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# The fiscal year 2021 final rule: A summary for skilled nursing facilities

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**On July 31,** following the stakeholder comment period that ended June 9, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year 2021 final rule for skilled nursing facilities (SNFs). This rule updates Medicare payment policies for SNFs. The policy changes outlined in the final rule will go into effect on October 1, 2020.

While there are no groundbreaking changes, or changes to the SNF Quality Reporting Program (QRP), there are some other program related changes that warrant review. This summary breaks down the final rule into digestible sections, helping skilled nursing providers better understand the impacts of the final rule.

## SNF Prospective Payment System (PPS) rates

From a reimbursement level, CMS projects a SNF PPS per diem market basket update of 2.2% minus the 0.0% multifactor productivity adjustment (MFP), which is down from the 2.3% increase as stated in the Proposed Rule, resulting in an average increase of 2.2% to SNFs or $750 million in payments to SNFs.

## Advancing health information exchange

As part of advancing Health Information Exchange (HIE), CMS encourages and supports the interoperability of health information technology (IT) in post-acute settings. CMS continues to push for health information exchange between all levels of healthcare, including provider to provider, and patient access to their information. These interoperable data elements can reduce provider burden by allowing the use and exchange of healthcare data, improve care coordination through provider exchange of electronic health information, support person-centered care, and real-time, data-driven, clinical decision making.

## SNF Value-Based Purchasing (VBP)

The SNF VBP program is used to determine a SNF's level of performance. Scores are used to measure thresholds established by CMS. The SNF VBP has only minor changes. These changes include:

- A 30-day Phase One Review and Correction Deadline for the baseline period quality measure report, typically issued in December;
- A renaming of the measure to Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge; and
- An amendment to the definition it uses for "performance standards".

CMS states that the proposed changes in definition will allow them "…to reflect our ability to update the numerical values of performance standards if we determine there is an error that affects the achievement threshold or benchmark."

## Changes to ICD-10 mapping for the Patient Driven Payment Model (PDPM)

PDPM, which went into effect on October 1, 2019, will not have any major methodology changes for FY 2021. However, CMS is completing some changes to ICD-10 and clinical mapping.

CMS has added certain cancer diagnosis codes that will now map to either of the following surgical clinical categories: "May be Eligible for the Non-Orthopedic Surgery Category" and "May be Eligible for One of the Two Orthopedic Surgery Categories."

| Non-orthopedic surgery categories | One of the two orthopedic surgery categories |
|---|---|
| • C15.3 through C26.9, which correspond to J2910 of the MDS (Cancers involving the GI tract)<br>• C33 through C39.9, which correspond to J2710 of the MDS (Cancers involving the respiratory system)<br>• C46.3 through C46.9 for Kaposi's sarcoma<br>• D37.09 through D39.9<br>• D3A.00 through D3A.8<br>• D40.0<br>• D40.11 through D44.9<br>• D48.3 through D48.4<br>• D48.61 through D48.7<br>• D49.0 through D49.7 | • C40.01 through C41.9 for cancers involving the bones |

CMS is adopting the following clinical mapping changes:

| Non-orthopedic surgery category | One of the two orthopedic surgery categories |
|---|---|
| Non-Surgical Orthopedic with the surgical option above<br>• Z48.21<br>• Z48.22<br>• Z48.23<br>• Z48.24<br>• Z48.280<br>• Z48.288<br>• Z48.29<br>• Z48.81<br>• Z48.81<br>• Z48.81<br>• Z48.81<br>• Z48.81 | Non-Surgical Orthopedic with the surgical option above<br>• S32.031D<br>• S32.19XD<br>• S82.001D<br>• S82.002D through S82.002J<br>Spinal stenosis codes to add the surgical option above<br>• M48.00 through M48.08 |

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CMS has proposed to change the clinical mapping of D75.A (Glucose-6-phosphate dehydrogenase deficiency without anemia) from Cardiovascular and Coagulations to Medical Management, and add the following ICD-10 codes to Return to Provider (RTP) mapping:

- S82.009A
- S82.013A
- S82.016A
- S82.023A
- S82.026A
- S82.033A
- S82.036A
- S82.099A

One last PDPM related change involves the Non-Therapy Ancillary (NTA) component. CMS is adding the seventh digit of D to T82.310A through T85.89XA to map to CC176 “Complications of Specified Implanted Device or Graft” to qualify for the NTA points calculation.

CMS continues its monitoring of PDPM and stated:

“We would note that we continue to monitor the impact of PDPM implementation on patient outcomes and program outlays, though we believe it would be premature to release any information related to these issues based on the amount of data currently available. We hope to release information in the future that relates to these issues. We also continue to monitor the impact of PDPM implementation as it relates to our intention to ensure that PDPM is implemented in a budget neutral manner. In future rulemaking, we may reconsider the adjustments made in the FY 2020 SNF PPS final rule to the case-mix weights used under PDPM to ensure budget neutrality and recalibrate these adjustments as appropriate, as we did after the implementation of RUG-IV in FY 2011.”

## Wage Index

Every year, CMS adjusts federal rates to account for differences in area wage levels in urban and rural settings. Geographic delineations provided by the Office of Management and Budget (OMG) are used to identify a SNF’s classification as urban or rural.

CMS is moving forward with changes in the wage index calculation for identifying SNFs as urban or rural, based on Office of Management and Budget (OMB) delineation and core-based statistical area (CBSA). They have indicated that 34 current urban counties will become rural, and 47 current rural counties will become urban.

Other changes include the creation of new CBSA’s and the splitting apart some existing CBSA’s. Forty-two percent of SNFs will see decreases in their area wage index. Two percent of providers will experience a significant decrease of up to 5 percent. CMS also states that 54 percent of SNFs will see an increase in their area wage index. CMS is utilizing a one-year transition period in which the amount a SNF area wage index can decrease is capped at five percent. Beginning in year two (FY2022) there is no cap on the decrease.

CMS is proposing a change to both the urban and rural per diem base rates for each of the six PDPM components.

**Urban**

| Rate component | Per diem amount |
|---|---|
| PT | $62.04 |
| OT | $57.75 |
| SLP | $23.16 |
| Nursing | $108.16 |
| NTA | $81.60 |
| Non-case-mix | $96.85 |

**Rural**

| Rate component | Per diem amount |
|---|---|
| PT | $70.72 |
| OT | $64.95 |
| SLP | $29.18 |
| Nursing | $103.34 |
| NTA | $77.96 |
| Non-case-mix | $98.64 |

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