American Hospital Association™
Advancing Health in America

Regulatory Advisory

August 20, 2019

Skilled Nursing Facility PPS: Final Rule for FY 2020

At A Glance

At Issue:
The Centers for Medicare & Medicaid Services (CMS) July 30 issued its fiscal year (FY) 2020 final rule for the skilled nursing facility (SNF) prospective payment system (PPS). The rule takes effect Oct. 1.

Our Take:
As finalized in last year's rulemaking, a redesigned SNF PPS payment model will be implemented in FY 2020, bringing transformational change to the field. This rule adds further policy details, which are relatively limited in scope, to the new model. We are pleased that the new model shifts resources to the higher-acuity patient population that is treated in hospital-based SNFs. With regard to the SNF Quality Reporting Program (QRP), AHA maintains that only measures endorsed by the National Quality Forum (NQF) should be adopted for CMS quality programs. Thus, we are disappointed that CMS will proceed to implement new QRP measures that lack NQF endorsement. In addition, we remain concerned about the burden associated with the volume of patient assessment items finalized.

What You Can Do:
- ✓ Share the attached summary with your senior management team to examine the impact these payment changes may have on your organization for FY 2020.
- ✓ Participate in the AHA-member call on Aug. 21 at 2 p.m. ET. AHA members may register here.

Key Takeaways

In FY 2020, this rule will:

- Increase overall SNF payments by 2.4% ($851 million) in FY 2020, with larger updates for hospital-based providers.
- Increase payments to both rural (23.1%) and urban (12.4%) hospital-based SNFs.
- Revise the patient assessment schedule under the new payment system.
- Make the definition of SNF group therapy more flexible.
- Add two new quality measures to the SNF Quality Reporting Program.
- Adopt several new SNF and long-term care hospital standardized patient assessment data elements.

Further Questions:
Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org for questions on payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org for questions on quality-related provisions.

August 20, 2019

Skilled Nursing Facility PPS: Final Rule for FY 2020

The Centers for Medicare & Medicaid Services (CMS) July 30 issued its final rule for fiscal year (FY) 2020 for the skilled nursing facility (SNF) prospective payment system (PPS). This rule addresses additional policy elements of the new SNF PPS payment model, known as the patient-driven payment model (PDPM), which CMS finalized last year.

Final FY 2020 Payment Update

Market-basket Update

CMS is updating overall SNF PPS payments in FY 2020 by 2.4%, which translates into an $851 million increase over FY 2019 payments. This net increase includes a 2.8% market basket update offset by a 0.4% productivity cut. For hospital-based SNFs, PDPM results in a larger net increase since the clinical profile of their patient populations aligns with the new model's priorities: greater resources for medically-complex cases and fewer resources for therapy-intensive cases. Specifically, in FY 2020, CMS increases payments to both rural (23.1%) and urban (12.4%) hospital-based SNFs. CMS did not implement a market-basket forecast error adjustment for FY 2020 since the difference between the actual and estimated market basket for FY 2018 did not exceed 0.5 percentage points.

Area Wage Index

To establish the SNF PPS wage index for FY 2020, CMS used the same methodology as prior years: using the pre-reclassified inpatient PPS hospital wage data, unadjusted for other policies, such as the occupational mix and the rural floor. Following the prior approach, the SNF wage index for FY 2020 will be calculated using hospital wage data from cost reports beginning in FY 2016. The final SNF PPS wage index tables applicable for FY 2020 are available on the CMS webpage.

Labor-related Share

As proposed, CMS finalized a labor-related share of 70.8% for FY 2020, an increase over the FY 2019 share of 70.5%. Table 8 in the rule provides the proposed share for FY 2020 compared to FY 2019 for the major cost categories.

Issues Relating to PDPM Implementation

On Oct. 1, as finalized in its FY 2019 rulemaking, CMS will significantly revise the SNF PPS by implementing the new PDPM, which bases payments on a composite profile of each patient, rather than volume of therapy services. The composite includes patients' clinical characteristics in five domains: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing and non-therapy ancillary (NTA) services. The new model, which is significantly different from the current payment model, is described in our FY 2019 SNF PPS final rule Regulatory Advisory.

The implementation of this new payment model will entail complex change for the clinical and financial operations of the field. As such, the rule notes CMS's plans to closely monitor PDPM implementation, as well as the possibility that it may propose future adjustments to account for any evidence that payments are either higher or lower than anticipated, or if provider costs change in such a manner that the current relationship between provider costs and provider payments changes from that currently observed.

In addition, with regard to concurrent post-acute care policy reforms required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, the rule states CMS's belief that the "PDPM will only serve to strengthen the various quality and payment reform initiatives throughout CMS, by shifting payment away from the current service-driven model that has produced nearly homogenized care for SNF beneficiaries, to a more resident-centered model that focuses more on the individual patient's needs and characteristics. We also believe that through the use of standardized assessment items…and changes to the assessment schedule to mirror that of other PAC settings that use a similar admission/discharge assessment model…the PDPM would better align with the current direction of PAC reform and standardization efforts supported by the IMPACT Act."

Patient Assessment Schedule

Under PDPM, the patient assessment schedule changes to reflect the elimination of mandatory assessments after the initial assessment. In a departure from the proposed rule, the final rule replaces the phrase "5-day assessment" with "initial Medicare assessment." Further, the rule clarifies that the assessment reference date for an initial Medicare assessment must be set no later than the eighth day of post-hospital SNF care. In addition, regarding the optional nature of "interim patient assessments," which are the assessments following the initial assessment that address clinical changes throughout a SNF stay that may alter the SNF PPS per diem rate, CMS emphasizes SNFs' "responsibility to remain fully aware of (and respond appropriately to) any changes in its resident's condition is in no way discretionary."

Group Therapy

Currently, CMS defines group therapy as the practice of one therapist or therapy assistant treating exactly four patients at the same time while the patients are

performing either the same or similar activities. In this rule, as proposed, CMS finalizes a new SNF group therapy definition — a less-restrictive definition applied by inpatient rehabilitation facilities (IRF): two to six patients performing the same or similar therapy activities under therapist supervision. Following its monitoring of therapy utilization patterns in SNFs and other settings, CMS found that therapists in SNFs have the clinical judgment to determine whether groups of different sizes would clinically benefit their patients. The rule also reminds stakeholders that CMS continues to believe that individual therapy is the preferred SNF therapy mode, with group therapy primarily effective as a supplement to individual therapy. This new definition also furthers CMS's efforts under the IMPACT Act to increase standardization across the post-acute care settings.

Sub-regulatory Process for Updating ICD-10 Code Mappings

The PDPM utilizes ICD-10 codes to assign patients to clinical categories for the physical PT, OT and SLP components of the payment model, and to assign certain comorbidities for classification under the SLP and NTA components. CMS intends to ensure that the codes used to identify clinical categories and comorbidities are synchronized with the most current ICD-10 data set. The ICD-10 mappings and lists used under the PDPM are available on CMS's PDPM website.

With regard to provider concerns about the use of ICD-10 codes with PDPM, CMS states that ICD-10 codes provide the most accurate coding and diagnosis information on patients, which should improve understanding of patients' conditions and resultant care plans. Further, the codes should help ensure that patients' unique conditions and goals are the primary driver of case mix classification. With regard to ICD-10 coding training, the agency believes that providers are responsible for professional training and the identification of the types of staff needed to ensure accurate coding, although the agency is considering providing case studies and other PDPM education resources to the field. Further, explicit instructions for recording diagnosis and procedure are pending in the minimum data set (MDS) resident assessment instrument manual.

CMS finalized its proposal, with one modification, to implement a two-tiered process for updating the ICD-10 code mappings and lists, as well as the SNF GROUPER software and other products related to patient classification and billing:

- Substantive Changes: Any change that goes beyond the intention of maintaining consistency with the most current ICD-10 medical code data set would be considered substantive and would be proposed and finalized through notice and comment rulemaking. As an example, 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. Another example 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 the other does not.

- Non-substantive Changes: Any change necessary to maintain consistency with the most current ICD-10 medical code data set would be considered non-substantive, and would be subject to a sub-regulatory process.

CMS's final ICD-10 provisions include a single change from the proposed rule that requires providers to select any surgical procedure from the prior hospital stay in a sub-item within Item J2000, rather than in the second line of item I8000, as proposed. In addition, through rulemaking, CMS will delete any code from the SNF GROUPER that does not reflect an increased cost of care. CMS will post on the PDPM webpage a mapping table with changes to codes in the GROUPER software and related documentation.

Administrative Presumption

As in the last several years of rulemaking, this rule reviews the administrative presumption that is applied to SNF patients based on information collected during the patient's 5-day assessment. This policy reflects CMS's position that there is a strong likelihood that a beneficiary's clinical profile during the immediate post-hospital period is correlated with the level of care needed by the patient. Therefore, clinical information collected during the 5-day assessment is used to automatically deem a patient with qualifying clinical characteristics as meeting the SNF level of care definition. As finalized in the FY 2019 final rule, CMS will apply the administrative presumption policy to cases that satisfy these four PDPM criteria:

- **Nursing** – One of these case-mix groups based on functional status and other conditions and needs: Extensive Services, Special Care High, Special Care Low, or Clinically Complex;
- **PT and OT** -- One of these categories based on condition and functional status: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, or TO;
- **SLP** – One of these categories based on condition and comorbidities: SC, SE, SF, SH, SI, SJ, SK, or SL; and
- **NTA**: A NTA function score of 12 or more.

The rule also restates CMS's position that the administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that any services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. In addition, CMS stresses the importance of carefully monitoring for changes in each patient's condition to determine whether there is a continuing need for Part A SNF benefits after the 5-day assessment.

Other Issues and Policy Clarifications

Consolidated Billing

As it has since its FY 2015 rulemaking, in this rule the agency reviews the requirement that SNFs submit consolidated medical bills for physical, occupational and speech-language therapy services for covered and non-covered Part A stays. In this rule, the agency again reviews the consolidated billing exclusions that allow separate billing under Part B for selected Part A "high-cost, low-probability" services that fall within these four categories:

- chemotherapy items;
- chemotherapy administration services;
- radioisotope services; and
- customized prosthetic devices.

Swing Beds

CMS again clarifies that all rates and wage indexes for the SNF PPS also apply to all non-critical access hospital swing beds, including that these rural hospitals must complete a MDS 3.0 swing-bed assessment. Information on the MDS for swing-bed rural hospitals is available on CMS's website.

SNF Quality Reporting Program (QRP)

The Affordable Care Act (ACA) mandated that reporting of quality measures for SNFs begin no later than FY 2014. Failure to comply with SNF QRP requirements will result in a 2 percentage point reduction to the SNF's annual market-basket update.

Table 1: Finalized Measures for the SNF QRP, FY 2019 – FY 2022

Measure	FY 2019	FY 2020	FY 2021	FY 2022
Percent of residents or patients with pressure ulcers that are new or worsened	X			
Application of Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X	X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Self-Care Score for Medical Rehabilitation Patients		X	X	X
Change in Mobility Score for Medical Rehabilitation Patients		X	X	X
Discharge Self-Care Score for Medical Rehabilitation Patients		X	X	X
Discharge Mobility Score for Medical Rehabilitation Patients		X	X	X

Measure	FY 2019	FY 2020	FY 2021	FY 2022
Medicare spending per beneficiary for post-acute care SNF QRP	X	X	X	X
Discharge to community –Post-acute care SNF	X	X	X	X
Potentially preventable 30-day post-discharge readmission measure for SNF QRP	X	X	X	X
Drug regimen review conducted with follow-up for identified issues		X	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		X	X	X
Transfer of Information to Provider				X
Transfer of Information to Patient				X

X = Finalized

FY 2022 Measurement Provisions

CMS will adopt two new process measures to the FY 2022 SNF QRP and modify one existing measure. Detailed specifications for the measures are available on CMS's SNF QRP website.

Transfer of Health Information to the Provider—Post Acute Care (PAC): CMS will adopt this process measure that assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the subsequent provider at the time of discharge or transfer from the patient's current PAC setting.

The IMPACT Act requires CMS to develop standardized and interoperable quality measures and implement them across all four PAC settings. These measures must meet certain domains, one of which is the transfer of health information and patient care preferences. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 Legislative Advisory. In the FY 2019 SNF PPS final rule, CMS stated that the agency intended to specify and propose two measures that would satisfy this domain for the FY 2022 SNF QRP. The measures, which have undergone pilot testing, public comment periods and review by several technical expert panels, were proposed to the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) in December 2019. The MAP conditionally supported the measures pending NQF endorsement. Measures are not required to be endorsed in order to be included in CMS quality programs, but the AHA strongly recommends that CMS only adopt measures that have gone through the rigorous NQF review and endorsement process. In response to AHA's and other stakeholder's comments regarding endorsement, CMS stated that it "plan[s] to submit the measure[s] to the NQF for consideration of endorsement as soon as feasible."

Performance on the measure is expressed as a proportion. The denominator for the Transfer of Health Information to the Provider measure is the total number of SNF patient stays ending in discharge to a subsequent provider. "Subsequent provider" is defined as a short-term general acute care hospital, intermediate care (i.e. intellectual and developmental disabilities providers), home under the care of a home health agency or hospice, institutional hospice, an IRF, another SNF, an inpatient psychiatric

facility (IPF), swing bed, long-term care hospital (LTCH), Medicaid nursing facility or a critical access hospital (CAH).

The numerator for this measure is the number of SNF patient stays with a SNF MDS discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at the time of discharge. For patients with multiple stays, each stay is eligible for inclusion in the measure.

Measure performance will be calculated using a new item in the SNF patient assessment tool, the MDS and will ask whether the assessor's facility provided the medication list to the subsequent provider. CMS notes in the final rule that "defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care," and that the agency does not have a data validation program in place "at this time."

Providers will be asked to complete an additional data element to indicate the route through which the list was transmitted, i.e. via an electronic health record, verbally, on paper, through a health information exchange organization or another method. This measure is not risk-adjusted or stratified.

SNFs will be required to submit data on the Transfer of Health Information to the Provider measure beginning with Oct. 1, 2020 admissions and discharges.

Transfer of Health Information to the Patient—Post Acute Care (PAC): CMS also will add this process measure that assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the patient, family or caregiver at the time of discharge to the home. This measure was developed in conjunction with the Transfer of Health Information to the Provider measure, and also lacks NQF endorsement.

This measure is specified identically to the previous measure and will employ similar SNF MDS items, except that the denominator is the total number of SNF patient stays ending in discharge to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home under the care of a home health agency or hospice.

SNFs will be required to submit data on the Transfer of Health Information to the Patient measure beginning with Oct. 1, 2020 admissions and discharges.

Update to Discharge to Community Measure: CMS will exclude baseline nursing facility residents, defined as patients who had a long-term nursing facility stay in the 180 days preceding their hospitalization and SNF stay with no intervening community discharge between the nursing facility stay and hospitalization, from the Discharge to Community measure beginning with the FY 2020 SNF QRP. The measure, originally adopted in the FY 2017 SNF PPS final rule, reports a SNF's risk-standardized rate of Medicare fee-for-service (FFS) patients who are discharged to the community (i.e., private

home/apartment, assisted living, or group home) following an SNF stay and do not have an unplanned readmission to an acute care hospital or LTCH and remain alive in the 31 days following discharge. CMS makes this change because SNF patients who lived in a nursing facility prior to their SNF stay are less likely to return to the community following their SNF stay and, as CMS has demonstrated through analysis of performance, skew measure performance unfairly.

Standardized Patient Assessment Data Elements (SPADEs)

In addition to requiring the adoption of standardized and interoperable quality measures, the IMPACT Act also requires that, for FY 2019 and each subsequent year, PAC providers must report SPADEs. The reporting of these data is required in the PAC quality reporting programs, and as a result, failure to comply with the requirements results in a payment reduction. The standardized patient assessment data elements must satisfy five domains as specified by the IMPACT Act, including functional status, cognitive function, special services, medical conditions and comorbidities, and impairments.

In the FY 2018 IRF PPS proposed rule, CMS proposed to adopt SPADEs that would satisfy all five categories. However, the agency did not finalize most of these proposals in response to the concerns raised by AHA and other commenters regarding the speed and magnitude of the additions to already lengthy patient assessment instruments. Stakeholders also were concerned that the data elements had not been tested for use in each specific PAC setting. That is, CMS proposed to adopt for all four settings data elements that were tested only in one PAC setting without determining whether those elements provided reliable and valid data in other settings. Instead, CMS finalized the adoption of SPADEs in just two categories (functional status and medical conditions and comorbidities) based on data elements already finalized for adoption in the various instruments. Please see AHA's Regulatory Advisory on the FY 2018 IRF PPS final rule for more details.

In this year's proposed rule, CMS asserted that SNFs have had enough time to familiarize themselves with other new reporting requirements adopted under the IMPACT Act. In addition, CMS cited the results of a recent National Beta Test of the data elements conducted by its contractor to suggest that the SPADEs are now tested adequately. Please see the research report from the National Beta Test for details and results from the analysis, as well as AHA's Regulatory Advisory on this year's proposed rule for our take on these results.

Despite continued opposition from commenters, CMS finalized the adoption of all SPADEs as proposed. The agency will require SNFs to report many of the same SPADEs it proposed for FY 2018 and a few new elements beginning with the FY 2022 SNF QRP. SNFs will be required to collect and report these data with respect to admission and discharge for patients discharged between Oct. 1, 2020 and Dec. 31, 2020. For each subsequent year, CMS will require SNFs to collect and report the data for admissions and discharges that occur during the subsequent calendar year (e.g.,

data for patients discharged between Jan. 1, 2021 through Dec. 31, 2021 will inform the FY 2023 SNF QRP).

Table2 summarizes the adopted SPADEs, whether adoption will result in a new item added to the SNF MDS, the number of elements associated with each item (i.e. the number of check boxes assessors will have to consider when completing the item) and the time to complete the item according to the National Beta Test.

Table 2. AHA Analysis of Adopted SPADEs

Domain	Element	New SNF MDS Item	Number of Elements	Time to Complete (minutes)
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	No	7	2.2
	Confusion Assessment Method (CAM)	No	6	1.4
	Patient Health Questionnaire-2 to 9	No^	2-9	1.7 for PHQ-2 2 only, 4 for PHQ-9
Special Services, Treatments, and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	No^	1-4 (1 principal; 3 sub)	0.22
	Cancer Treatment: Radiation	No	1	0.22
	Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High-concentration)	No^	1-2 (1 principal; 3 sub either/or)	0.22
	Respiratory Treatment: Suctioning (Scheduled, As needed)	No^	1-2 (1 principal; 2 sub either/or)	0.22
	Respiratory Treatment: Tracheostomy Care	No	1	0.22
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	No^	1-3 (1 principal; 2 sub)	0.22
	Respiratory Treatment: Invasive Mechanical Ventilator	No (will rename current SNF item)	1	0.22
	Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)	No^	1-5 (1 principal; 4 sub)	0.22
	Transfusions	No	1	0.22
	Dialysis (Hemodialysis, Peritoneal dialysis)	No^	1-2 (1 principal; 2 sub either/or)	0.22

	Intravenous (IV) Access (Peripheral IV, Midline, Central line)	Yes	1-4 (1 principal; 3 sub)	0.22
	Nutritional Approach: Parenteral/IV Feeding	No	1	0.22
	Nutritional Approach: Feeding Tube	No	1	0.22
	Nutritional Approach: Mechanically Altered Diet	No	1	0.22
	Nutritional Approach: Therapeutic Diet	No	1	0.22
	High-Risk Drug Classes: Use and Indication	Yes	0-12 (indicate whether patient is taking any medication within each of 6 drug classes, for each that patient is noted as taking indicate whether patient has indication for drug in class)	1.1
Medical Condition & Comorbidity	Pain Interference	No^	3 (sleep, therapy activities, day-to-day activities)	2.6
Impairment	Hearing*	No	1	0.3
	Vision*	No	1	0.3

*SNFs will only need to submit data on these elements with respect to admission and will not need to collect and report the data again at discharge, as it is unlikely that patient status for these elements will change.
^While the MDS contains one element in this item, an additional element or sub-elements will be added.

Social Determinants of Health (SDOH). In addition to the five domains that SPADEs must meet according to the IMPACT Act, CMS finalized its proposal to add a sixth domain. This domain will collect and assess data about SDOH, also known as social risk factors. Each of the data elements that will be adopted is identified in the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) report "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors," which was commissioned by the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE). In this report, NASEM identified these factors as having impact on care use, cost and outcomes for Medicare beneficiaries.

Despite many comments stating concern for the lack of detail on how CMS plans to use these data elements (i.e. in "future adjustments" to quality measures and payments, as stated in the proposed rule), CMS finalized nearly all the SDOH SPADEs as proposed. The agency made a technical change to the Ethnicity element — by adding the word "of," as seen bolded in the table below — and will only require the collection of the

Preferred Language and Interpreter Services items upon admission (rather than both admission and discharge), as the agency agrees with comments that suggested these SPADEs are unlikely to change over time. All of the other elements will be required for collection at both admission and discharge, as CMS disagreed with comments suggesting these, too, would be unlikely to change over time; for each, the agency responded that "a patient could lose a family member or caregiver between admission and discharge, which could impact" the answer to the element.

Table 3 summarizes the adopted SPADEs that will inform the new SDOH domain, whether adoption will result in a new item added to the SNF MDS, the number of discrete elements associated with each item, and a description of the item.

Table 3. AHA Analysis of Adopted SPADEs to Inform New SDOH Domain

Item	New SNF MDS Item	Number of Elements	Description
Race*	No	1-15 (15 sub options, check all that apply)	Asks "What is your race?" Replaces current item on Race & Ethnicity with two items
Ethnicity*	No	1-6 (6 sub options, check all that apply)	Asks "Are you **of** Hispanic, Latino/a, or Spanish origin?" Replaces current item on Race & Ethnicity with two items
Preferred Language*	No	1	Open-ended (What is your preferred language?) to allow for indication of American Sign Language (ASL)
Interpreter Services*	No	1	1 with 3 sub options (Do you need or want an interpreter to communicate with a doctor or health care staff?)
Health Literacy	Yes	1	Uses Single Item Literacy Screener (SILS) question, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?" with six options of Never to Always and patient unable to respond
Transportation	Yes	1-4 (4 sub options, check all that apply)	Uses single transportation data element from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PREPARE) tool that is part of the Accountable Health Communities (AHC) Screening tool. Asks "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" and answers differentiate between medical and non-medical appointments/activities

Social Isolation	Yes	1	Uses single social isolation data element that is part of the AHC Screening Tool. Asks "How often do you feel lonely or isolated from those around you?" with six options of Never to Always and patient unable to respond

*SNFs will only need to submit data on these elements with respect to admission and will not need to collect and report the data again at discharge, as it is unlikely that patient status for these elements will change.

Overall, CMS will add five new items to the SNF MDS, which are associated with more than 20 new data elements that could be necessary to complete depending on the patient.

Other Quality Reporting Program Updates

Reporting SNF MDS Data on All Patients Regardless of Payer: CMS did not finalize its proposal to require SNFs to collect and report MDS data for the purposes of the SNF QRP on all patients, regardless of payer.

CMS initially made the proposal to expand reporting as the agency believed that the most accurate representation of the quality provided in SNFs would be best calculated using data on all residents; in addition, comments on past proposals suggested that this expansion would not be overly burdensome (as "most of their organizations' members currently complete the SNF MDS on all patients, regardless of payer"). However, comments on this year's proposed rule raised several questions on the required data collection pertained to, the intended use of the data from payers other than Medicare, and how the proposal would affect penalties for non-compliance in the SNF QRP. Commenters also disagreed that the expansion would not be overly burdensome, and that the implementation timeline would be challenging considering the addition of several SPADEs to the MDS (CMS proposed that expanded data collection would begin FY 2022).

CMS agreed that further details are needed before the agency requires expanded data reporting. While the proposal was not finalized in this rule, the agency states that it plans to propose the expansion again in future rulemaking.

Public Reporting of Measure Data: CMS will begin publicly displaying data for the Drug Regimen Review Conducted with Follow-Up for Identified Issues measure beginning CY 2020 "or as soon as technically feasible." Data collection on this measure began with patients discharged on or after Oct. 1, 2018.

CMS will display four rolling quarters of data on *SNF Compare*, initially using discharges from Jan.1, 2019 through Dec. 31, 2019. SNFs with fewer than 20 cases during any four consecutive rolling quarters of data for any of these measures will not have a rate displayed; instead, the site will display a note stating that the number of cases/patient stays is too small to publicly report.

Update to CMS System for Reporting. Currently, SNFs submit MDS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system. CMS will be migrating to a new internet-based QIES over the next few years and thus will designate that new system as the submission system for SNFs once it becomes available. This will be no later than Oct. 1, 2021.

Because of this planned change, CMS will replace references to the QIES ASAP and Certification and Survey Provider Enhanced Reports (CASPER) systems in regulatory text with "CMS designated data submission." This change is effective Oct. 1, 2019.

SNF Value-based Purchasing Program (VBP)

The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019. The SNF VBP program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access, swing-bed rural hospitals. The SNF VBP program must tie a portion of SNF Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs or a "potentially avoidable readmission" measure. A pool of funding is created by reducing each SNF's Medicare per-diem payments by 2%. However, as finalized in the FY 2018 SNF PPS final rule, only 60% of the total pool is distributed back to SNFs as incentive payments, which will be applied as a percentage increase to the Medicare per-diem rate. SNFs scoring at or below the 40th percentile of performance are not eligible for any incentive payment, and will receive the full 2% reduction. Details on the finalized scoring methodology can be found in the FY 2018 SNF PPS final rule Regulatory Advisory.

In this rule, CMS finalizes its proposal to rename the "potentially avoidable readmission" measure slated for future use in the program and provides the final values for the performance benchmarks.

Renaming the Potentially Preventable Readmission Measure. As a prerequisite to implementing the SNF VBP program, CMS adopted the all-cause, all-condition hospital readmission measure in the FY 2017 SNF PPS final rule. In addition, in that rule, CMS adopted the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR), which PAMA requires CMS to use in the SNF VBP program instead of the all-cause all-condition measure "as soon as practicable." CMS believes that FY 2021 would be the first opportunity to make this replacement, but has not yet determined whether this timeline is feasible.

CMS will change the name of the SNFPPR measure to "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge." The agency believes this will reduce confusion with a similarly named potentially preventable measure that is used in the SNF QRP, "Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program," which assesses readmissions post-SNF discharge (as opposed to post-hospital discharge).

Final FY 2022 Performance Standards. In this rule, CMS provides the final numerical values of the achievement threshold and the benchmark for the FY 2022 program year.

Performance standards are based upon the higher of a SNF's achievement during the performance period (for the FY 2022 program year, the performance period if FY 2020) on the all-cause readmission rate measure versus a CMS-determined performance standard or its improvement versus its own performance on the measure in the baseline year (for the FY 2022 program year, the baseline year is FY 2018). For the SNF 30-days All-Cause Readmission measure, CMS estimates the achievement threshold to be 0.79476. If using the improvement score, CMS will determine whether the score is equal to or higher than the benchmark; if it is, the SNF will score 90 points, which is the most possible when using the improvement score. The estimated and final standards are:

	Estimated (Proposed Rule)	**Final (Final Rule)**
Achievement	0.79476	0.79025
Benchmark	0.83212	0.82917

Public Reporting of SNF Performance Scores. Beginning with the FY 2019 program year, CMS publishes SNF performance scores and rankings along with provider ID, facility name and address, baseline and performance period risk-standardized readmission rates, achievement score, and improvement score. In the FY 2019 SNF PPS final rule, CMS finalized its proposals regarding which scores are displayed for low-volume SNFs (i.e. SNFs with fewer than 25 eligible stays during the baseline or performance periods). In the rule, CMS notes that is might be confusing for the public to display only the achievement or only the improvement scores on the *Nursing Home Compare* website for low-volume SNFs. As a solution, CMS will display the following scores depending on SNF volume:

- If a SNF has fewer than 25 eligible stays in the baseline period but at least 25 eligible stays during the performance period, CMS will display the risk-standardized readmission rate during the performance period, the achievement score, and the total performance score.
    - The baseline rate and the improvement score will not be shown.

- If a SNF has fewer than 25 eligible stays in the performance period, CMS will display the assigned performance score.
    - The risk-standardized readmission rate during the performance period, the achievement score, and the improvement score will not be displayed.

- If a SNF has zero eligible stays during the performance period, CMS will not display any information for that SNF.

Update to Phase One Review and Correction Deadline. In the FY 2017 SNF PPS final rule, CMS adopted a two-phase review and corrections process that allows SNFs to request a review and correction of quality measure data used to calculate measure

rates included in SNFs' quarterly confidential feedback reports. Under this process, CMS accepts Phase One corrections to any quarterly report provided during a calendar year until the following March 31. However, CMS believes this March 31 deadline creates uncertainty for SNFs and has adverse effects on the value-based incentive payment calculations. Because of this, CMS will adopt a policy to allow SNFs 30 days from the date that CMS issues the confidential feedback report to submit a correction request.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org, with any questions about the quality-related provisions.