of the withheld payments to SNFs as incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure.

CMS will calculate rates for the sole SNF VBP measure, Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM), using one year of data for each of the baseline and performance periods. The baseline and performance periods for each program year for FFYs 2022+ are set to the following one year period for each of the baseline and performance periods from the prior program year.

CMS will use the following baseline and performance periods for the FFY 2023 program year:

Baseline period	Performance Period	Payment Period
October 1, 2018– September 30, 2019	**October 1, 2020 – September 30, 2021**	**FFY 2023**

In this FFY 2021 final rule, CMS is adopting the following performance standards for the SNFRM measure for the FFY 2023 program year, based on the most recent available data:

Measure ID	Adopted Performance Standards
SNFRM	**Achievement threshold 0.79270 (proposed at 0.79025)**
	Benchmark 0.83028 (proposed at 0.82917)

In the FFY 2017 final rule, CMS finalized that they will replace the SNFRM measure in the SNF VBP Program with the SNF 30-Day Potentially Preventable Readmission measure (SNFPPR) as soon as is practical.

The SNFPPR is one of two potentially preventable readmission measures which apply to the SNF setting, the other being the "Potentially Preventable 30-Day Post-Discharge Readmission Measure" currently in use under the SNF QRP program. As the SNFPPR uses a 30-day post-hospital discharge window, rather than the 30-day post-SNF discharge window used under SNF QRP, CMS will attempt to reduce confusion between the two measures by renaming the SNFPPR to "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge." This name update was adopted in this final rule.

CMS intends to submit the renamed measure to the National Quality Forum (NQF) for endorsement review during the fall 2021 cycle and will develop transition to include the SNFPPR measure into the SNF VBP.

Codifying and Amending Previously Adopted VBP Proposals

Federal Register pages 47625-47627

CMS is adopting its proposal to codify and/or amend the following previously adopted VBP policies:

- the performance standards correction policy finalized in the FFY 2019 SNF FR (*Federal Register pages 39,276-39,277)* to be codified in the SNF VBP by amending the definition of "Performance standards" at § 413.338(a)(9);
- the data suppression policy for low-volume SNF performance information found in the FFY 2020 SNF Final Rule (*Federal Register pages 38,823-38,824*) to be codified in the SNF VBP at § 413.338(e)(3)(i), (ii), and (iii);
- the two-phase review and corrections process for public display of SNF quality measure data and performance information found in the FFY 2017 SNF final rule (*Federal Register pages 52,007-52,009)* as well as adopting the 30-day deadline for Phase One review and corrections to the baseline period quality measure report typically issued in December to align the deadline timeframes; both to be codified by amending the ''Confidential feedback reports and public reporting'' paragraph in the SNF VBP at § 413.338(e)(1); and
- amending the policy to make SNF VBP performance information available to the public on the Nursing Home Compare website finalized in the FFY 2018 SNF FR (*Federal Register pages 36,622-36,623)*, at §

413.338(e)(3) in the SNF VBP, to account for the situation where the Nursing Home Compare website is replaced.

SNF Quality Reporting Program (QRP)

FFY 2020 Federal Register pages 38754 - 38755

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the implementation of a quality reporting program for SNFs. Beginning in FFY 2018, the IMPACT Act requires a 2 percentage point penalty, applied to the standard market basket rate adjustment, for those SNFs that fail to submit required quality data to CMS.

Summary Table of Domains and Measures Currently Adopted for the FFY 2021 SNF QRP	
Short Name	**Measures**
Resident Assessment Instrument Minimum Data Set Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/Care Plan	Application of Percent of Patients or Residents 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 Inpatient Rehabilitation Facility (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
Claims-Based Measures	
MSPB SNF	Total Estimated Medicare Spending per Beneficiary (MSPB)
DTC	Discharge to Community
PPR	Potentially Preventable 30-Day Post Discharge Readmission Measure

There are no proposals or updates to the SNF QRP in this final rule.

Consolidated Billing

Federal Register pages 47608-47610

CMS requires a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) that must include services its residents receive during a Part A stay. A small list of services are currently excluded from consolidated billing and are separately billable under Part B when furnished to a SNF's Part A resident. CMS has invited public comment to identify additional HCPCS codes that might meet criteria for exclusion from SNF consolidated billing and included comments and responses in this final rule.

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