Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs), Updates to the Quality Reporting Program and Value-Based Purchasing Program for Fiscal Year (FY) 2020

[CMS-1718-F]

Summary of Final Rule

TABLE OF CONTENTS

I. Overview

On August 7, 2019, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule updating for FY 2020 the Medicare skilled nursing facility (SNF) payment rates, quality reporting requirements, and the SNF Value-Based Purchasing Program (VBP) (84 FR 38728 - 38833). Of particular note, and as finalized in the FY 2019 SNF PPS final rule, CMS is implementing beginning FY 2020 a new case-mix classification system called the Patient Driven Payment Model (PDPM). This replaces the prior case-mix classification methodology, referred to as the Resource Utilization Groups, Version IV (RUG-IV) model.

For FY 2020, the net SNF market basket update will be 2.4 percent. For the SNF Quality Reporting Program (QRP) CMS finalizes, among other changes, two new quality measures to assess how health information is shared and adopt a number of standardized patient assessment data elements (SPADEs) that assess factors such as cognitive function and mental status, special services, and social determinants of health. CMS does not finalize its proposal to expand data collection for SNF QRP quality measures to all skilled nursing facility residents, regardless of their payer.

On the SNF VBP, CMS updates policies, including the performance and baseline periods for the FY 2022 VBP Program year, public reporting requirements for SNFs with fewer than 25 eligible stays, and a 30-day deadline for Phase One Review and Corrections requests.

CMS estimates that the overall impact of the final rule will be an increase of $851 million (2.5 percent) in Medicare payments to SNFs during FY 2020. This overall total and percentage increase, however, does not take into account the estimated reduction of $213.6 million in aggregate payments to SNFs from the SNF VBP program during FY 2020.[1]

II. Background on SNF PPS

CMS reviews the 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 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.

III. SNF PPS Rate Setting Methodology and FY 2020 Update

A summary of key data for the final SNF PPS for FY 2020 is presented below with additional details in the subsequent sections.

Summary of Key Data for Final SNF PPS for FY 2020		
Market basket update factor		
Market basket increase		+2.8%
Forecast error adjustment for FY 2018		0.0%
Required multifactor productivity (MFP) adjustment		-0.4%
Net MFP-adjusted update		**+2.4%**
Wage index budget neutrality adjustment		1.0002
Labor-related share		70.9%
FY 2019[a] Unadjusted Federal Rates Per Diem		
Rate component–RUG IV	**Urban**	**Rural**
Nursing-case-mix adjusted	$181.44	$173.34
Therapy-case-mix adjusted	$136.67	$157.60
Therapy-non-case-mix adjusted	$18.00	$19.23
Non-case-mix adjusted	$92.60	$94.31
FY 2020 Unadjusted Federal Rates Per Diem		
Rate component – PDPM	**Urban**	**Rural**

[1] 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 $534.1 million for FY 2020. (In the Accounting Statement and elsewhere in the impact analysis, this figure is shown as $527.4 million, but the figures provided for specific amounts distributed under the SNF VBP Program, all unchanged from the proposed rule, do not match that total.) Under the 60-percent payback provision and before application of the low-volume adjustment, an estimated $320.4 million will be returned to SNFs and total savings to the Medicare program will be $213.6 million. However, as noted in section VII.E in this summary, the low-volume adjustment is estimated to return an additional $8.1 million to SNFs in FY 2020, increasing the payback percentage to 61.51 percent and reducing the federal savings to $205.5 million.

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	$95.4.84	$96.59
[a/]FY 2019 from FY 2019 Final Rule (83 *FR 39162*-39290), August 8, 2018		

A. Federal Base Rates

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

B. SNF Market Basket Update

CMS finalizes a market basket increase for FY 2020 of 2.8 percent. CMS updated the proposed market basket estimate of 3.0 percent, based on the second quarter 2019 forecast from IHS Global Insight, Inc. (IGI), which measures the percentage increase in the FY 2014-based SNF market basket index for routine, ancillary, and capital-related expenses.

An adjustment to the market basket update would account for forecast errors in previous market basket estimates. The previously adopted threshold for making that adjustment is an error of more than 0.5 percentage points. The most recent year for which actual data are available is FY 2018. The forecast FY 2018 market basket increase was 2.6 percentage points and the actual increase was 2.6 percentage points. Because the difference between the estimated and actual amount of change in the market basket index was the same in this case and thus did not exceed the 0.5 percentage point threshold, CMS finalizes that there is no FY 2020 forecast error adjustment to the 2.8 percent forecast market basket update.

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, 2020, based on IGI's second quarter 2019 forecast.

The resulting net SNF market basket update would equal 2.4 percent (2.8 percent less the 0.4 percentage point MFP reduction).

Based on that MFP-adjusted update, CMS finalizes FY 2020 unadjusted federal rates for each component of the payment for urban and rural areas. CMS Tables 3 and 4 in the final rule, summarized below, present the per diem rates for FY 2020. Under the new 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). One component is a non-case-mix component, as exists under RUG-IV.

Unadjusted FY 2020 Federal Rate Per Diem, Urban and Rural[a/]		
	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	$94.84	$96.59
[a/] Based on CMS Tables 3 and 4		

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 2020 SNF QRP. CMS explains that this is derived by subtracting 2.0 percentage from the MFP-adjusted market basket update of 2.4 percent resulting in positive 0.4 percentage point update.

C. Case-Mix Adjustment

In the FY 2019 final rule, CMS replaced its existing case-mix classification methodology, the RUG-IV model, with a revised case-mix methodology called 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 2020 payment rates reflect the use of the PDPM classification system from October 1, 2019 through September 30, 2020.

CMS lists the final case-mix adjusted PDPM payment rates for FY 2020, for urban and rural SNFs, in Tables 6 and 7 (reproduced in the appendix).

CMS finalized the implementation of the PDPM in a budget neutral manner. To accomplish this, as discussed in the FY 2019 SNF PPS, the unadjusted PDPM case mix indexes (CMIs) were multiplied by 1.46 so that the total estimated payments under the PDPM would be equal to the total actual payments under RUG-IV. In the proposed rule, CMS proposed to update the payment year data used as the basis for the calculation of the standardization multiplier and budget neutrality multiplier from FY 2017 data to FY 2018 data. There were no changes proposed to the methodology. The final standardization and budget neutrality multipliers are shown in Table 5 (reproduced below). CMS shows them to the thousandths place to highlight the effect of this change. CMS also notes that the CMIs provided in Tables 6 and 7 reflect the use of the final multiplier shown in Table 5, which are based on FY 2018 data.

Table 5: PDPM Standardization and Budget Neutrality Multipliers				
Component	**FY 2017 Data**		**FY 2018 Data**	
	Standardization Multiplier	**Budget Neutrality Multiplier**	**Standardization Multiplier**	**Budget Neutrality Multiplier**
PT	1.031	1.458	1.028	1.463
OT	1.030	1.458	1.028	1.463
SLP	0.995	1.458	0.996	1.463
Nursing	0.995	1.458	0.996	1.463
NTA	0.817	1.458	0.811	1.463

D. Wage-Index Adjustment

CMS continues to apply the wage index adjustment to the labor-related portion of the federal rate. As in the past, CMS uses the pre-reclassified IPPS hospital wage data, unadjusted for occupational mix and the rural floor, as the basis for the SNF PPS wage index. For FY 2020, CMS uses updated wage data for hospital cost reporting periods in FY 2016.

CMS adopts, as in the past, a wage index budget neutrality adjustment, and computes that adjustment at 1.0002 for FY 2020.[2] CMS notes 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.

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 2020 price levels. This process includes computing the FY 2020 price index level for the total market basket and each cost category of the market basket. Based on this update, the final SNF labor-related share is 70.9 percent (similar to the 2019 estimate of 70.5 percent). Table 8 in the final rule summarizes the final, revised labor-related share for FY 2020 (based on the updated IGI second quarter 2019 forecast) compared with FY 2019 overall, and 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 2020 labor-related share percentage (as shown in Table 9 in the final rule). 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.

Tables 9, 10, and 11 in the final rule provide illustrative examples of how payment would be calculated during FY 2020 under PDPM for a hypothetical 30-day SNF stay.

In response to commenters' concerns about using the inpatient hospital wage index in lieu of a SNF-specific wage index, CMS discusses the numerous difficulties with establishing a SNF PPS wage index, including the volatility of existing SNF wage data and the significant resources required to improve the data quality. CMS will consider suggestions for modifying the current hospital wage data and suggestions for developing a SNF-specific occupational mix adjustment in future rulemaking. CMS does not agree with comments recommending a rural floor under the

[2] CMS notes it identified a programming error and an erroneous classification of a provider as an urban Core-Base Statistical Area (CBSA) in the calculations of the wage index values as described in the proposed rule. As a result of correcting this wage index error, the budget neutrality factor calculated for the proposed rule (1.0060) was revised. CMS corrected these errors and the corrected amounts are reflected in the tables on the CMS website.

SNF PPS and notes that MedPAC recommended eliminating the rural floor policy from the calculation of the IPPS wage index.[3]

IV. 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. It also notes that as it gains actual operating experience under the new classification model, it may make further adjustments.

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.

[3] See Chapter 3 of MedPAC's March 2013 Report to Congress available at http://www.medpac.gov/docs/default-source/reports/mar13_ch03.pdf.

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 invited comments to identify 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.

In response to comments about creating an exclusion from consolidated billing for clotting factor and non-factor medication therapies for patients with hemophilia, CMS states that hemophilia treatments are outside the exclusions authorized by statute[4] and establishing an exclusion category for hemophilia treatment services, or any other service category not specified in the statute, would require legislation. In response to a comment that CMS should focus on the cost of chemotherapy and set an overall cap on chemotherapy expenditures, CMS also indicates that the statute does not authorize or provide for setting an overall cap on chemotherapy expenditures.

As to the recurring request to exclude the oral chemotherapy REVLIMID, CMS discusses it prior consideration in the FY 2019 SNF PPS final rule (83 FR 3918) about whether a Part D covered chemotherapy drug would be excluded from consolidated billing. CMS continues to believe that the applicable provisions at section 1888e(2)(A) of the Act do not provide a basis for excluding Part-D only chemotherapy drugs from consolidated billing. After further consideration, CMS believes restrictive language in section 1888e(2)(A)(i) of the Act, which defines the covered SNF services included in the SNF per diem rate, does not include Part-D drugs from consolidated billing. The section defines the term “”covered SNF services” in subclause (1) as Part A post-hospital extended care services (SNF services) as defined in section 1861(i) of the Act, and in subclause (II) as “all items and services (other than items and services described in clauses (ii), (iii), and (iv) <u>for which payment may be made under Part B</u>” and which are furnished during the course of a Medicare-covered SNF stay (emphasis added). Accordingly, while therapeutic drugs such as REVLIMID would fall within the scope of the Part A SNF bundle (subclause (1)), the only items and services that could potentially be carved out from the bundle under subclause (II) would be those that otherwise would be separately payable under <u>Part B</u>. Expanding the existing statutory drug coverage available under Part B to include such drugs is not within its authority. CMS also notes the accompanying legislative history[5] specifically <u>reaffirmed</u> the Part-B only nature of the consolidated billing exclusions. CMS notes that the PDPM will make a separate SNF payment component for NTA services which will more accurately account for NTA services such as drugs, furnished in the SNF setting.

C. Payment for SNF-level Swing-bed Services

CMS discusses the legislation enacted in section 203 in the BBA establishing 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

[4] Section 1888(e)(2)(A)(iii)
[5] House Ways and Means Comm. Rep. No. 108-178, Part 2 at 209.

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 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html.

V. Issues Relating to PDPM Implementation

A. Revised Group Therapy Definition

Effective October 1, 2019 under the PDPM, each therapy component is case-mix adjusted based on patient characteristics instead of the volume of therapy services furnished. In the FY 2019 SNF PPS final rule (83 FR 39237 - 39243), CMS finalized a combined limit on concurrent and group therapy furnished to a patient. For each therapy discipline, CMS finalized that no more than 25 percent of the therapy services furnished to a patient in a covered Medicare Part A stay may be in a group or concurrent setting.

In the FY 2012 SNF PPS final rule, CMS defined group therapy as the practice of one therapist or therapy assistant treating four patients at the same time while the patients are performing either the same or similar activities (76 FR 48511 - 48517). CMS thought that group therapy gave patients the opportunity to benefit from observing and interacting with other participants but that groups with five or more participants were too large to promote patient engagement and allow adequate supervision.

As discussed in the FY 2019 SNF PPS final rule, CMS has monitored group therapy utilization and found that group therapy represents a very small proportion of therapy provided to SNF patients (83 FR 39237). Commenters suggested CMS revise the definition of group therapy to include two to six participants doing the same or similar activities; this would align with the Inpatient Rehabilitation Facility (IRF) setting and allow increased flexibility in smaller SNFs. In response to this comment, CMS reviewed the use of group therapy in the IRF (group therapy size of two to six participants) and outpatient settings (group therapy size as two or more participants) and found that therapists can manage groups of various sizes and have the clinical judgement to determine the appropriate group size for their patients. Although CMS continued to maintain some concerns about group size and patient interaction, it believed it would be appropriate to allow therapists greater flexibility to perform therapy in groups of different sizes. Given the similarity between the IRF and SNF settings in terms of the intensity and patient acuity, CMS concluded the IRF PPS definition would be more appropriate in the SNF setting. CMS continues to believe that individual therapy is the preferred mode of therapy and that group therapy is primarily effective as a supplement to individual therapy.

CMS finalizes its proposal to define group therapy in the SNF part A setting 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, effective October 1, 2019. Therapist will still need to document why group therapy is the most appropriate mode of therapy for the patient. In addition, SNFs should include in the patient's plan of care an explicit justification for the use of group, rather than individual or concurrent therapy. At a minimum, this description should include how the prescribed type and amount of group therapy will meet the patient's needs and

assist the patient in reaching the documented goals. CMS plans on monitoring the usage of group therapy and if the monitoring efforts indicate substantial noncompliance with the 25 percent limit, it may take additional action in future rulemaking.

In response to a comment requesting clarification about the documentation requirements regarding group therapy, CMS notes there is no change in the documentation requirement and that the need for group therapy should be documented in the plan of care or in the medical record if the need for group therapy is made after a plan of care is completed. CMS agrees with comments that clinicians should determine the most appropriate mode of therapy for a patient and that individual therapy should be the primary mode of therapy and the standard of care for SNF patients. CMS appreciates comments suggesting revising the definition of group therapy to two to four patients and if appropriate, it might consider this in future rulemaking.

Several comments were concerned that the simultaneous implementation of PDPM and the change to the definition of group therapy will impact CMS' ability to compare RUG-IV and PDPM utilization of group therapy. In addition, several comments did not support the change to the definition of group therapy and raised concerns that PDPM will incentivize SNFs to provide less therapy in general and the proposal will increase the amount of group therapy provided. CMS acknowledges this difficulty but thinks this change will benefit SNF patients and should be implemented without any delay. CMS discusses the safeguards and monitoring mechanisms it has to monitor the percentage of group therapy provided, including the provision that for each therapy discipline, no more than 25 percent of the therapy services furnished to a patient in a covered Medicare Part A stay may be in a group or concurrent setting.

B. Updating ICD-10 Code Mappings and Lists

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.

The ICD-10 Coordination and Maintenance Committee meets biannually and publishes updates to the ICD-10 medical code data set every June which become effective October 1 of the year in which the updates are issued. The committee can also make changes that are effective on April 1 but has not yet done this. Providers are required to follow the most up to date coding issued by this committee (45 CFR part 162, subpart J).

CMS proposed 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, through a subregulatory process which would consist of posted updated code mappings and list on the PDPM website. Beginning with the FY 2020 updates, 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.

- 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 noted that changes to the assignment of a code to a comorbidity or other changes that amount to a change in policy would be a substantive change. An example of a substantive change would be the separation of an ICD-10 code for a particular condition into two or more codes when one code represents a condition that is predictive of the costs of care in a SNF and one which is not predictive of the costs of care. CMS stated it would propose through rulemaking to delete the code that does not reflect increased costs of care from the SNF GROUPER. CMS proposed to indicate all changes to codes in the GROUPER software by posting a compete ICD-10 mapping table, including the complete list of ICD-10 codes associated with the SNF PDPM clinical categories and SLP/NTA comorbidities in the SNF GROUPER documentation, on the PDPM website. CMS discussed how the proposed subregulatory process is in alignment with similar policies in the SNF and IRF PPS.

CMS **finalizes** this proposal and plans to post these updated mappings and lists on the SNF PPS website prior to October 1, 2019.

In response to a commenter requesting additional guidance on what constitutes a "substantive" change CMS provides additional examples and explains that if it believes a new code is not predictive of SNF costs of care and wants to remove the new code from the mappings and lists of PDPM comorbidities, this would be a substantive change, because it changes an existing policy and would only make such a change through notice and comment. If an existing code is revised and split into two separate codes that are mapped to a comorbid condition, CMS would consider this a non-substantive change and would make this change through the subregulatory process. In response to comments, CMS notes it will continue to provide a number of educational materials on the PDPM website and will issue an Medicare Learning Network (MLN) article about this policy.

C. Revisions to the Regulation Text

CMS proposed to make certain revisions to the regulations text at §413.343(b) to reflect the revised assessment schedule finalized for the PDPM (83 FR 39229).

- CMS proposed to revise the resident assessment schedule to reflect the elimination of the scheduled assessment after the initial "5-day" to the "8-day" assessment window which incorporates the 3 grace days. To ensure consistency, CMS proposed to make a conforming revision to the regulatory text so that the introductory paragraph would be "initial patient assessment" instead of "the 5-day assessment. CMS also proposed to include a conforming revision to make clear that the actual deadline for completing this assessment is no later than the 8th day of posthospital SNF care.
- CMS proposed to revise the language that requires completion of "other assessments that are necessary to account for changes in patient care needs" to state "such other interim

payment assessments as the SNF determines are necessary to account for changes in patient care needs. CMS stated this would make it clear that the SNF is responsible for recognizing those situations that warrant a decision to complete an Interim Payment Assessment (IPA)in order to appropriately account for a change in patient status.

Some commenters expressed concern that the term "initial patient assessment" would be confused with the interim payment assessment, or IPA and suggested alternative text. In response to comments, to distinguish the "5-day assessment" more clearly from the IPA, CMS will use the terms "initial Medicare assessment".

Commenters also noted confusion over that "8-day" assessment window. To clarify the "8-day" assessment window, CMS will revise the regulations text to require the performance of an initial Medicare assessment "with an assessment reference date that is set for no later than the 8th day of posthospital SNF care". CMS notes that as explained in section 2.9 of the RAI Version 3.0 Manual, the initial Medicare assessment itself need not be actually completed by the 8th day; rather the assessment reference date (ARD) for this assessment must be set for a date that is no later than the 8th date of posthospital SNF care (in other words, the facility cannot designate Day 9 or later as this assessment's ARD). In order to clarify this policy, CMS will make a conforming revision in the introductory paragraph of the regulations text at 42 CFR 409.30 by specifying that the ARD for this assessment "must be set for (rather than "must occur") no later than the 8th day of posthospital SNF care.

In response to comments about the IPA, including suggestions to regulations text, CMS states that while a SNF's decision to complete the IPA is optional, the SNF's underlying responsibility is to remain fully aware of (and respond appropriately to) any changes in its resident's condition is not discretionary. CMS believes the discussion of the IPA in the FY 2019 SNF PPS final rule (83 FR 39233) clearly establishes the IPA as one mechanism that the SNF can utilize in providing its ongoing patient monitoring responsibilities.

After consideration of comments, CMS **finalizes** the proposed changes to the regulation text in §§413.343 and 409.30, with the modifications discussed above.

VI. SNF Quality Reporting Program (QRP)

The SNF QRP was established pursuant to the IMPACT Act. Under the program, freestanding SNFs, SNFs affiliated with acute care hospitals and all non-CAH swing bed rural hospitals must meet resident assessment and quality data reporting requirements or be subject to a 2.0 percentage point reduction in the update factor beginning in FY 2018.

SNFs report data on SNF QRP assessment-based measures and standardized resident assessment data by reporting the designated data elements for each applicable resident on the Minimum Data Set (MDS) resident assessment instrument and then submitting completed instruments to CMS using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system.

A table at the end of this section (VI.F) displays the measures previously adopted for the SNF QRP for FY 2021 and newly finalized for FY 2022.

A. New Measures for FY 2022

CMS adopts two new process measures for the SNF QRP beginning with FY 2022 for a new quality measure domain entitled "Transfer of Health Information." In addition, the specifications for the Discharge to Community PAC SNF QRP measure are updated in order to exclude baseline nursing facility (NF) residents from the measure. Final specifications for the measures (with changes from the proposed rule versions) are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Final-Specifications-for-SNF-QRP-Quality-Measures-and-SPADEs.pdf.

- Transfer of Health Information to the Provider — Post-Acute Care (PAC) Measure. This measure assesses whether a current reconciled medication list is given to the subsequent provider when an individual transitions from a PAC setting to another setting. Specifically, the measure calculates the proportion of resident stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at discharge. The denominator is the total number of SNF resident stays ending in discharge to a subsequent provider (an acute care hospital, intermediate care, home under the care of a home health service organization or hospice, institutional hospice, SNF, long-term care hospital (LTCH), IRF, inpatient psychiatric facility, or a CAH). The numerator is the number of SNF resident stays with an MDS discharge assessment indicating a current reconciled medication list was provided to the subsequent provider at discharge.
- Transfer of Health Information to the Patient— PAC Measure. This related new measure assesses whether a current reconciled medication list was provided to the patient (resident), family, or caregiver when a patient was discharged from a PAC setting to a private home/apartment, board or care home, assisted living, group home, transitional living, or home under care of a home health service organization or hospice. The measure denominator is the total number of SNF resident stays ending in discharge to the locations listed above, and the numerator is the number of SNF resident stays with an MDS discharge assessment indicating that a current reconciled medication list was provided to the resident, family, or caregiver at discharge.
- Update to the Discharge to Community PAC Measure. The specifications for this measure are updated to remove baseline nursing facility residents. The measure reports a SNF's risk-standardized rate of Medicare fee-for-service residents who are discharged to the community following a SNF stay, who within the following 31 days remain alive and do not have an unplanned readmission to an acute care hospital or LTCH. CMS will exclude baseline NF residents from the measure beginning with the FY 2020 SNF QRP, with baseline NF residents 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 the final measure specifications, CMS further clarifies that a long-term NF stay is identified by the presence of a non-SNF

PPS MDS assessment in the 180 days preceding the qualifying prior acute care admission and index SNF stay.

CMS responds to comments regarding the transfer of information measures. It states that it plans to submit them for NQF endorsement as soon as feasible. CMS believes that the burden of reporting these measures will not be significant. They conclude this based on Technical Expert Panel feedback and pilot testing, and because the measures are based on one item only and associated activities are consistent with existing patient safeguard requirements for information transfer at the time of discharge.

Regarding exclusion of baseline nursing facility residents from the discharge to community measure, CMS reports that MedPAC did not support this change. CMS disagrees with MedPAC and says that "community" is generally understood by policy makers, providers and other stakeholders to mean non-institutional settings, and that baseline nursing facility residents are an inherently different patient population.

Data submission requirements for the two new measures are discussed in VI.D below.

B. SNF QRP Quality Measures, Measure Concepts and Standardized Patient Assessment Data Elements (SPADEs) under Consideration for Future Years

CMS describes the responses it received in reply to its request for comment on the importance, relevance, appropriateness and applicability of the following measures, SPADEs and concepts under consideration for future years. (From Table 13 in the final rule.) These comments will be considered in future policy making.

- Assessment-based Quality Measures and Measure Concepts
    - Functional maintenance outcomes
    - Opioid use and frequency
    - Exchange of electronic health information and interoperability
- Claims-Based
    - Healthcare-associated infections in SNF
- Standardized Patient Assessment Data Elements
    - Cognitive complexity, such as executive function and memory
    - Dementia
    - Bladder and bowel continence including appliance use and episodes of incontinence
    - Care preferences, advance care directives, and goals of care
    - Caregiver Status
    - Veteran Status
    - Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

C. Standardized Patient Assessment Data Reporting Beginning with FY 2022

The IMPACT Act requires that, beginning in FY 2019, SNFs must report SPADEs as required for at least the quality measures with respect to certain categories, summarized here as functional

status; cognitive function; special services and interventions; medical conditions and comorbidities; impairments; and other categories deemed necessary and appropriate by the Secretary. The standardized patient assessment data must be reported under the SNF QRP at least with respect to SNF admissions and discharges, but the Secretary may require the data to be reported more frequently.

In this rule, CMS finalizes requirements that SNFs report a new series of SPADEs. The list of newly adopted SPADEs, along with information on their current use in PAC patient assessment instruments and whether changes apply to the MDS are summarized in a table below. Detailed specifications for the SPADEs are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Final-Specifications-for-SNF-QRP-Quality-Measures-and-SPADEs.pdf. A final change table and mockup of SNF QRP items are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html. These latter two documents also include the data elements associated with the new transfer of health information measures discussed above.

For each SPADE, the final rule discusses the rationale, whether the element is currently used in any PAC patient assessment instruments, describes past comments from stakeholders and pilot testing and responds to comments on the proposed rule. Most of the newly adopted SPADEs were proposed as part of FY 2018 rulemaking but were not finalized at that time. Those that were newly discussed in this year's rulemaking involve functional status (six mobility-related data elements already adopted for the other three PAC settings); high risk drug classes; pain interference; and social determinants of health, which is a newly added category of SPADEs. These address race, ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation. Responding to commenters regarding burden, CMS says that it modified many current MDS items to minimize the additional burden of new SPADEs, responding that only 59.5 items were added across the admission and discharge assessments. With a change from the proposed rule, CMS finalizes that if certain SPADEs are submitted with respect to admission only, they will be deemed to have been submitted for both admission and discharge as generally required. This policy is finalized because assessment of certain elements is unlikely to change between admission and discharge. As proposed, this policy is finalized for the Hearing, Vision, and Race and Ethnicity SPADEs. In addition, based on comments received from stakeholders, CMS will also apply this policy to the new SPADEs regarding preferred language and interpreter services. CMS disagrees with comments suggesting the policy also apply to other SPADEs, including social isolation and health literacy.

Comments were received regarding the addition of SPADEs generally and on individual SPADEs. CMS reiterates its intention to use reported SPADEs to inform care planning, the common standards and definitions to facilitate interoperability, and for developing standardized measures. It intends to continue to collaborate with stakeholders during the policy development process and through future rulemaking. Research identifiable files of data collected in the

National Beta Test[6] of candidate data elements are being created and will be made available through a data use agreement sometime in 2019. Additional volumes of the Beta Test Report will also be made available in late 2019, including supplemental analyses of the SPADEs.

In the impact analysis section of the final rule CMS estimates that the addition of the SPADEs, including those for the two new quality measures, will result in the addition of 59.5 assessment items (including both the PPS 5-day and discharge assessments). The total cost of collecting these additional items is estimated at $1,873.28 per SNF annually, or $29 million across all 15,471 SNFs. (In the proposed rule, CMS estimated no impact on its previous total burden estimates.) CMS estimates the total burden of all assessments across all facilities to be $288 million.

Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to MDS**
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS IRF-PAI	Add to discharge assessment (currently admission only)
Confusion Assessment Method	LCDS (6 items) MDS (4 items)	Add to discharge assessment (currently admission only)
Patient Health Questionnaire-2 to 9 (depression screening)	MDS (PHQ-9) OASIS (PHQ-2)	Replace PHQ-9 with PHQ-2 to 9
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS (single)	Modify MDS items (add IV access item) and assess at both
Cancer Treatment: Radiation	MDS	
Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High-concentration Oxygen Delivery)	MDS OASIS PAC PRD	
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS PAC PRD	
Respiratory Treatment: Tracheostomy Care	MDS	
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS	
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS	
Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)	MDS OASIS	
Transfusions	MDS PAC PRD	

[6] The National Beta Test collected data from 3,121 patients and residents across 143 PAC providers (26 LTCHs, 60 SNFs, 22 IRFs, and 35 HHAs) from November 2017 to August 2018 to evaluate the feasibility, reliability, and validity of candidate data elements across PAC settings.

Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to MDS**
Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS	admission and discharge
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)		
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS IRF-PAI OASIS	
Nutritional Approach: Feeding Tube	MDS OASIS IRF-PAI PAC PRD	
Nutritional Approach: Mechanically Altered Diet	MDS OASIS IRF-PAI	
Nutritional Approach: Therapeutic Diet	MDS	
High-Risk Drug Classes: Use and Indications	MDS	Modify MDS item
Medical Condition and Comorbidity Data		
Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities)	OASIS MDS	Modify MDS item
Impairment		
Hearing	MDS	Existing item**
Vision	MDS OASIS	Existing item**
Social Determinants of Health		
Race	MDS	
Ethnicity	LCDS IRF-PAI OASIS	Modify MDS items**
Preferred Language and Interpreter Services	MDS LCDS	Modify MDS item**
Health Literacy		New item
Transportation	PREPARE/AHC screening tool	New item
Social Isolation	PROMISE/AHC screening tool	New item
*This column reflects whether the final rule indicates that the specific elements, or similar or related elements, are included in the current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: MDS; Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI); Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS); and OASIS for home health agencies.		

Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to MDS**
** SNFs submitting these SPADEs with respect to admission only are deemed to have submitted them for both admission and discharge, because it is unlikely that assessment of these SPADEs would change during the SNF stay.		

D. Form, Manner, and Timing of Data Submission

1. Reporting System Update

CMS reports that it is upgrading the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system used by SNFs to report the MDS data to CMS. The new system will be called the internet QIES (iQIES) and CMS modifies the regulatory text to reflect this change. A general reference to use of a "CMS-designated data submission system" will replace the existing references to QIES ASAP system.

While the proposed rule indicated that the new system will be effective no later than October 1, 2021, it now says it can no longer commit to that date. It will make the change as soon as technically feasible.

2. Schedule for Reporting Transfer of Health Information Quality Measures

As summarized in section VI.A above, two new measures are adopted beginning with FY 2022 payment. SNFs will be required to collect data for these measures beginning with residents discharged on or after October 1, 2020.

3. Schedule for Reporting SPADEs

Similarly, with respect to reporting on the new SPADEs as summarized in section VI.C above, SNFs must submit data beginning with residents discharged on or after October 1, 2020 at both admission and discharge. As noted above, for certain SPADEs, collection by SNFs at admission only will be deemed to meet this requirement.

Specifically, for FY 2022 the data will be reported with respect to both admissions and discharges occurring between October 1, 2020 and December 31, 2020. For FY 2023 and later years, the data will be required for admissions and discharges that occur during a calendar year – 2021 for the FY 2023 SNF QRP, 2022 for the FY 2024 SNF QRP, etc.

4. All-Resident Data Reporting for the SNF QRP

CMS does not finalize its proposal to require SNFs to report MDS data on all residents, regardless of payer, beginning October 1, 2020. After consideration of public comments CMS intends to better quantify the new reporting burden on SNFs before proceeding with this policy. It intends to further evaluate which assessments are appropriate for reporting and better define

the population of residents. It will propose a revised policy for all-payer reporting of MDS data in the future.

E. Policies Regarding Public Display of Measure Data for the SNF QRP

The SNF QRP measure "Drug Regimen Review Conducted with Follow-Up for Identified Issues" will be added to the *Nursing Home Compare* website at https://www.medicare.gov/nursinghomecompare/search.html.

Display will begin with 2020 or as soon as technically feasible. The data display will be for a rolling four quarters of data, initially using data for discharges occurring during calendar year 2019. Data for SNFs with fewer than 20 eligible cases in any four consecutive rolling quarters will not be publicly displayed. For those SNFs, the website will indicate that the number of cases is too small to publicly report.

F. Table of SNF QRP Measures

Quality Measures Previously Adopted for the FY 2021 SNF QRP and Newly Adopted for FY 2022

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set	
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).
Beginning in FY 2022	Transfer of Health Information to the Provider – PAC Measure
Beginning in FY 2022	Transfer of Health Information to the Patient – PAC Measure
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).
* Measure updated to remove baseline nursing facility patients beginning in FY 2020.	

VII. SNF Value Based Purchasing (VBP) Program

A. Background

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 SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR). As required by statute, CMS intends to replace the SNFRM with the SNFPPR as soon as is practicable and also states that it intends to submit it to the National Quality Forum for review as soon as feasible. 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.

B. SNFPPR: Change of Measure Name

CMS is changing the name of the SNFPPR to "SNF Potentially Preventable Readmissions after Hospital Discharge," which it believes responds to stakeholder confusion and will more clearly differentiate this measure from the SNF QRP potentially preventable readmission measure. That measure, the Potentially Preventable 30-Day Post-Discharge Readmission Measure, is aligned with the SNFPPR in terms of exclusion criteria and risk adjustment approach but the readmission windows for the two measures differ. The SNFPPR uses a 30-day *post-hospital* discharge readmission window, whereas the SNF QRP measure uses a 30-day *post-SNF* discharge readmission window. CMS believes these windows assess different aspects of SNF care, and notes that the SNF QRP potentially preventable readmissions measure aligns with the readmission window used for similar measures involving other PAC providers.

C. FY 2022 Performance Standards, and Performance and Baseline Periods

Under previous established policy, the performance period for the FY 2022 SNF VBP program year will be FY 2020, and the baseline period will be FY 2018. Using that baseline period, the final performance standards for FY 2022 are shown in Table 15, reproduced below.

Table 15: Final FY 2022 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79025	0.82917

D. SNF VBP Performance Scoring

No changes are made to the SNF VBP Program performance scoring methodology; none were proposed.

E. 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.

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 2019 payment results represent the best estimate of FY 2020 performance. The SNF VBP Program Facility-Level Dataset for FY 2019 is available at https://data.medicare.gov/Nursing-Home-Compare/SNF-VBP-Facility-Level-Dataset/284v-j9fz.

Impact modeling by CMS of the low-volume adjustment policy that was finalized in the FY 2019 SNF PPS final rule to begin in FY 2020 shows that this policy will redistribute an estimated $8.1 million to low-volume SNFs in that year. This increases the SNF VBP payback percentage for FY 2020 from 60 percent to 61.51 percent of the 2.0 percent withhold.

F. 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 this rule, CMS modifies the circumstances under which data on a SNF's performance will be suppressed from public display. It is concerned that under current policies, a SNF with fewer than 25 eligible stays during the baseline period is not eligible for an improvement score and therefore no improvement score would be displayed. Similarly, a SNF with fewer than 25 eligible stays during a performance period is assigned a performance score such that its SNF federal per diem rate is unaffected by the SNF VBP Program. CMS is concerned that publishing performance information based on insufficient data does not convey a complete and reliable picture of a SNF's performance.

Specifically, CMS will suppress the SNF information available to display as follows:

- If a SNF has fewer than 25 eligible stays during a baseline period, the baseline risk-standardized readmission rate (RSRR) or improvement score will not be displayed. The related performance period RSRR, achievement score and total performance score for this SNF will still be displayed if the SNF had sufficient data during the performance period.
- If a SNF has fewer than 25 eligible stays during the performance period and therefore receives an assigned SNF performance score, the assigned score will not be displayed and the performance period RSRR, the achievement score and improvement score will not be displayed.
- No information will be displayed for a SNF with zero eligible cases during a performance period.

CMS believes this policy will result in it publishing as much meaningful information as possible provided about SNF VBP Program performance while ensuring that the information published is reliable.

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

G. Update to Phase One Review and Correction Deadline

Based on its initial experience, CMS modifies the deadline for SNFs to request a data correction. Under the previously adopted two-phase review and corrections process, CMS accepts Phase One corrections to any quarterly report provided by a SNF until the following March 31. While it intended to provide SNFs more time to review the data, it now believes a shorter time frame is sufficient and preferable.

In this rule CMS adopts instead to use a 30-day deadline for Phase One correction requests. The 30-day period will begin 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 will have 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.

H. Impact Analysis

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 $534.1 million for FY 2020. (In the Accounting Statement and elsewhere in the impact analysis, this figure is shown as $527.4 million, but the figures provided for specific amounts distributed under the SNF VBP Program, all unchanged from the proposed rule, do not match that total.) Under the 60-percent payback provision and before application of the low-volume adjustment, an estimated $320.4 million will be returned to SNFs and total savings to the Medicare program will be $213.6 million. However, as noted in section VII.E above, the low-volume adjustment is estimated to return an additional $8.1 million to SNFs in FY 2020, increasing the payback percentage to 61.51 percent and reducing the federal savings to $205.5 million.

In Table 19 of the final rule, reproduced below, CMS displays the estimated effects in FY 2020 of the SNF VBP Program by types of providers and location. (The table is unchanged from the proposed rule.) Mean standardized readmission rates, and therefore performance scores and incentive multipliers, vary in particular by region.

Table 19: Estimated SNF VBP Program Impacts for FY 2020

Characteristic	Number of facilities	Mean Risk-Standardized Readmission Rate (SNFRM) (%)	Mean performance score	Mean incentive multiplier	Percent of total incentive payment
Group					
Total	15,421	19.42	37.2169	0.99309	100.00
Urban	11,007	19.47	36.1519	0.99262	85.16
Rural	4,414	19.31	39.8729	0.99426	14.84
Hospital-based urban	355	19.08	42.6453	0.99546	2.14
Freestanding urban	10,602	19.48	35.9056	0.99251	82.98
Hospital-based rural	246	18.98	46.9882	0.99756	0.57
Freestanding rural	3,943	19.32	39.3322	0.994	14.11
Urban by Region					
New England	786	19.54	33.0786	0.99119	5.75
Middle Atlantic	1,473	19.25	38.8823	0.99365	15.92
South Atlantic	1,869	19.56	35.6803	0.99256	17.39
East North Central	2,122	19.52	34.5595	0.99174	14.08
East South Central	551	19.69	32.2849	0.99095	3.68
West North Central	923	19.46	36.7211	0.99281	4.01
West South Central	1,336	19.84	31.4446	0.99065	7.32
Mountain	530	18.92	44.5446	0.99634	3.63
Pacific	1,411	19.20	40.4522	0.99475	13.36
Outlying	6	19.38	41.5899	0.99252	0.00
Rural by region					
New England	134	19.12	39.8964	0.99396	0.67
Middle Atlantic	214	19.14	40.4625	0.99406	0.86
South Atlantic	493	19.42	36.8815	0.99294	2.22
East North Central	931	19.15	40.6763	0.99452	3.43
East South Central	520	19.60	34.5229	0.99178	2.31
West North Central	1,064	19.14	44.0171	0.99615	1.93
West South Central	738	19.85	33.6008	0.99171	2.16
Mountain	222	18.78	49.4262	0.99862	0.65
Pacific	97	18.30	55.1379	1.00141	0.62
Outlying	1	18.98	37.0195	0.98788	0.00
Ownership					
Government	982	19.11	43.3338	0.99568	3.70
Profit	10,810	19.52	35.3904	0.99229	75.38
Non-Profit	3,629	19.20	41.0027	0.99478	20.92

VIII. Economic Analyses

CMS estimates that in FY 2020 SNFs would experience an increase of about $851 million in payments or an average increase of 2.4 percent, compared with FY 2019. 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 would reduce aggregate payments to SNFs by an estimated $213.6 million.

Table 18 of the final rule (reproduced below) shows the estimated impact of various elements of the proposed rule by SNF classification. This includes the effect of the transition to PDPM and the effect of the annual update to the wage index, which are both implemented in a budget neutral manner. CMS estimates that in FY 2020 hospital-based SNFs would experience the largest estimated increase in payment of 23.1 percent in rural areas and 12.4 percent in urban areas. Freestanding SNFs would have smaller increases of 5.6 percent in rural areas and 1.4 percent in urban areas. Among ownership type, payments to government SNFs are expected to experience the largest increase of 7.0 percent and for-profit SNFs the smallest increase of 1.8 percent. Among regions, SNFs in the urban outlying areas would experience the largest estimated increase in payment of 60.5 percent and SNFs in urban areas in the Middle Atlantic region would experience a decrease in payment of -0.8 percent.

Table 18: Impact to the SNF PPS for FY 2020

	Number of Facilities FY 2020	PDPM Impact	Update Wage Data	Total Change
Group				
Total	15,078	0.0%	0.0%	2.4%
Urban	10,951	-0.7%	0.0%	1.7%
Rural	4,127	3.7%	0.2%	6.2%
Hospital-based urban	380	9.9%	0.1%	12.4%
Freestanding urban	10,571	-1.0%	0.0%	1.4%
Hospital-based rural	245	20.4%	0.3%	23.1%
Freestanding rural	3,882	3.1%	0.2%	5.6%
Urban by region				
New England	775	2.0%	-0.4%	4.0%
Middle Atlantic	1,470	-3.1%	-0.1%	-0.8%
South Atlantic	1,868	-0.7%	-0.2%	1.5%
East North Central	2,118	0.1%	0.0%	2.4%
East South Central	536	0.7%	-0.2%	2.9%
West North Central	921	3.8%	0.6%	6.8%
West South Central	1,323	-1.3%	0.2%	1.3%
Mountain	527	0.1%	0.2%	2.7%
Pacific	1,407	-0.9%	0.1%	1.6%
Outlying	6	58.5%	-0.4%	60.5%
Rural by region				
New England	126	5.4%	-1.5%	6.3%
Middle Atlantic	194	2.3%	0.0%	4.8%
South Atlantic	462	4.2%	0.4%	7.0%
East North Central	908	3.4%	-0.1%	5.7%
East South Central	452	2.4%	0.3%	5.1%
West North Central	1,020	10.2%	0.4%	13.1%
West South Central	666	-0.5%	0.3%	2.2%
Mountain	207	6.0%	1.2%	9.6%
Pacific	92	1.4%	0.3%	4.1%

	Number of Facilities FY 2020	PDPM Impact	Update Wage Data	Total Change
Ownership				
For profit	10,729	-0.6%	0.0%	1.8%
Non-profit	3,469	1.5%	0.0%	3.9%
Government	880	4.5%	0.1%	7.0%
Note: The Total column includes the 2.4 percent market basket increase factor. Additionally, CMS found no SNFs in rural outlying areas.				

CMS considers the final rule economically significant and hence a major rule under the Congressional Review Act. CMS concludes that the final rule would not have a significant impact on a substantial number of small entities (a cost or revenue impact of 3 to 5 percent is considered significant). CMS postulates that for most facilities (when all payers are included in the revenue stream), the overall impact on total revenue should be substantially less than those presented. CMS also determined that it would not have a significant impact (that is, not greater than 3 percent) on rural hospitals, but anticipates that the changes proposed will be positive. CMS also concludes that the proposed rule will not have a substantial effect on state or local governments, preempt state law, or otherwise have a federalism implication.

Appendix Tables

CMS notes that under both RUG-IV and PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim in order to bill for covered SNF services. The characters in the codes, however, represent different things. Under PDPM, 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.

Column 1 of Tables 6 and 7 in the final rule (recreated below) 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 6: 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	$92.95	1.49	$84.26	0.68	$15.42	ES3	4.06	$430.04	3.24	$258.91
B	1.70	$103.28	1.63	$92.18	1.82	$41.28	ES2	3.07	$325.17	2.53	$202.17
C	1.88	$114.21	1.69	$95.57	2.67	$60.56	ES1	2.93	$310.35	1.84	$147.03
D	1.92	$116.64	1.53	$86.52	1.46	$33.11	HDE2	2.40	$254.21	1.33	$106.28
E	1.42	$86.27	1.41	$79.74	2.34	$53.07	HDE1	1.99	$210.78	0.96	$76.71
F	1.61	$97.81	1.60	$90.48	2.98	$67.59	HBC2	2.24	$237.26	0.72	$57.54
G	1.67	$101.45	1.64	$92.74	2.04	$46.27	HBC1	1.86	$197.01	-	-
H	1.16	$70.47	1.15	$65.03	2.86	$64.86	LDE2	2.08	$220.31	-	-
I	1.13	$68.65	1.18	$66.73	3.53	$80.06	LDE1	1.73	$183.24	-	-
J	1.42	$86.27	1.45	$82.00	2.99	$67.81	LBC2	1.72	$182.18	-	-
K	1.52	$92.34	1.54	$87.09	3.70	$83.92	LBC1	1.43	$151.47	-	-
L	1.09	$66.22	1.11	$62.77	4.21	$95.48	CDE2	1.87	$198.07	-	-
M	1.27	$77.15	1.30	$73.52	-	-	CDE1	1.62	$171.59	-	-
N	1.48	$89.91	1.50	$84.83	-	-	CBC2	1.55	$164.18	-	-
O	1.55	$94.16	1.55	$87.65	-	-	CA2	1.09	$115.45	-	-
P	1.08	$65.61	1.09	$61.64	-	-	CBC1	1.34	$141.93	-	-
Q	-	-	-	-	-	-	CA1	0.94	$99.56	-	-
R	-	-	-	-	-	-	BAB2	1.04	$110.16	-	-

TABLE 6: 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**
S	-	-	-	-	-	-	BAB1	0.99	$104.86	-	-
T	-	-	-	-	-	-	PDE2	1.57	$166.29	-	-
U	-	-	-	-	-	-	PDE1	1.47	$155.70	-	-
V	-	-	-	-	-	-	PBC2	1.22	$129.22	-	-
W	-	-	-	-	-	-	PA2	0.71	$75.20	-	-
X	-	-	-	-	-	-	PBC1	1.13	$119.69	-	-
Y	-	-	-	-	-	-	PA1	0.66	$69.91	-	-

TABLE 7: RUG-IV 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	$105.95	1.49	$94.76	0.68	$19.43	ES3	4.06	$410.87	3.24	$247.34
B	1.70	$117.73	1.63	$103.67	1.82	$52.00	ES2	3.07	$310.68	2.53	$193.14
C	1.88	$130.19	1.69	$107.48	2.67	$76.28	ES1	2.93	$296.52	1.84	$140.47
D	1.92	$132.96	1.53	$97.31	1.46	$41.71	HDE2	2.40	$242.88	1.33	$101.53
E	1.42	$98.34	1.41	$89.68	2.34	$66.85	HDE1	1.99	$201.39	0.96	$73.29
F	1.61	$111.49	1.60	$101.76	2.98	$85.14	HBC2	2.24	$226.69	0.72	$54.96
G	1.67	$115.65	1.64	$104.30	2.04	$58.28	HBC1	1.86	$188.23	-	-
H	1.16	$80.33	1.15	$73.14	2.86	$81.71	LDE2	2.08	$210.50	-	-
I	1.13	$78.25	1.18	$75.05	3.53	$100.85	LDE1	1.73	$175.08	-	-
J	1.42	$98.34	1.45	$92.22	2.99	$85.42	LBC2	1.72	$174.06	-	-
K	1.52	$105.26	1.54	$97.94	3.70	$105.71	LBC1	1.43	$144.72	-	-
L	1.09	$75.48	1.11	$70.60	4.21	$120.28	CDE2	1.87	$189.24	-	-
M	1.27	$87.95	1.30	$82.68	-	-	CDE1	1.62	$163.94	-	-
N	1.48	$102.49	1.50	$95.40	-	-	CBC2	1.55	$156.86	-	-
O	1.55	$107.34	1.55	$98.58	-	-	CA2	1.09	$110.31	-	-
P	1.08	$74.79	1.09	$69.32	-	-	CBC1	1.34	$135.61	-	-
Q	-	-	-	-	-	-	CA1	0.94	$95.13	-	-
R	-	-	-	-	-	-	BAB2	1.04	$105.25	-	-
S	-	-	-	-	-	-	BAB1	0.99	$100.19	-	-
T	-	-	-	-	-	-	PDE2	1.57	$158.88	-	-
U	-	-	-	-	-	-	PDE1	1.47	$148.76	-	-
V	-	-	-	-	-	-	PBC2	1.22	$123.46	-	-
W	-	-	-	-	-	-	PA2	0.71	$71.85	-	-
X	-	-	-	-	-	-	PBC1	1.13	$114.36	-	-
Y	-	-	-	-	-	-	PA1	0.66	$66.79	-	-