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-P]

Summary of Proposed Rule

On April 10, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a proposed 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 April 15, 2020. The proposed rule would update the federal per diem rates under the SNF Prospective Payment System (SNF PPS) by 2.3 percent; update the wage areas with a transition that would limit wage index reductions to 5 percent for one year (FY 2021); modify the ICD-10 code mappings for patient classification; and make updates to the SNF VBP Program. No changes are proposed to the SNF Quality Reporting Program (SNF QRP) or to the Patient Driven Payment Model (PDPM) patient classification system. **Comments on the proposed rule are due by June 9, 2020.**

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I. Background on 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. **Stakeholders are invited to comment on any observations or information related to the impact of PDPM implementation on providers or on patient care.**

II. SNF PPS Rate Setting Methodology and FY 2021 Update

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

Summary of Key Data under Proposed SNF PPS for FY 2021		
Market basket update factor		
Market basket increase		+2.7%
Forecast error adjustment for FY 2018		0.0%
Required multifactor productivity (MFP) adjustment		-0.4%
Net MFP-adjusted update		**+2.3%**
Wage index budget neutrality adjustment		0.9982*
Labor-related share		71.3%
Final FY 2020 Unadjusted Federal Rates Per Diem**		
Rate component – PDPM	**Urban**	**Rural**
Physical Therapy	$60.75	$69.25
Occupational Therapy	$56.55	$63.60
Speech-Language Pathology	$22.68	$28.57
Nursing	$105.92	$101.20
Non-Therapy Ancillaries	$79.91	$76.34
Non-case mix adjusted	$95.48	$96.59
Proposed FY 2021 Unadjusted Federal Rates Per Diem		
Rate component – PDPM		
Physical Therapy	$62.04	$70.72
Occupational Therapy	$57.75	$64.95
Speech-Language Pathology	$23.16	$29.17
Nursing	$108.16	$103.34
Non-Therapy Ancillaries	$81.60	$77.96
Non-case mix adjusted	$96.85	$98.63
* In different places in the proposed rule, the wage index budget neutrality adjustment is shown as 0.9982 and 0.9986. The figure implied by the proposed per diem rates shown in the rule is 0.9982. **From FY 2020 Final Rule (84 FR 38728 - 38833), August 7, 2019		

A. Federal Base Rates

CMS reviews the history of the process for setting the federal base rates.

B. SNF Market Basket Update

CMS proposes a market basket increase for FY 2021 of 2.7 percent based on the first quarter 2020 forecast from IHS Global Insight, Inc. (IGI), with historical data through fourth quarter 2019. The forecast addresses the percentage increase in the FY 2014-based SNF market basket index for routine, ancillary, and capital-related expenses.

No adjustment to the market basket update is proposed 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 multifactor productivity (MFP) adjustment required under the Affordable Care Act (ACA) is estimated to be -0.4 percentage points. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in MFP for the period ending September 30, 2021, based on IGI's first quarter 2020 forecast.

The resulting proposed SNF market basket update equals 2.3 percent (2.7 percent less the 0.4 percentage point MFP reduction). The update may change in the final rule as more recent data and forecasts for the market basket MFP adjustment become available. 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 2.3 percent resulting in a positive 0.3 percentage point update for FY 2021.

Based on the proposed MFP-adjusted update, CMS proposes FY 2021 unadjusted federal rates for each component of the payment for urban and rural areas. CMS Tables 3 and 4 in the proposed rule, summarized below, present the proposed 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 the proposed rule it proposes changes to the delineation of urban and rural areas for FY 2021. (See section IV.A of this summary.)

Proposed Unadjusted FY 2021 Federal Rate Per Diem, Urban and Rural[a/]		
	Urban	**Rural**
Physical Therapy	$62.04	$70.72
Occupational Therapy	$57.75	$64.95
Speech-Language Pathology	$23.16	$29.17
Nursing	$108.16	$103.34
Non-Therapy Ancillaries	$81.60	$77.96
Non-case-mix adjusted	$96.85	$98.63
[a/] From proposed rule Tables 3 and 4		

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 proposed 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 proposed rule (reproduced in an appendix to this summary). 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

CMS proposes to continue to apply 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 proposes to use updated wage data for hospital cost reporting periods in FY 2017. It 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 proposed rule, CMS proposes to adopt the latest revisions by 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 below.)

CMS notes that that wage index tables are available exclusively through the CMS Web site, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. Tables A and B show, respectively, the urban and rural wage indexes for FY 2021 by area. Among the files provided is a supplemental data file that shows, by provider, the FY 2020 and

FY 2021 wage indexes, 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 proposed 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 proposed rule summarizes the proposed labor-related share for FY 2021 (based on the IGI first 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 proposed rule illustrate how payment would 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 data (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 a number of "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.

CMS invites comments to identify specific HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. It may consider excluding a particular service if it meets the criteria for exclusion: they must be included in the four categories and also must meet criteria as high cost and low probability in the SNF setting.[1] If for the final rule CMS identifies any new services that actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, it will identify these additional excluded services by means of the HCPCS codes that are in effect as of October 1, 2020.

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 and that 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 in order 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 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

[1] See the FY 2001 final rule (65 FR 46790) for discussion of these criteria, which are tied to the Conference Report discussion section 103(a) of the Balanced Budget Reduction Act (P.L. 106-113); (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.))

D. Changes to Regulatory Text

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

First, the regulatory text at §409.35(a) uses the previous annual caps on Part B payment for outpatient therapy services as an example. The text is illustrating the requirement that a beneficiary must need and receive skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis, and in making a "practical matter" determination, consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. The current example indicates that Medicare's nonpayment for services that exceed the (previous) cap on therapy services would not, in itself, serve as a basis for determining that needed care can only be provided in a SNF. CMS proposes to revise the regulation text to eliminate reference to the cap and provide as an example that the unavailability of Medicare payment for *outpatient* therapy due to the beneficiary's nonenrollment in Part B cannot serve as a basis for finding that the needed care can only be provided on an *inpatient* basis in a SNF.

Second, a minor technical correction is proposed 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 discusses the history of reliance on OMB designations of Metropolitan and Micropolitan Statistical Areas[2] for purposes of establishing wage areas used for the SNF wage index. In particular, 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 this 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.

The changes included in OMB Bulletin No 18-04 would result in new Core Based Statistical Areas (CBSAs), changes 34 urban counties to rural, change 47 rural counties to urban, and would split some existing CBSAs. Tables 11, 12, and 14 in the proposed 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.

[2] 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.

After assessing the effect of these changes, CMS reports that adoption of the changes in OMB Bulletin No. 18-04 would lower 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 would 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) that would be located in new CBSA 35154 (New Brunswick-Lakewood, NJ) under the proposed changes to the CBSA-based labor market area delineations would experience a nearly 17 percent decrease in the wage index as a result of the proposed change.

To mitigate the negative impact of these changes in the wage index, CMS proposes to adopt the changes in OMB Bulletin 18-04 beginning with the FY 2021 SNF PPS wage index, and 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 would provide for what CMS refers to as a one-year transition (or a two-year phase-in) to the new wage index areas. No cap would be applied in FY 2022. Readers are referred to proposed rule wage index Table A (link provided above) which shows the current and revised wage areas, counties included in the revised area, and the proposed transition year wage index for the area for FY 2021.

The proposed wage index budget neutrality adjustment, stated separately in the rule as equal to 0.9986 or 0.9982[3], would be applied to the unadjusted federal per diem rates for FY 2021 so that the proposed changes in the wage index – including the proposed 5 percent cap on decreases -- would not have any effect on aggregate payments to SNFs. To calculate the budget neutrality adjustment, CMS estimates aggregate SNF PPS payments using the FY 2020 wage 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.

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 final rule, CMS finalized the process it uses 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. CMS finalized that nonsubstantive changes to the ICD-10 codes would be applied through the subregulatory process and substantive revisions would be proposed and finalized through notice and comment rulemaking.

[3] In different places in the proposed rule, the wage index budget neutrality adjustment is shown as 0.9982 and 0.9986. The figure implied by the proposed per diem rates shown in the rule is 0.9982.

- Nonsubstantive changes would be changes that are necessary to maintain consistency with the most current ICD-10 medical code data set. CMS intends to ensure that the codes used to identify clinical categories and comorbidities are synchronized with the most current ICD-10 data set.
- Substantive change would be any change that goes beyond the intention of maintaining consistency with the most current ICD-10 medical code data set.

CMS proposes the following substantive changes to the PDPM ICD-10 code mappings and list:

- Include the surgical clinical category option "May be Eligible for the Non-Orthopedic Surgery Category" for the ICD-10 cancer codes listed below because these conditions can sometimes require surgery:
    - Gastrointestinal tract cancer codes C15.3 through C26.9 which correspond to J2910 of the MDS;
    - Respiratory system cancer codes C33 through C39.9, which corresponds to J2710 of the MDS;
    - Malignant neoplasm of bones of skull and face C410
    - Kaposi's sarcoma codes C46.3 through C46.9; and
    - Neoplasms identified by codes D37.09 through D39.9, D3A.00 through D3A.8, D40.0, D40.11through D44.9, D48.3 through D48.4, D48.61 through D48.7, and D49.0 through D49.7.
- Include the surgical clinical category option "May be Eligible for One of the Two Orthopedic Surgery Categories" option for codes C40.01 through C41.9 for bone cancers. CMS notes it included C41.0, Malignant neoplasm of bones of skull and face under the "May be Eligible for the Non-Orthopedic Surgery Category" option because this type of cancer is more likely to be treated by non-orthopedic instead of orthopedic surgery.
- Change the assignment of Glucose-6-phosphate dehydrogenase (G6PD) deficiency without anemia, D75.A from the clinical category "Cardiovascular and Coagulations" to "Medical Management". CMS states that compared to other blood diseases in the D75 code family, G6PD deficiency without anemia is very minor and generally asymptomatic.
- Change the default clinical category to "Non-Surgical Orthopedic" with the surgical option of "May be Eligible for One of the Two Orthopedic Surgery Categories" for the following facture codes: S32.031D, S32.19XD, S82.001D, and S82.002D through S82.002J. CMS notes it will continue to address changes to the mapping of fracture codes as they are raised by stakeholders.
- Change the default clinical category to "Return to Provider" for the following fracture codes: S82.009A, S82.013A, S82.016A, S82.023A, S82.33A, S82.036A, and S82.099A. CMS notes these are unspecific codes and lack the level of detail provided by more specific codes as to whether the fracture is on the right or left side of the body.
- Add the surgical option of "May be Eligible for One of the Two Orthopedic Surgery Categories" to spinal stenosis codes M48.00 through M48.08.
- Add the surgical option of "May be Eligible for the Non-Orthopedic Surgery Category" to the following surgery aftercare codes: Z48.21, Z48.22, Z48.23, Z48.24, Z48.280,

Z48.288, Z48.290, Z48.298, Z48.3, Z48.811, Z48.812, Z48.813, Z48.815, Z48.816, and Z48.29. CMS believes this will promote more accurate clinical category assignment.

In the FY 2020 NTA comorbidity mapping, ICD-10 codes for initial encounter codes (T82.310A through T85.89XA) map to the NTA comorbidity CC176 "Complications of Specified Implanted Device or Graft". This mapping is based on the Part C risk adjustment model condition category mapping which only included ICD-10 codes for acute encounters for complications of internal devices. In response to requests received from stakeholders, CMS proposes to add codes in this range with the seventh digit of D (subsequent encounter) for use in the ICD-10 code mapping to the NTA comorbidity CC176 for calculating the PDPM NTA score. CMS does not propose adding the seventh digit of S (sequela) because sequela can be coded years after the event and are generally not a reason for SNF treatment.

CMS invites comments on the proposed changes as well as comments on additional substantive and nonsubstantive changes.

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, and 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 proposes to correct 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 are proposed. No changes are proposed to the previously adopted numerical performance standards (achievement level or benchmark) for FY 2021 or 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 proposes, however, 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. **CMS welcomes public comments on this proposal to codify the performance standards correction policy finalized in the FY 2019 SNF PPS final rule.**

The numerical performance standards estimated for FY 2023 for the SNFRM SNF 30-Day All-Cause Readmission Measure (NQF #2510) as shown in Table 15 of the proposed rule consist of an achievement threshold of 0.79025 and a benchmark of 0.82917.

3. SNF VBP Performance Scoring

No changes are proposed 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 proposed to the 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 FY 2021 performance. 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 proposes to codify this policy (without changes) at §413.338(e)(3)(i), (ii), and (iii).

Further, CMS proposes to amend §413.338(e)(3) 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 proposed 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 proposes to also apply the 30-day deadline to the baseline period quality measure report that it typically issues in December. This would begin with baseline period quality measure quarterly reports issued on or after October 1, 2020. Under this proposal, SNFs would 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 would be communicated to SNFs through memos, emails, notices on the CMS SNF VBP website and other routine communications.

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 proposed rule, reproduced below, CMS displays the estimated effects in FY 2021 of the SNF VBP Program by types of providers and location. 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

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
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
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 proposed rule, in FY 2021 SNFs would experience an increase of about $784 million in payments or an average increase of 2.3 percent, compared with FY 2020. This results from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment. CMS notes that these impact numbers, however, do not incorporate the SNF VBP reductions and the proposed low-volume adjustment, which it estimates would reduce aggregate payments to SNFs by an estimated $200 million.

Table 16 of the proposed rule (reproduced below) shows the estimated impact of various elements of the proposed rule by SNF classification (excluding the SNF VBP Program impacts). The table includes the effect of the proposed market basket update and the proposed 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 2.3 percent overall increase.

TABLE 16: Impact to the SNF PPS for FY 2021

Provider Characteristics	# Providers	Update Wage Data	Update OMB Delineation	Total Change (Total Wage Update + Market Basket Update)
Group				
Total	15,078	0.0%	0.0%	2.3%
Urban	10,951	0.0%	0.0%	2.3%
Rural	4,127	0.1%	0.1%	2.5%
Hospital-based urban	380	0.3%	0.1%	2.7%
Freestanding urban	10,571	0.0%	0.0%	2.2%
Hospital-based rural	245	0.1%	0.1%	2.5%
Freestanding rural	3,882	0.1%	0.1%	2.5%

Provider Characteristics	# Providers	Update Wage Data	Update OMB Delineation	Total Change (Total Wage Update + Market Basket Update)
Urban by region				
New England	775	-1.2%	-0.1%	1.0%
Middle Atlantic	1,470	0.6%	0.2%	3.2%
South Atlantic	1,868	0.0%	-0.1%	2.2%
East North Central	2,118	-0.2%	-0.1%	2.0%
East South Central	536	-0.2%	-0.1%	1.9%
West North Central	921	-0.6%	-0.1%	1.5%
West South Central	1,323	0.0%	0.0%	2.2%
Mountain	527	-0.5%	0.0%	1.7%
Pacific	1,407		0.0%	2.5%
Outlying	6	0.1%	-0.1%	2.3%
Rural by region				
New England	126	-0.5%	-0.1%	1.7%
Middle Atlantic	194	0.8%	-0.1%	3.0%
South Atlantic	462	-0.1%	0.2%	2.4%
East North Central	908	0.6%	0.1%	3.0%
East South Central	452	-0.1%	0.1%	2.2%
West North Central	1,020	-0.2%	0.1%	2.2%
West South Central	666	0.1%	0.0%	2.5%
Mountain	207	-0.2%	-0.1%	2.0%
Pacific	92	1.2%	-0.1%	3.4%
Ownership				
For profit	10,729	0.0%	0.0%	2.3%
Non-profit	3,469	0.0%	0.0%	2.3%
Government	880	0.1%	0.0%	2.4%

Note: The Total column includes the 2.3 percent market basket increase factor. Additionally, CMS found no SNFs 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 proposed rule (recreated below) show the case-mix adjusted federal rates and associated indexes for PDPM groups for urban and rural SNFs, respectively. 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	$53.09	ES2	3.07	$317.25	2.53	$197.24
C	1.88	$132.95	1.69	$109.77	2.67	$77.88	ES1	2.93	$302.79	1.84	$143.45
D	1.92	$135.78	1.53	$99.37	1.46	$42.59	HDE2	2.40	$248.02	1.33	$103.69
E	1.42	$100.42	1.41	$91.58	2.34	$68.26	HDE1	1.99	$205.65	0.96	$74.84
F	1.61	$113.86	1.60	$103.92	2.98	$86.93	HBC2	2.24	$231.48	0.72	$56.13
G	1.67	$118.10	1.64	$106.52	2.04	$59.51	HBC1	1.86	$192.21	-	-
H	1.16	$82.04	1.15	$74.69	2.86	$83.43	LDE2	2.08	$214.95	-	-
I	1.13	$79.91	1.18	$76.64	3.53	$102.97	LDE1	1.73	$178.78	-	-
J	1.42	$100.42	1.45	$94.18	2.99	$87.22	LBC2	1.72	$177.74	-	-
K	1.52	$107.49	1.54	$100.02	3.7	$107.93	LBC1	1.43	$147.78	-	-
L	1.09	$77.08	1.11	$72.09	4.21	$122.81	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	-	-