



SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM



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Learn about these Skilled Nursing Facility Prospective Payment System (SNF PPS) topics:

- Background
- SNF PPS Elements
- Patient Driven Payment Model (PDPM)
- Minimum Data Set (MDS) Changes
- SNF Quality Reporting Program (QRP)
- SNF Value Based Purchasing Program (VBP)
- Resources

BACKGROUND

[Social Security Act \(SSA\) § 1888\(e\)\(4\)\(E\)](#) sets up a SNF services per diem PPS. For cost reporting periods since July 1, 1998, Medicare pays the SNF PPS per diem for all covered Part A SNF services (routine, ancillary, and capital-related costs), except costs for operating-approved educational activities and services excluded from SNF Consolidated Billing (CB).

SNF PPS ELEMENTS

Rates

Payment rates reflect SNF historical costs from cost reports since fiscal year (FY) 1995. Rates include a Part B add-on to account for the estimated cost of services furnished during the FY 1995 base period paid by Part B for SNF patients during a Part A covered stay.

Medicare bases the standardized per diem rates on national data from urban and rural areas. Case-mix and wage adjustments also apply to per diem rates. Under a three-phase transition provision, SNFs initially got a blend of a facility-specific rate (reflecting the SNF's actual historical cost experience) and the Federal case-mix adjusted rate. Since FY 2002, Medicare pays the full Federal rate.

Federal rate adjustments reflect:

- Geographic differences in wage rates, using the hospital wage index
- Patient case-mix (amount of resources needed for each patient's clinical condition identified through the resident assessment process), using a new patient classification system called the **Patient Driven Payment Model (PDPM)**

CMS updates Federal rates annually:

- To reflect SNF care inflation in the cost of goods and services using the SNF market basket index

PDPM

Beginning October 1, 2019, you must use the PDPM patient-classification model. There is no transition period from RUG-IV to the PDPM.

- To reflect a Multifactor Productivity Adjustment (MFP) to the SNF market basket index, which accounts for increases in provider productivity that could reduce the actual cost of providing services
- To use a forecast error adjustment whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold for the most recently available FY data
- To reflect changes in local wage rates using the latest hospital wage index
- To reflect a facility's performance in the SNF VBP Program

Refer to the [List of SNF Federal Regulations](#) for more information about the most current payment updates.

PDPM PROVISION

Effective October 1, 2019, PDPM is the basis for classifying SNF patients in covered Part A stays to determine Medicare payment. This new classification system replaces the Resource Utilization Group (RUG)-IV payment system. This model will improve SNF payments made under the PPS by:

- Improving payment accuracy by focusing on the patient, rather than the volume of services provided
- Reducing administrative burden on providers
- Improving SNF payments to currently underserved patients without increasing total Medicare payments

Under the old system, RUG-IV, there were two case-mix adjusted components:

- Therapy (based on volume of services or Non-Case-Mix Base Rate)
- Nursing (does not reflect variations in non-therapy ancillary use)

PDPM classifies patients into a separate group for each of the five Case-Mix Index (CMI) adjusted components:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Language Pathology (SLP)
- Nursing
- Non-Therapy Ancillary (NTA)

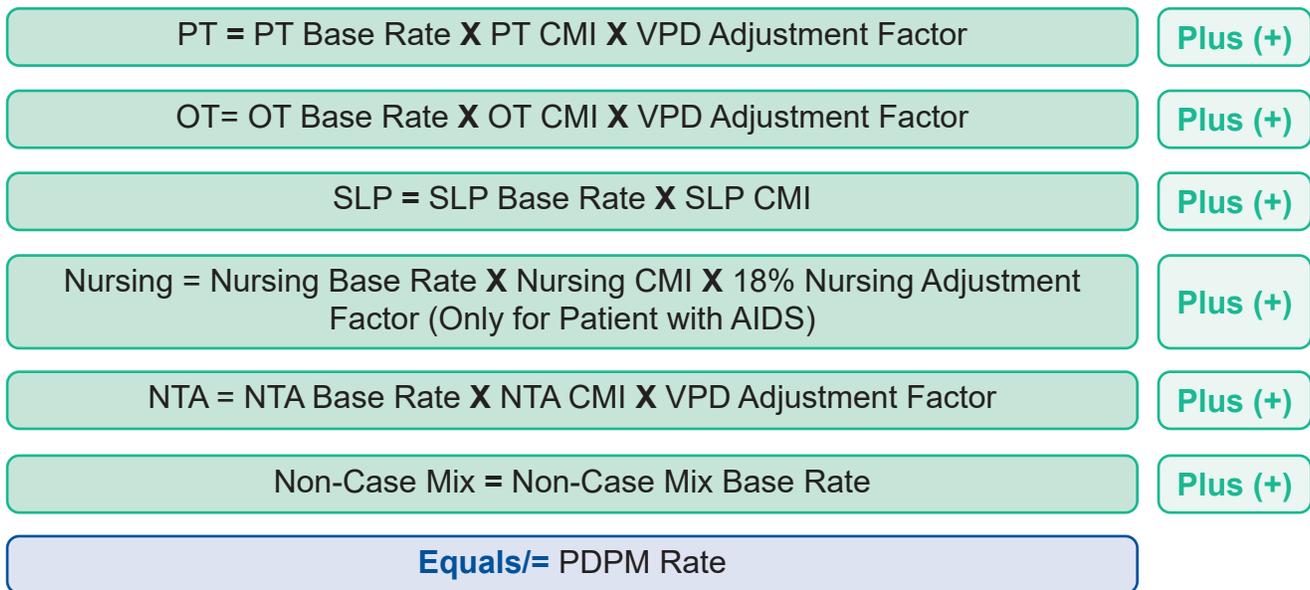
PDPM also adjusts the Variable Per Diem (VPD) rate over the stay to account for the changes in resource use. Under the PDPM **only**, the PT, OT, and NTA payments are subject to VPD adjustments.

Each component uses different criteria for patient classification:

- PT: Clinical Category, Functional Score
- OT: Clinical Category, Functional Score

- SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically Altered Diet, Swallowing Disorder
- Nursing: Same characteristics as under RUG-IV
- NTA: NTA Comorbidity Score

In order to calculate the payment for each of these components, multiply the CMI that corresponds to the patient’s Case Mix Group (CMG) by the wage-adjusted component base rate, then by the specific day in the VPD schedule, when applicable. Then add the payments for each component together along with the non-case mix component payment rate to create the patient’s PDPM per diem rate. The following graphic provides a snapshot of the process for calculating the PDPM classification.



PT and OT components use two classifications: **clinical category** and **functional status**. Medicare bases the clinical category on the primary diagnosis code for the SNF stay by mapping the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, coded on the Minimum Data Set (MDS) in Item I0020B, to a PDPM clinical category. A surgical procedure occurring during the prior inpatient stay may adjust the clinical category and map to one of these clinical categories:

PDPM Primary Diagnosis Clinical Categories*

- Acute Infections
- Acute Neurologic
- Cancer
- Cardiovascular and Coagulations
- Major Joint Replacement or Spinal Surgery
- Medical Management
- Non-Orthopedic Surgery

- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic – Surgical Extremities (Except Major Joint or Spinal Surgery)
- Pulmonary

*A mapping of the ICD-10-CM diagnosis and/or surgical category that classifies a SNF resident into each of the 10 clinical categories is available on the [PDPM website](#).

Given similar costs among certain clinical categories related to PT and OT costs, Centers for Medicare & Medicaid Services (CMS) grouped certain clinical categories together for patient clinical classification.

PDPM PT/OT Clinical Categories

- Major Joint Replacement or Spinal Surgery
 - Major Joint Replacement or Spinal Surgery
- Non-Orthopedic Surgery and Acute Neurologic
 - Acute Neurologic
 - Non-Orthopedic Surgery
- Other Orthopedic
 - Non-Surgical Orthopedic/Musculoskeletal
 - Orthopedic – Surgical Extremities Not Major Joint
- Medical Management
 - Acute Infections
 - Cancer
 - Cardiovascular & Coagulations
 - Medical Management
 - Pulmonary

Medicare calculates the PDPM functional score using data from Section GG of the MDS 3.0 rather than Section G items (which were used under prior payment systems) and bases the sum of the scores on the following ten Section GG items:

- Two bed mobility items
- Three transfer items
- One eating item
- One toileting item
- One oral hygiene item
- Two walking items

Table 1. Section GG Items Included in the PT and OT Functional Score

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0–4
GG0130B1 – Self-care: Oral Hygiene	0–4
GG0130C1 – Self-care: Toileting Hygiene	0–4
GG0170B1 – Mobility: Sit to Lying	0–4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	0–4 (average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0–4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	0–4 (average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	0–4 (average of 3 items)
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0–4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	0–4 (average of 2 items)

The PDPM Nursing Functional Score uses the same basic classification structure as RUG-IV, with the following changes:

- Based on Section GG of the MDS 3.0
- Reduced functional groups from 42 to 25
- Uses the same scoring algorithm described in Section GG-based PT and OT Functional score non-walking items

Table 2. Section GG Items Included in Calculating the Nursing Functional Score

Section GG item	Functional Score Range
GG0130A1 – Self-care: Eating	0–4
GG0130C – Self-care: Toileting Hygiene	0–4
GG0170B1 – Mobility: Sit to Lying	0–4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on Side of Bed	0–4 (average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0–4 (average of 3 items)
GG0170E1 – Mobility: Chair/Bed-to-Chair Transfer	0–4 (average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	0–4 (average of 3 items)

Medicare bases the PDPM cognitive score on the Cognitive Function Scale (CFS). The CFS combines scores from the Brief Interview for Mental Status (BIMS) and Cognitive Performance Scale (CPS) into one scale used to compare cognitive function across all patients.

CMS identified 12 SLP-related comorbidities that predict higher SLP costs. Rather than separately account for each of these 12 conditions, any of these conditions qualify the patient under this aspect of the SLP component criteria:

SLP Comorbidities*

- ALS
- Aphasia
- Apraxia
- CVA, TIA, or Stroke
- Laryngeal Cancer
- Oral Cancers
- Tracheostomy (while resident)
- Traumatic Brain Injury
- Speech & Language Deficits
- Ventilator (while resident)

*Mapping between ICD-10-CM diagnosis and the SLP comorbidities is available on the [PDPM website](#).

PDPM calculates a patient’s cognitive score the same as under RUG-IV. Specifically, Medicare bases the patient’s cognitive score on the CFS, which provides consistent scoring across the BIMS, or through a staff assessment using the Cognitive Performance Scale (CPS).

After completion of the BIMS or CPS, use the Cognitive Measure Classification methodology in the following table to determine the BIMS and CPS scores:

Table 3. Cognitive Measure Classification

PDPM Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13–15	0
Mildly Impaired	8–12	1–2
Moderately Impaired	0–7	3–4
Severely Impaired	–	5–6

For the NTA classification, CMS identified 50 conditions and extensive services that increase NTA costs. Providers report these conditions and extensive services on the MDS 3.0 with the ICD-10-CM codes identified by ICD-10-CM conditions coded in Item I8000 of the MDS. Mapping between these ICD-10-CM codes and the NTA patient classification comorbidities is available at the [PDPM website](#).

The PDPM NTA comorbidity score results from a weighted count of a patient’s comorbidities, rather than using a simple count of comorbidities. Using a simple count ignores the difference in relative costliness between different comorbidities and looking at just the costliest comorbidity ignores the effect of a patient having multiple comorbidities. To achieve this weighted count, Medicare assigns a certain number of points between one and eight to each of the 50 PDPM comorbidities used to classify the patient’s NTA based on its relative costliness.

To determine the patient's NTA comorbidity score, identify all the patient's qualifying comorbidities and then add the points for each comorbidity together. A list of these comorbidities and scores is available in the [NTS Comorbidity Score Fact Sheet](#). The resulting sum represents the patient's NTA comorbidity score, which is then used to classify the patient into an NTA component classification group.

Table 4. NTA Component Classification

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis – Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1

Table 4. NTA Component Classification (cont.)

Condition/Extensive Service	Source	Points
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer – Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy – Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity – Except: RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

In addition to the case-mix changes, PDPM also includes policy changes to the SNF PPS.

MDS CHANGES

Streamlined Assessment Schedule

- The PPS assessments under PDPM are the:
 - 5-day PPS assessment, which follows the same schedule as the current SNF PPS
 - Interim Payment Assessment (IPA), an optional assessment completed at any point during a PPS stay when there is a patient clinical change
 - PPS Discharge assessment
- Providers bill the default HIPPS code for late assessments the same way as the RUG-IV, for the number of days out of compliance and then the 5-day assessment HIPPS code for the remainder of the stay, unless the provider is completing an IPA. Late assessments also affect the VPD. For example, if a 5-day assessment is two days late, then Medicare adjusts the VPD for Days 1 and 2 of the stay and calculates it using the default HIPPS code. The 5-day assessment HIPPS code controls payment beginning Day 3 of the VPD schedule.

New MDS Item Sets: IPA and Optional State Assessment (OSA)

- Providers may complete an IPA to report a change in the patient's PDPM classification with no impact on the VPD schedule. It changes the payment beginning on the assessment review date until the end of the Part A stay or until another IPA is completed.
- Providers only use an OSA to report on Medicaid-covered stays per their states' requirements which allows providers to use RUG-III or RUG-IV models as the basis for Medicaid payment.

New and Revised MDS Items

- A new item I0020B enables providers to use an ICD-10-CM code to report a patient's primary diagnosis. This item asks, "What is the main reason this person is being admitted to the SNF?" Item I0020B is coded when Item I0020 is coded as any response 1–13. Medicare is retiring item I0020A under PDPM and providers can only use I0020 and I0020B.
- New items J2100–J5000 capture major surgical procedures occurring during the hospital stay immediately preceding the SNF admission. Medicare uses these items with the diagnosis captured in I0020B to classify patients into the PT and OT case-mix classifications. Get additional information on the [PDPM Classification Walkthrough webpage](#).
- Section O of the MDS contains new items O425A1 – O0425C5 to report by each therapy discipline mode (for example, individual, group or concurrent therapy), and the amount of therapy (in minutes) the patient receives. Users get an error message if the total amount of group/concurrent minutes comprises more than 25 percent of the total amount of therapy for that discipline.
- Using MDS section GG items as a basis for patient functional assessments, capture the patient's interim performance. The new column look-back period is a 3-day window preceding the IPA's Assessment Reference Date (ARD).

- Medicare is adding several existing MDS items to the Swing Bed PPS Assessment under PDPM:
 - K0100: Swallowing Disorder
 - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease
 - I4300: Active Diagnosis: Aphasia
 - O0100D2: Special Treatments, Procedures & Programs: Suctioning, While a Resident
- Existing MDS item added to 5-day PPS Assessment and IPA:
 - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease

Concurrent and Group Therapy Limit

The PDPM combined limit for both concurrent (one therapist with two patients doing different activities) and group therapy (one therapist with two to six patients doing the same or similar activities) cannot equal more than 25 percent of the therapy SNF patients get for each therapy discipline. The Discharge Assessment monitors compliance with the therapy limit. It includes the number of minutes per mode, per discipline for the entirety of the PPS stay. To see how to calculate therapy minutes, go to the [Concurrent and Group Therapy Limit fact sheet](#).

Interrupted Stay Policy

CMS defines an “interrupted” SNF stay as one in which a patient is discharged from Part A covered SNF care and subsequently readmitted to Part A covered SNF care in the **same** SNF (not a different SNF) during interruption window. Note that if a resident drops to a non-skilled level of care or otherwise leaves Part A SNF care, the patient is considered to have been discharged for the purposes of the interrupted stay policy, even if the patient remains in the facility.

The interruption window is a 3-day period that begins on the first non-covered day following a Part A covered SNF stay and ends at 11:59 pm on the 3rd consecutive non-covered day. It should be noted that the first non-covered day may be different depending on if the patient leaves the facility or simply leaves Part A coverage.

If both conditions are met, the subsequent stay is considered a continuation of the previous “interrupted” stay for the purposes of both the variable per diem schedule and the assessment schedule. The variable per diem schedule continues from the day of the previous discharge. For example, if the patient was discharged from Part A on Day 17 (that is, Day 17 was the last covered SNF day), payment rates resume at Day 18 upon readmission. The assessment schedule also continues from the day of the Part A discharge. Thus, no new 5-day assessment is required upon the subsequent readmission, although the optional IPA may be completed at the provider’s discretion.

If the patient is readmitted to the same SNF **outside the interruption window**, OR in **any** instance when the patient is **admitted to a different SNF** (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating a new 5-day assessment.

Administrative Presumption

The SNF PPS includes an administrative presumption in which a patient who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring a SNF level of care through the assessment reference date for that assessment. Those patients that do not get assigned to one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition, but instead get an individual determination using the existing administrative criteria. PDPM classifiers designated under this administrative presumption are:

- Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories
- PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO
- SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL
- The NTA component's uppermost (12+) comorbidity group

Payment for Patients with AIDS

PDPM addresses costs for patients with AIDS by assigning the highest point value (8 points) of any condition or service for classification purposes under its NTA component and adds 18 percent to the nursing component.

Revised HIPPS Coding

To accommodate the new payment groups, Medicare revised the PDPM HIPPS algorithm as follows:

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator

CB PROVISION

The CB provision is like hospital bundling. It requires a SNF to include all Medicare-covered services a patient gets during a covered Part A stay on the Part A bill, except a small list of excluded services billed separately under Part B by an outside entity. CB requires SNFs to bill Medicare for **all** patients' PT, OT, and SLP services, regardless of whether the patient getting services is in a covered Part A stay.

Medicare requires you to **submit all Medicare claims for services you furnish during a covered Part A stay** when furnished to your patients by an outside supplier, except for specifically excluded services outside the PPS bundle and separately billable under Part B. These services are **categorically excluded** from SNF CB:

- Physician services defined by the Medicare Physician Fee Schedule (PFS), including the professional component of diagnostic tests (representing the physician's interpretation of the test); the technical component of physician services must be billed to and reimbursed by the SNF
- Physician professional services defined by the Medicare PFS when furnished by physician assistants, nurse practitioners, and clinical nurse specialists working with a physician
- Services of certified nurse-midwives
- Services of qualified psychologists
- Services of certified registered nurse anesthetists
- Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies
- Part B coverage of Epoetin Alfa (EPO) and Darbepoetin Alfa for certain dialysis patients
- Services by a Rural Health Clinic or Federally Qualified Health Center that would otherwise fall within one of the exclusion categories listed
- Hospice care related to a patient's terminal condition
- An ambulance trip that takes a patient to the SNF for the initial admission or from the SNF following a final discharge
- These categories of exceptionally intensive outpatient hospital services (along with transportation from the SNF to the hospital and back when the patient's medical condition requires an ambulance), which are so far beyond the typical scope of SNF care plans they require a safe and effective hospital setting (this exclusion **does not apply** if these services are furnished in a freestanding [non-hospital] setting):
 - Cardiac catheterization
 - Computerized axial tomography (CT) scans
 - Magnetic resonance imaging (MRI) services
 - Ambulatory surgery that uses an operating room or comparable setting
 - Emergency services
 - Radiation therapy services
 - Angiography, lymphatic, venous, and related procedures
- Certain specified "high-cost, low probability" items within these categories of services, identified by HCPCS codes:
 - Chemotherapy items and their administration
 - Radioisotope services
 - Customized prosthetic devices
- Ambulance services to transport a SNF patient off-site to receive Part B dialysis services
- Two radiopharmaceuticals, Zevalin and Bexxar (refer to the Code of Federal Regulations [CFR] at [42 CFR § 411.15\(p\)\(2\)\(xv\)](#))

Chart A: Determining Institutional Services Consolidated Billing

These charts provide information to determine whether institutional or professional services are included or excluded from CB.

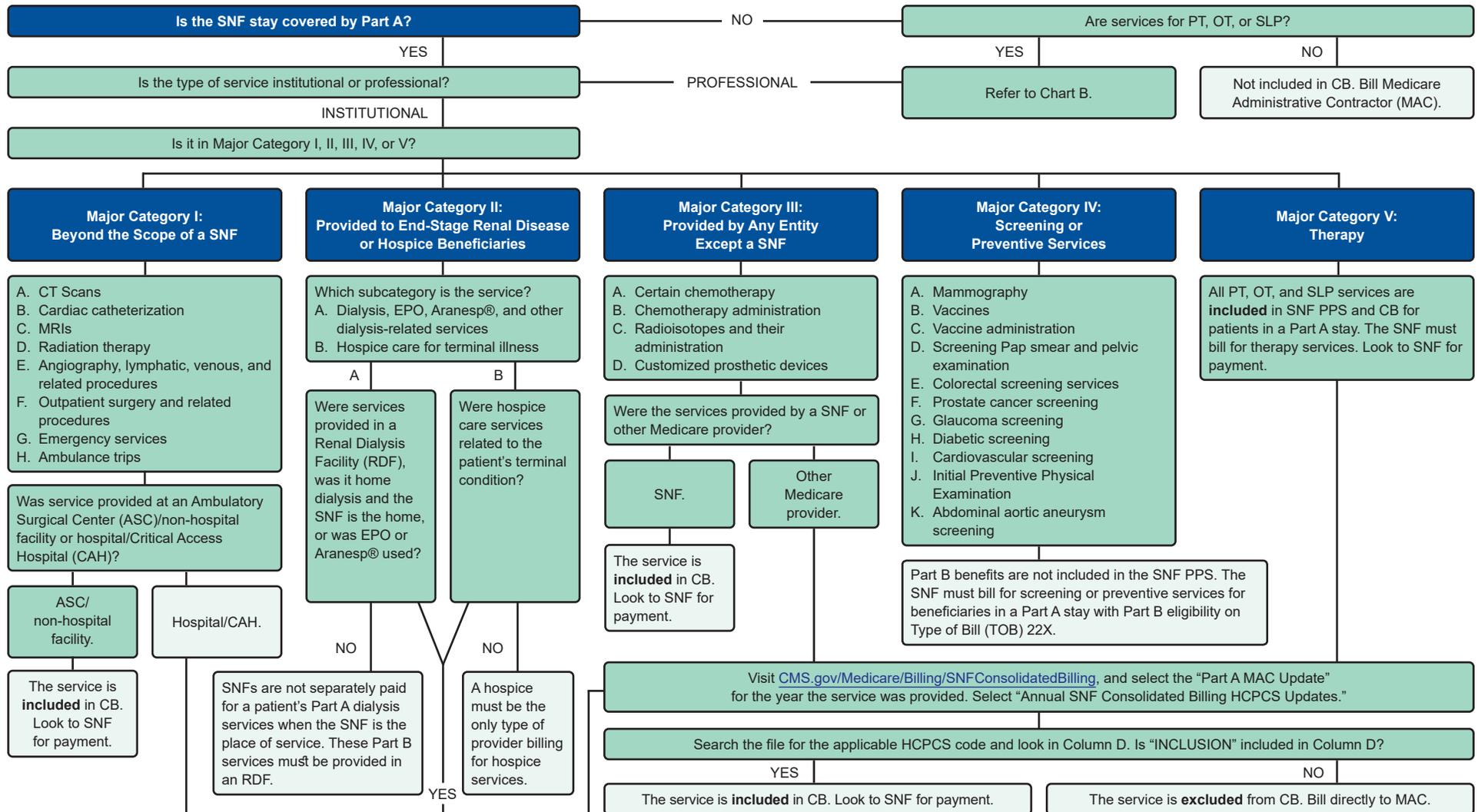
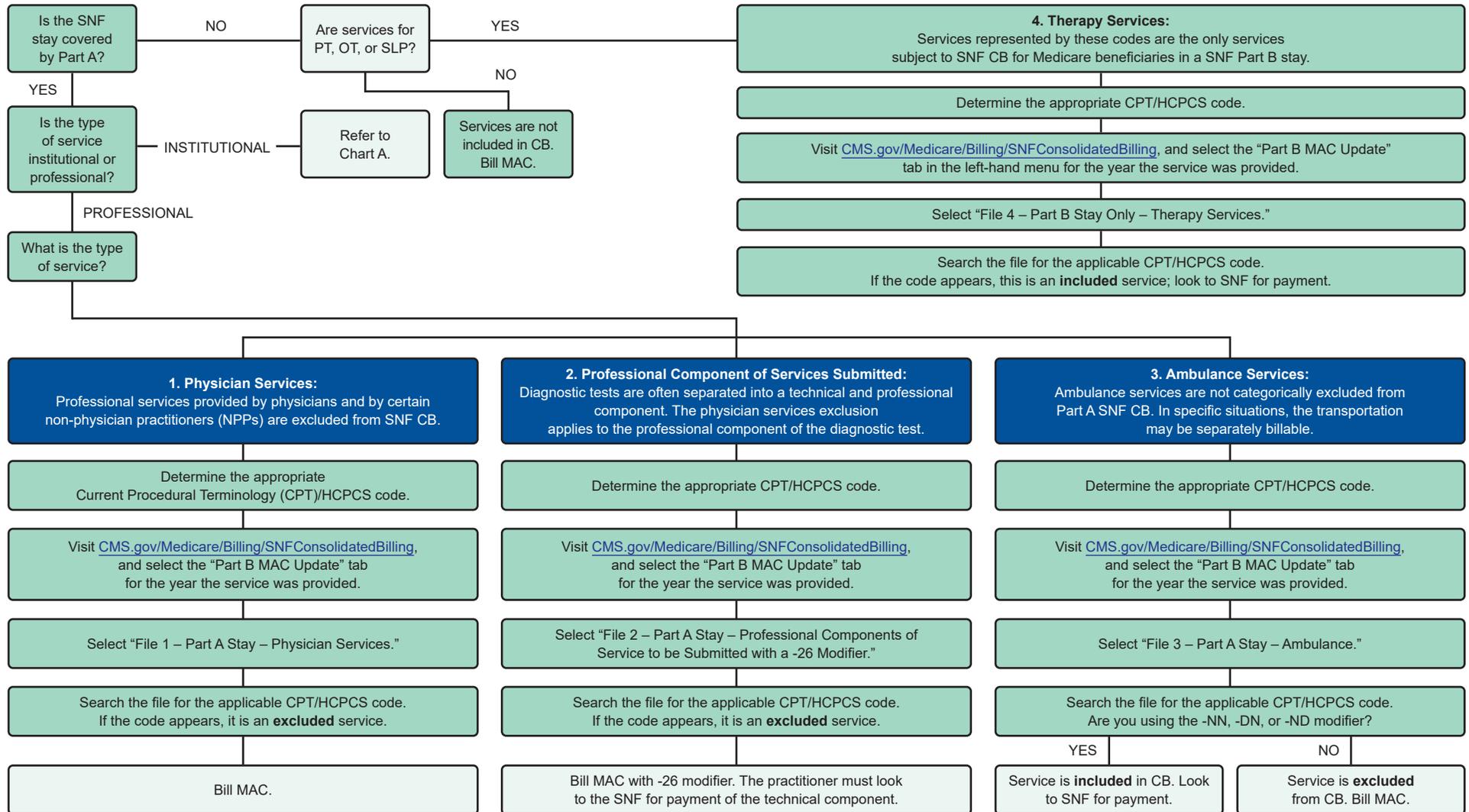


Chart B: Determining Professional Services Consolidated Billing



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SNF QRP

[SSA § 1888\(e\)\(6\)\(B\)\(i\)\(II\)](#) set up the SNF QRP. It applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH non-swing bed rural hospitals. SNFs must submit quality data measures specified by the Secretary of Health & Human Services.

Beginning with FY 2018 and each subsequent FY, CMS will reduce the market basket update by 2 percentage points for SNFs that do not comply with quality data submission requirements for any FY.

Measures for Annual Payment Update

This table provides the measures for the FY 2020 annual payment update. Refer to the [SNF Quality Reporting Program Data Submission Deadlines](#) and the “Downloads” section at the bottom of the webpage for more information.

Table 5. Measures Required for FY 2020 Annual Payment Update

Measure Name	Data Source
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Short Stay)	MDS Assessment
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	MDS Assessment
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)	MDS Assessment
Drug Regimen Review Conducted with Follow-Up for Identified Issues—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	MDS Assessment
Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)	MDS Assessment
Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)	MDS Assessment
Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)	MDS Assessment
Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)	MDS Assessment
Medicare Spending Per Beneficiary (MSPB)—Post-Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Claims-Based Measure No additional data submission required by SNFs

Table 5. Measures Required for FY 2020 Annual Payment Update (cont.)

Measure Name	Data Source
Discharge to Community—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Claims-Based Measure No additional data submission required by SNFs
Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Claims-Based Measure No additional data submission required by SNFs

SNF VBP PROGRAM

Since October 1, 2018, Medicare pays value-based incentive payments to SNFs based on their performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510). SNFs get incentive payments at the start of each new FY. The adjusted Federal per diem rate is reduced by 2 percent, and the resulting rate is adjusted by the amount earned by the SNF for that FY.

The claim-based SNFRM assesses the risk-standardized rate of all-cause, all-condition, and unplanned inpatient hospital readmissions of Medicare Fee-For-Service SNF patients within 30 days of discharge from admission to an Inpatient Prospective Payment System hospital, CAH, or psychiatric hospital. SNFs get confidential quarterly and annual reports about their performance.

RESOURCES

Table 6. SNF PPS Resources

Resource	Website
PDPM	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/PPDM
SNF PPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912 (Chapters 6 and 7)
SNF QRP	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information
SNF VBP	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page

Table 7. Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR § 411.15(p)(2)(xv)	https://www.ecfr.gov/cgi-bin/text-idx?SID=e1e969a1347299167e2cbf25c496fa54&mc=true&node=pt42.2.411&rgn=div5#se42.2.411_115
Concurrent and Group Therapy Limit Fact Sheet	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
List of SNF Federal Regulations	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations
NTS Comorbidity Score Fact Sheet	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_NTAComorbidityScoring_v2_508.pdf
PDPM Classification Walkthrough Webpage	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_PDPM_Classification_Walkthrough_v2.pdf
PDPM Website	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
SNF Quality Reporting Program Data Submission Deadlines	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Data-Submission-Deadlines
Social Security Act (SSA) § 1888(e)(4)(E) SSA § 1888(e)(6)(B)(i)(II)	https://www.ssa.gov/OP_Home/ssact/title18/1888.htm

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