DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409 and 413

[CMS–1737–F]

RIN 0938–AU13

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2021. We are also making changes to the case-mix classification code mappings used under the SNF PPS and making two minor revisions in the regulation text. Additionally, we are adopting the recent revisions in Office of Management and Budget (OMB) statistical area delineations. This rule also updates the Skilled Nursing Facility Value-Based Purchasing (VBP) Program that affects Medicare payment to SNFs.

DATES: These regulations are effective on October 1, 2020.

FOR FURTHER INFORMATION CONTACT:

Penny Gershman, (410) 786–6643, for information related to SNF PPS clinical issues.

Anthony Hodge, (410) 786–6645, for information related to consolidated billing, and payment for SNF-level swing-bed services.

John Kane, (410) 786–0557, for information related to the development of the payment rates and case-mix indexes, and general information.

Kia Sidbury, (410) 786–7816, for information related to the wage index.

Lang Le, (410) 786–5693, for information related to the skilled nursing facility value-based purchasing program.

SUPPLEMENTARY INFORMATION:

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the internet on the CMS website. The wage index tables for this final rule can be accessed on the SNF PPS Wage Index home page, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Readers who experience any problems accessing any of these online SNF PPS wage index tables should contact Kia Sidbury at (410) 786–7816.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

Table of Contents

I. Executive Summary

A. Purpose

This final rule updates the SNF prospective payment rates for fiscal year (FY) 2021 as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication of certain specified information relating to the payment update (see section II.C. of this final rule) in the **Federal Register**, before the August 1 that precedes the start of each FY. As discussed in section III.C.4. of this final rule, it also makes two minor revisions in the regulation text. In addition, we are making changes to the code mappings used under the SNF PPS for classifying patients into case-mix groups. Additionally, we are also updating the OMB delineations used to identify a facility's status as an urban or rural facility and to calculate the wage index. This final rule also updates the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP). There are no updates in this final rule related to the Skilled Nursing Facility Quality Reporting Program (SNF QRP).

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, the federal rates in this final rule will reflect an update to the rates that we published in the SNF PPS final rule for FY 2020 (84 FR 38728). In this final rule, we adopt the most recent OMB delineations, which are used to identify a provider's status as either an urban or rural facility and to calculate the provider's wage index. This final rule also includes two revisions to the regulations text. This final rule also includes revisions to the International Classification of Diseases, Version 10 (ICD–10) code mappings used under Patient Driven Payment Model (PDPM) to classify patients into case-mix groups.

Additionally, we are finalizing a several updates to our SNF VBP regulations, including a 30-day Phase One Review and Correction deadline for the baseline period quality measure report that is typically issued in December.

C. Summary of Cost and Benefits

TABLE 1: Cost and Benefits

Provision Description	Total Transfers
FY 2021 SNF PPS payment rate update.	The overall economic impact of this final rule is an estimated increase of $750 million in aggregate payments to SNFs during FY 2021.
FY 2021 SNF VBP changes.	The overall economic impact of the SNF VBP Program is an estimated reduction of $199.54 million in aggregate payments to SNFs during FY 2021.

D. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their health information. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

To further interoperability in post-acute care settings, CMS continues to explore opportunities to advance electronic exchange of patient information across payers, providers and with patients, including developing systems that use nationally recognized health IT standards such as the Logical Observation Identifiers Names and Codes (LOINC), the Systematized Nomenclature of Medicine (SNOMED), and the Fast Healthcare Interoperability Resources (FHIR). In addition, CMS and ONC established the Post-Acute Care Interoperability Workgroup (PACIO) to facilitate collaboration with industry stakeholders to develop FHIR standards that could support the exchange and reuse of patient assessment data derived from the minimum data set (MDS), inpatient rehabilitation facility patient assessment instrument (IRF–PAI), long term care hospital continuity assessment record and evaluation (LCDS), outcome and assessment information set (OASIS) and other sources.

The Data Element Library (DEL) continues to be updated and serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards. The DEL furthers CMS' goal of data standardization and interoperability. These interoperable data elements can reduce provider burden by allowing the use and exchange of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Standards in the Data Element Library (*https://del.cms.gov/DELWeb/pubHome*) can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2020 ISA is available at *https://www.healthit.gov/isa.*

In the September 30, 2019 **Federal Register**, CMS published a final rule, ''Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning'' (84 FR 51836) (''Discharge Planning final rule''), that revises the discharge planning requirements that hospitals (including psychiatric hospitals, long-term care hospitals, and inpatient rehabilitation facilities), critical access hospitals (CAHs), and home health agencies, must meet to participate in Medicare and Medicaid programs. The rule supports CMS' interoperability efforts by promoting the exchange of patient information between health care settings, and by ensuring that a patient's necessary medical information is transferred with the patient after discharge from a hospital, CAH, or post-acute care services provider. For more information on the Discharge planning requirements, please visit the final rule at *https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals.*

The 21st Century Cures Act (Cures Act) (Pub. L. 114–255, enacted on December 13, 2016) requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. On May 1 2020, ONC and CMS published the final rules, ''21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program,'' (85 FR 25642) and ''Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access'' (85 FR 25510), respectively, to promote secure and more immediate access to health information for patients and healthcare providers through the use of standards-based application programming interfaces (APIs) that enable easier access to electronic health information. The CMS Interoperability and Patient Access rule also finalizes a new regulation under the Conditions of Participation for hospitals (85 FR 25584), including CAHs and psychiatric hospitals, which will require these providers to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to appropriate recipients, including applicable post-acute care providers and suppliers. These notifications can help alert post-acute care providers and suppliers when a patient has been seen in the ED or admitted to the hospital, supporting more effective care coordination across settings. We invite providers to learn more about these important developments and how they are likely to affect SNFs.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997) (Pub. L. 105–33, enacted August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In

addition, a detailed discussion of the legislative history of the SNF PPS is available online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.*

Section 215(a) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93, enacted April 1, 2014) added section 1888(g) to the Act requiring the Secretary to specify an all-cause all-condition hospital readmission measure and an all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a VBP program for SNFs. Finally, section 2(c)(4) of the IMPACT Act amended section 1888(e)(6) of the Act, which requires the Secretary to implement a QRP for SNFs under which SNFs report data on measures and resident assessment data.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the federal case-mix adjusted rate. The transition extended through the facility's first 3 cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments for SNFs entirely on the adjusted federal per diem rates, we no longer include adjustment factors under the transition related to facility-specific rates for the upcoming FY.

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2020 (84 FR 38728).

Section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** the following:

- The unadjusted federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- The factors to be applied in making the area wage adjustment for these services.

Along with other revisions discussed later in this preamble, this final rule provides the required annual updates to the per diem payment rates for SNFs for FY 2021.

III. Analysis of and Responses to Public Comments on the FY 2021 SNF PPS Proposed Rule

In response to the publication of the FY 2021 SNF PPS proposed rule (85 FR 20914), we received 47 public comments from individuals, providers, corporations, government agencies, private citizens, trade associations, and major organizations. The following are brief summaries of each proposed provision, a summary of the public comments that we received related to that proposal, and our responses to the comments.

A. General Comments on the FY 2021 SNF PPS Proposed Rule

In addition to the comments we received on specific proposals contained within the proposed rule (which we address later in this final rule), commenters also submitted the following, more general, observations on the SNF PPS and SNF QRP generally. A discussion of these comments, along with our responses, appears below.

Comment: We received a significant number of comments and recommendations that are outside the scope of the proposed rule addressing a number of different policies, including the Coronavirus disease 2019 (COVID–19) pandemic, the group and concurrent therapy limit under PDPM, and other suggested changes to the PDPM case-mix classification model and quality programs under the SNF PPS.

Response: We greatly appreciate these comments and suggestions for revisions to policies under the SNF PPS. However, because these comments are outside the scope of the current rulemaking, we are not addressing them in this final rule, but will take them under consideration.

Comment: We received several comments on the SNF QRP. The proposed rule contained no SNF QRP proposals. Several commenters thanked CMS for granting an exception to the SNF QRP reporting requirements for quarter 1 and quarter 2 of 2020. Several commenters requested that CMS modify the use of COVID–19 affected data in the SNF QRP, by excluding or delineating the data. One commenter requested that measure reliability analyses be performed and shared to ensure the accuracy of measure calculations in light of truncated, incomplete, or COVID–19 affected data. One commenter requested CMS conduct stakeholder meetings to address the impacts of the truncated performance period on performance compliance. One commenter recommended that all SNFs be held harmless for non-compliance during the FY 2022 performance period. Several commenters provided recommendations for the addition of new SNF QRP measures. Finally, a commenter recommended measures be modified to protect specialty populations.

Response: These comments fall outside the scope of the current rulemaking. We refer providers to 85 FR 27596 through 27597 regarding the delay in the adoption of the MDS 3.0 v1.18.1. We also refer providers to our June 23, 2020 announcement at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-quality-Reporting-Program-Spotlights-and-Announcements* that effective July 1, 2020 providers must resume reporting their quality data.

B. SNF PPS Rate Setting Methodology and FY 2021 Update

1. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the federal rates also incorporated a Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for geographic variations in wages and for the costs of facility differences in case mix. In compiling the database used to compute the federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA 1997 prescribed, we set the federal

rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas, and adjusted the portion of the federal rate attributable to wage-related costs by a wage index to reflect geographic variations in wages.

2. SNF Market Basket Update

a. SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), we revised and rebased the market basket index, which included updating the base year from FY 2010 to 2014.

The SNF market basket index is used to compute the market basket percentage change that is used to update the SNF federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage update is adjusted by a forecast error correction, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.2.d. of this final rule. In the FY 2021 SNF PPS proposed rule (85 FR 20916), we proposed the FY 2021 SNF market basket update of 2.7 percent based on IHS Global Inc.'s (IGI's) first quarter 2020 forecast of the 2014-based SNF market basket with historical data through fourth quarter 2019. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket and/or the MFP), we would use such data, if appropriate, to determine the FY 2021 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, or MFP adjustment in the SNF PPS final rule (85 FR 20918).

For this final rule, based on IGI's second quarter 2020 forecast with historical data through the first quarter of 2020, the FY 2021 growth rate of the 2014-based SNF market basket is estimated to be 2.2 percent. We note that the first quarter 2020 forecast used for the proposed market basket update was developed prior to the economic impacts of the COVID–19 pandemic. This lower update (2.2 percent) for FY 2021 relative to the proposed rule (2.7 percent) is primarily driven by slower than anticipated compensation growth for both health-related and other occupations as labor markets are expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery.

In section III.B.2.e. of this final rule, we discuss the 2 percent reduction applied to the market basket update for those SNFs that fail to submit measures data as required by section 1888(e)(6)(A) of the Act.

b. Use of the SNF Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of the previous FY to the midpoint of the current FY. For the federal rates set forth in this final rule, we use the percentage change in the SNF market basket index to compute the update factor for FY 2021. This factor is based on the FY 2021 percentage increase in the 2014-based SNF market basket index reflecting routine, ancillary, and capital-related expenses. As stated above, in the proposed rule, the SNF market basket percentage was estimated to be 2.7 percent for FY 2021 based on IGI's first quarter 2020 forecast (with historical data through fourth quarter 2019). In this final rule, the SNF market basket percentage is estimated to be 2.2 percent for FY 2021 based on IGI's second quarter 2020 forecast (with historical data through first quarter 2020).

c. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003 final rule (68 FR 46057 through 46059), 42 CFR 413.337(d)(2) provides for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058), the adjustment will reflect both upward and downward adjustments, as appropriate.

For FY 2019 (the most recently available FY for which there is final data), the forecasted or estimated increase in the market basket index was 2.8 percentage points, and the actual increase for FY 2019 is 2.3 percentage points, resulting in the difference between the estimated and actual increase to be 0.5 percentage point. In the FY 2014 final rule (78 FR 47946 through 47947), we finalized our proposal to report the forecast error to the second significant digit in only those instances where the forecast error rounds to 0.5 percentage point at one significant digit, so that we can determine whether the forecast error adjustment threshold has been exceeded. As we stated in the FY 2014 SNF PPS final rule, once we determine that a forecast error adjustment is warranted, we will continue to apply the adjustment itself at one significant digit (otherwise referred to as a tenth of a percentage point). When rounded to the second significant digit, the percent change in the estimated market basket is 2.75 percent and the actual FY 2019 market basket increase is 2.34 percent. Subtracted, this yields a forecast error of 0.41 percentage point (2.75 − 2.34). Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, we stated in the proposed rule (85 FR 20917) that under the policy previously described (comparing the forecasted and actual increase in the market basket), the FY 2021 market basket percentage change would not be adjusted to account for the forecast error correction.

However, as discussed in the FY 2019 SNF PPS final rule (83 FR 39166), the market basket increase for FY 2019 was set at 2.4 percent, as a result of section 53111 of the Bipartisan Budget Act of 2018 (BBA 2018) (Pub. L. 115–123, enacted on February 9, 2018), which amended section 1888(e) of the Act to add section 1888(e)(5)(B)(iv) of the Act. Given that the market basket adjustment for FY 2019 was set by law, meaning that the forecasted 2014-based market

basket percentage increase for FY 2019 was not used to calculate the SNF PPS per diem rates for FY 2019, and because the forecast error adjustment discussed in this section is intended to correct for differences between the forecasted market basket increase for a given year and the actual market basket increase for that year, we stated in the proposed rule that we do not believe that it would be appropriate to apply a forecast error correction for FY 2019.

Table 2 shows the forecasted and actual market basket amounts for FY 2019.

TABLE 2: Difference Between the Forecasted and Actual Market Basket Increases for FY 2019

Index	Forecasted FY 2019 Increase*	Actual FY 2019 Increase**	FY 2019 Difference
SNF	2.75	2.34	-0.41

*Published in **Federal Register**; based on second quarter 2018 IGI forecast (2014-based index).
**Based on the second quarter 2020 IGI forecast, with historical data through the first quarter 2020 (2014-based index).

d. Multifactor Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148, enacted March 23, 2010) requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the multifactor productivity (MFP) adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the MFP adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost-reporting period, or other annual period). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS website at *http://www.bls.gov/mfp* for the BLS historical published MFP data.

MFP is derived by subtracting the contribution of labor and capital inputs growth from output growth. The projections of the components of MFP are currently produced by IGI, a nationally recognized economic forecasting firm with which CMS contracts to forecast the components of the market baskets and MFP. To generate a forecast of MFP, IGI replicates the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models. For a discussion of the MFP projection methodology, we refer readers to the FY 2012 SNF PPS final rule (76 FR 48527 through 48529) and the FY 2016 SNF PPS final rule (80 FR 46395). A complete description of the MFP projection methodology is available on our website at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.*

(1) Incorporating the MFP Into the Market Basket Update

Per section 1888(e)(5)(A) of the Act, the Secretary shall establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding fiscal year. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

In the FY 2021 SNF PPS proposed rule (85 FR 20917), we proposed a MFP adjustment of 0.4 percentage point based on IGI's first quarter 2020 forecast. Based on the more recent data available for this FY 2021 SNF PPS final rule, the current estimate of the 10-year moving average growth of MFP for FY 2021 would be −0.1 percentage point. This MFP is based on the most recent macroeconomic outlook from IGI at the time of rulemaking (released June 2020) in order to reflect more current historical economic data. IGI produces monthly macroeconomic forecasts, which include projections of all of the economic series used to derive MFP. In contrast, IGI only produces forecasts of the more detailed price proxies used in the 2014-based SNF market basket on a quarterly basis. Therefore, IGI's second quarter 2020 forecast is the most recent forecast of the 2014-based SNF market basket percentage.

We note that it has typically been our practice to base the projection of the market basket price proxies and MFP in the final rule on the second quarter IGI forecast. For this FY 2021 SNF final rule, we are using the IGI June 2020 macroeconomic forecast for MFP because it is a more recent forecast, and it is important to use more recent data during this period when economic trends, particularly employment and labor productivity, are notably uncertain because of the COVID–19 pandemic. Historically, the MFP adjustment based on the second quarter IGI forecast has been very similar to the MFP adjustment derived with IGI's June macroeconomic forecast. Substantial changes in the macroeconomic indicators in between monthly forecasts are atypical.

Given the unprecedented economic uncertainty as a result of the COVID–19 pandemic, the changes in the IGI

macroeconomic series used to derive MFP between the IGI second quarter 2020 forecast and the IGI June 2020 macroeconomic forecast is significant. Therefore, we believe it is appropriate to use IGI's more recent June 2020 macroeconomic forecast to determine the MFP adjustment for the final rule as it reflects more recent historical data. For comparison purposes, the 10-year moving average growth of MFP for FY 2021 is projected to be –0.1 percentage point based on IGI's June 2020 macroeconomic forecast compared to a FY 2021 projected 10-year moving average growth of MFP of 0.7 percentage point based on IGI's second quarter 2020 forecast. Mechanically subtracting the negative 10-year moving average growth of MFP from the SNF market basket percentage using the data from the IGI June 2020 macroeconomic forecast would have resulted in a 0.1 percentage point increase in the FY 2021 SNF payment update percentage. However, under section 1888(e)(5)(B)(ii) of the Act, the Secretary is required to reduce (not increase) the SNF market basket percentage by changes in economy-wide productivity. Accordingly, we will be applying a 0.0 percentage point MFP adjustment to the SNF market basket percentage. Therefore, the SNF payment update percentage for FY 2021 is 2.2 percent.

Consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), the market basket percentage for FY 2021 for the SNF PPS is based on IGI's second quarter 2020 forecast of the SNF market basket percentage, which is estimated to be 2.2 percent. As discussed above, given that applying the 10-year moving average growth of MFP of –0.1 percentage point would have resulted in an increase in the market basket percentage, contrary to the provisions of section 1888(e)(5)(B)(ii) of the Act, we are applying a 0.0 percentage point MFP adjustment to the FY 2021 SNF market basket percentage. The FY 2021 SNF market basket update is, therefore, equal to 2.2 percent.

e. Market Basket Update Factor for FY 2021

Sections 1888(e)(4)(E)(ii)(IV) and (e)(5)(i) of the Act require that the update factor used to establish the FY 2021 unadjusted federal rates be at a level equal to the market basket index percentage change. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2019, through September 30, 2020 to the average market basket level for the period of October 1, 2020, through September 30, 2021. We stated in the proposed rule that this process yields a percentage change in the 2014-based SNF market basket of 2.7 percent. However, as stated above, based on a more recent forecast, in this final rule, this process yields a percentage change in the 2014-based SNF market basket of 2.2 percent.

As further explained in section III.B.2.c. of this final rule, as applicable, we adjust the market basket percentage change by the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the difference between the forecasted FY 2019 SNF market basket percentage change and the actual FY 2019 SNF market basket percentage change (FY 2019 is the most recently available FY for which there is historical data) did not exceed the 0.5 percentage point threshold, in the proposed rule, the FY 2021 market basket percentage change was not adjusted by the forecast error correction. Moreover, given that the market basket for FY 2019 was set independent of these estimates, as discussed previously, we stated in the proposed rule that we do not believe a forecast error adjustment would be warranted even if the difference for FY 2019 exceeded 0.5 percentage point.

Section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage change by the 10-year moving average of changes in MFP for the period ending September 30, 2021 which, in the proposed rule, was estimated to be 0.4 percent, as described in section III.B.2.d. of this final rule. We stated that the resulting net SNF market basket update would equal 2.3 percent, or 2.7 percent less the projected 10-year moving average growth of MFP of 0.4 percentage point . Thus, as discussed in the FY 2021 SNF PPS proposed rule, we proposed to apply the SNF market basket update factor of 2.3 percent in our determination of the FY 2021 SNF PPS unadjusted federal per diem rates, which reflected a market basket increase factor of 2.7 percent, less the projected 0.4 percentage point MFP adjustment.

However, as discussed in the FY 2021 SNF PPS proposed rule, our policy is that if more recent data become available (for example, a more recent estimate of the SNF market basket and/or MFP), we would use such data, if appropriate, to determine the FY 2021 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, or MFP adjustment in the SNF PPS final rule. As discussed previously in this section, based on IGI's second quarter 2020 forecast, the SNF market basket percentage is estimated to be 2.2 percent. Further, as discussed above, based on IGI's June 2020 macroeconomic forecast, the 10-year moving average growth of MFP is estimated to be −0.1 percent, which, absent the statutory directive to ''reduce'' the market basket, *see* section 1888(e)(5)(B)(ii) of the Act, would have resulted in an increase in the FY 2021 SNF payment update percentage. In keeping with § 1888, therefore, we are applying a 0.0 percentage point MFP adjustment for FY 2021.

We also note that section 1888(e)(6)(A)(i) of the Act provides that, beginning with FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year involved, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket index percentage change being less than zero for a fiscal year, and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act applies only to the fiscal year involved, and that the reduction cannot be taken into account in computing the payment amount for a subsequent fiscal year.

Commenters submitted the following comments related to the proposed market basket update factor for FY 2021. A discussion of these comments, along with our responses, appears below.

Comment: Many commenters supported the proposed market basket increase factor for FY 2021. A few commenters suggested that CMS consider reweighting the cost categories used in calculating the SNF market basket in relation to COVID–19.

Response: We appreciate the support for applying the market basket increase factor in calculating the FY 2021 SNF PPS per diem rates. With regard to the comment that we consider reweighting the cost categories based on changes in

SNF costs resulting from COVID–19, we do not believe that sufficient data exists to perform this type of analysis. We may consider this analysis in the future, when more data become available.

After considering the comments received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing the market basket update factor of 2.2 percent, utilizing the more recent forecast data. Based on more recent forecast data, as discussed previously in this section, the FY 2021 market basket update factor is 2.2 percent, which is based on an FY 2021 SNF market basket percentage increase of 2.2 percent.

f. Unadjusted Federal Per Diem Rates for FY 2021

As discussed in the FY 2019 SNF PPS final rule (83 FR 39162), in FY 2020 we implemented a new case-mix classification system to classify SNF patients under the SNF PPS, the PDPM. As discussed in section V.B. of that final rule, under PDPM, the unadjusted federal per diem rates are divided into six components, five of which are case-mix adjusted components (Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and Non-Therapy Ancillaries (NTA)), and one of which is a non-case-mix component, as exists under RUG–IV. In the proposed rule (85 FR 20918), we used the SNF market basket, adjusted as described previously, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2021 from the average prices for FY 2020. We stated we would further adjust the rates by a wage index budget neutrality factor, described later in this section. Further, in the past, we used the revised OMB delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634), with updates as reflected in OMB Bulletin Nos, 15–01 and 17–01, to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. As discussed in the FY 2021 SNF PPS proposed rule and later in this final rule, we proposed to adopt the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) to identify a facility's urban or rural status.

Tables 3 and 4 reflect the updated unadjusted federal rates for FY 2021, prior to adjustment for case-mix.

TABLE 3: FY 2021 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$62.04	$57.75	$23.16	$108.16	$81.60	$96.85

TABLE 4: FY 2021 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$70.72	$64.95	$29.18	$103.34	$77.96	$98.64

Commenters submitted the following comments related to the proposed unadjusted federal per diem rates for FY 2021. A discussion of these comments, along with our responses, appears below.

Comment: One commenter raised concerns with how the base rates used under the SNF PPS, which have been adjusted by the SNF market basket each year, are based on cost reports from 1995. The commenters requested that CMS update the cost reporting base year used in deriving the unadjusted federal rates.

Response: We appreciate the commenter's suggestion regarding updating the cost reporting base year used for deriving the unadjusted federal per diem rates. However, section 1888(e)(4)(A) of the Act requires that we use the ''allowable costs of extended care services (excluding exception payments) for the facility for cost reporting periods beginning in 1995.'' As such, we do not have the statutory authority to update the cost reporting base year used to derive the SNF PPS federal per diem rates.

Accordingly, after considering the comments received, for the reasons specified in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing the unadjusted federal per diem rates set forth in Tables 3 and 4, which we derived using the SNF market basket update factor of 2.2 percent and a budget neutrality factor of 0.9992 (as discussed later in this preamble).

3. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the FY 2019 final rule (83 FR 39162, August 8, 2018), we finalized a new case-mix classification model, the PDPM, which took effect beginning October 1, 2019. The previous RUG–IV model classified most patients into a therapy payment group and primarily used the volume of therapy services provided to the patient as the basis for payment classification, thus inadvertently creating an incentive for SNFs to furnish therapy regardless of the individual patient's unique characteristics, goals, or needs. PDPM eliminates this incentive and improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing the administrative burden on SNFs.

As we noted in the FY 2021 SNF PPS proposed rule, we would 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 will 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, as discussed in the FY 2020 SNF PPS final rule (84 FR 38734). 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.

The PDPM uses clinical data from the MDS to assign case-mix classifiers to each patient that are then used to calculate a per diem payment under the SNF PPS, consistent with the provisions of section 1888(e)(4)(G)(i) of the Act. As discussed in section III.C.1. of this final rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the timeframes for MDS completion in our Resident Assessment Instrument (RAI) Manual. As we have stated in prior rules, for an MDS to be considered valid for use in determining payment, the MDS assessment should be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html*.

Under section 1888(e)(4)(H) of the Act, each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2021 payment rates set forth in this final rule reflect the use of the PDPM case-mix classification system from October 1, 2020, through September 30, 2021. In the FY 2021 SNF PPS proposed rule (85 FR 20920 through 20921), we listed the proposed case-mix adjusted PDPM payment rates for FY 2021, provided separately for urban and rural SNFs, in Tables 5 and 6 with corresponding case-mix values.

We stated in the proposed rule that given the differences between the previous RUG–IV model and PDPM in terms of patient classification and billing, it was important that the format of Tables 5 and 6 reflect these differences. More specifically, under both RUG–IV and PDPM, providers use a Health Insurance Prospective Payment System (HIPPS) code on a claim to bill for covered SNF services. Under RUG–IV, the HIPPS code included the three-character RUG–IV group into which the patient classified as well as a two-character assessment indicator code that represented the assessment used to generate this code. Under PDPM, while providers would still use a HIPPS code, the characters in that code represent different things. For example, the first character represents the PT and OT group into which the patient classifies. If the patient is classified into the PT and OT group ''TA'', then the first character in the patient's HIPPS code would be an A. Similarly, if the patient is classified into the SLP group ''SB'', then the second character in the patient's HIPPS code would be a B. The third character represents the Nursing group into which the patient classifies. The fourth character represents the NTA group into which the patient classifies. Finally, the fifth character represents the assessment used to generate the HIPPS code.

Tables 5 and 6 reflect the PDPM's structure. Accordingly, Column 1 of Tables 5 and 6 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.

Tables 5 and 6 reflect the final PDPM case-mix adjusted rates and case-mix indexes for FY 2021. We would note that these numbers differ from those in the FY 2021 SNF PPS proposed rule, as we have used more recent data in calculating the final budget neutrality factor, that is used in calculating the FY 2021 SNF PPS unadjusted federal per diem rates, as discussed in section III.D.1.d. of this final rule. Tables 5 and 6 do not reflect adjustments which may be made to the SNF PPS rates as a result of the SNF VBP program, discussed in section III.D. of this final rule, or other adjustments, such as the variable per diem adjustment. Further, in the past, we used the revised OMB delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634), with updates as reflected in OMB Bulletin Nos, 15–01 and 17–01, to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. As discussed in this final rule and in the FY 2021 SNF PPS proposed rule (85 FR 20928), we proposed to adopt the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) to identify a facility's urban or rural status.

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TABLE 5: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—URBAN

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$94.92	1.49	$86.05	0.68	$15.75	ES3	4.06	$439.13	3.24	$264.38
B	1.70	$105.47	1.63	$94.13	1.82	$42.15	ES2	3.07	$332.05	2.53	$206.45
C	1.88	$116.64	1.69	$97.60	2.67	$61.84	ES1	2.93	$316.91	1.84	$150.14
D	1.92	$119.12	1.53	$88.36	1.46	$33.81	HDE2	2.40	$259.58	1.33	$108.53
E	1.42	$88.10	1.41	$81.43	2.34	$54.19	HDE1	1.99	$215.24	0.96	$78.34
F	1.61	$99.88	1.60	$92.40	2.98	$69.02	HBC2	2.24	$242.28	0.72	$58.75
G	1.67	$103.61	1.64	$94.71	2.04	$47.25	HBC1	1.86	$201.18	-	-
H	1.16	$71.97	1.15	$66.41	2.86	$66.24	LDE2	2.08	$224.97	-	-
I	1.13	$70.11	1.18	$68.15	3.53	$81.75	LDE1	1.73	$187.12	-	-
J	1.42	$88.10	1.45	$83.74	2.99	$69.25	LBC2	1.72	$186.04	-	-
K	1.52	$94.30	1.54	$88.94	3.7	$85.69	LBC1	1.43	$154.67	-	-
L	1.09	$67.62	1.11	$64.10	4.21	$97.50	CDE2	1.87	$202.26	-	-
M	1.27	$78.79	1.30	$75.08	-	-	CDE1	1.62	$175.22	-	-
N	1.48	$91.82	1.50	$86.63	-	-	CBC2	1.55	$167.65	-	-
O	1.55	$96.16	1.55	$89.51	-	-	CA2	1.09	$117.89	-	-
P	1.08	$67.00	1.09	$62.95	-	-	CBC1	1.34	$144.93	-	-
Q	-	-	-	-	-	-	CA1	0.94	$101.67	-	-
R	-	-	-	-	-	-	BAB2	1.04	$112.49	-	-
S	-	-	-	-	-	-	BAB1	0.99	$107.08	-	-
T	-	-	-	-	-	-	PDE2	1.57	$169.81	-	-
U	-	-	-	-	-	-	PDE1	1.47	$159.00	-	-
V	-	-	-	-	-	-	PBC2	1.22	$131.96	-	-
W	-	-	-	-	-	-	PA2	0.71	$76.79	-	-
X	-	-	-	-	-	-	PBC1	1.13	$122.22	-	-
Y	-	-	-	-	-	-	PA1	0.66	$71.39	-	-

TABLE 6: PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.53	$108.20	1.49	$96.78	0.68	$19.84	ES3	4.06	$419.56	3.24	$252.59
B	1.70	$120.22	1.63	$105.87	1.82	$53.11	ES2	3.07	$317.25	2.53	$197.24
C	1.88	$132.95	1.69	$109.77	2.67	$77.91	ES1	2.93	$302.79	1.84	$143.45
D	1.92	$135.78	1.53	$99.37	1.46	$42.60	HDE2	2.40	$248.02	1.33	$103.69
E	1.42	$100.42	1.41	$91.58	2.34	$68.28	HDE1	1.99	$205.65	0.96	$74.84
F	1.61	$113.86	1.60	$103.92	2.98	$86.96	HBC2	2.24	$231.48	0.72	$56.13
G	1.67	$118.10	1.64	$106.52	2.04	$59.53	HBC1	1.86	$192.21	-	-
H	1.16	$82.04	1.15	$74.69	2.86	$83.45	LDE2	2.08	$214.95	-	-
I	1.13	$79.91	1.18	$76.64	3.53	$103.01	LDE1	1.73	$178.78	-	-
J	1.42	$100.42	1.45	$94.18	2.99	$87.25	LBC2	1.72	$177.74	-	-
K	1.52	$107.49	1.54	$100.02	3.7	$107.97	LBC1	1.43	$147.78	-	-
L	1.09	$77.08	1.11	$72.09	4.21	$122.85	CDE2	1.87	$193.25	-	-
M	1.27	$89.81	1.30	$84.44	-	-	CDE1	1.62	$167.41	-	-
N	1.48	$104.67	1.50	$97.43	-	-	CBC2	1.55	$160.18	-	-
O	1.55	$109.62	1.55	$100.67	-	-	CA2	1.09	$112.64	-	-
P	1.08	$76.38	1.09	$70.80	-	-	CBC1	1.34	$138.48	-	-
Q	-	-	-	-	-	-	CA1	0.94	$97.14	-	-
R	-	-	-	-	-	-	BAB2	1.04	$107.47	-	-
S	-	-	-	-	-	-	BAB1	0.99	$102.31	-	-
T	-	-	-	-	-	-	PDE2	1.57	$162.24	-	-
U	-	-	-	-	-	-	PDE1	1.47	$151.91	-	-
V	-	-	-	-	-	-	PBC2	1.22	$126.07	-	-
W	-	-	-	-	-	-	PA2	0.71	$73.37	-	-
X	-	-	-	-	-	-	PBC1	1.13	$116.77	-	-
Y	-	-	-	-	-	-	PA1	0.66	$68.20	-	-

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4. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. In the FY 2021 SNF PPS proposed rule (85 FR 20921), we proposed to continue this practice for FY 2021, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the inpatient prospective payment system (IPPS) also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we stated in the proposed rule that we would continue to use the pre-reclassified IPPS hospital wage data, without applying the occupational mix, rural floor, or outmigration adjustment, as the basis for the SNF PPS wage index. For FY 2021, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2016 and before October 1, 2017 (FY 2017 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000) authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF PPS wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. In addition, adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are inpatient hospitals. Therefore, we stated in the proposed rule that while we continue to believe that the development of such an audit process could improve SNF cost reports in such a manner as to permit us to establish a SNF-specific wage index, we do not believe this undertaking is feasible at this time.

In addition, we proposed to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2020 SNF PPS wage index. For rural geographic areas

that do not have hospitals, and therefore, lack hospital wage data on which to base an area wage adjustment, we stated we would use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2021, there are no rural geographic areas that do not have hospitals, and thus, this methodology will not be applied. For rural Puerto Rico, we stated we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we stated we would continue to use the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we stated we would use the average wage indexes of all of the urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2021, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

The wage index applicable to FY 2021 is set forth in Tables A and B available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), after the expiration of this 1-year transition on September 30, 2006, we used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided minor updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. In addition, on August 15, 2017, OMB issued Bulletin No. 17–01 which announced a new urban CBSA, Twin Falls, Idaho (CBSA 46300). As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), we noted in the proposed rule (85 FR 20922) that this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index. To this end, as discussed in this final rule and in the FY 2021 SNF PPS proposed rule (85 FR 20922), we proposed to adopt the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1-year transition for FY 2021 under which we stated we would apply a 5 percent cap on any decrease in a hospital's wage index compared to its wage index for the prior fiscal year (FY 2020). We stated that we believe these updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and that use of such delineations would allow us to more accurately determine the appropriate wage index and rate tables to apply under the SNF PPS. Thus, we stated that we believe it is appropriate to use these updated OMB delineations for these purposes, to enhance the accuracy of payments under the SNF PPS. These changes are discussed further in section III.D.1.a. of this final rule. We solicited comments on this proposal. A discussion of these comments, along with our responses, appears in section III.D.1. of this final rule.

The final wage index applicable to FY 2021 is set forth in Tables A and B and are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Table A provides a crosswalk between the FY 2021 wage index for a provider using the current OMB delineations in effect in FY 2020 and the FY 2021 wage index using the revised OMB delineations, as well as the final transition wage index values that would be in effect in FY 2021.

We stated in the proposed rule, once calculated, we would apply the wage index adjustment to the labor-related portion of the federal rate. Each year, we calculate a revised labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are labor-intensive and vary with the local labor market) in the input price index. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), we finalized a proposal to revise the labor-related share to reflect the relative importance of the 2014-based SNF market basket cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2021. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2021 than the base year weights from the SNF market basket. We calculate the labor-related relative importance for FY 2021 in four steps. First, we compute the FY 2021 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2021 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2021 relative importance for

each cost category by multiplying this ratio by the base year (2014) weight. Finally, we add the FY 2021 relative importance for each of the labor-related cost categories (Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-related services; and a portion of Capital-Related expenses) to produce the FY 2021 labor-related relative importance. Table 7 summarizes the final labor-related share for FY 2021, based on IGI's second quarter 2020 forecast with historical data through first quarter 2020, compared to the labor-related share that was used for the FY 2020 SNF PPS final rule.

TABLE 7: Labor-Related Relative Importance, FY 2020 and FY 2021

	Relative importance, labor-related, FY 2020 19:2 forecast[1]	Relative importance, labor-related, FY 2021 20:2 forecast[2]
Wages and salaries	50.6	51.1
Employee benefits	10.0	9.9
Professional Fees: Labor-Related	3.7	3.7
Administrative and facilities support services	0.5	0.5
Installation, Maintenance and Repair Services	0.6	0.6
All Other: Labor Related Services	2.6	2.6
Capital-related (.391)	2.9	2.9
Total	**70.9**	**71.3**

[1] Published in the **Federal Register (84 FR 38738)**; based on second quarter 2019 IGI forecast

[2] Based on second quarter 2020 IGI forecast, with historical data through first quarter 2020.

In the proposed rule, we stated that to calculate the labor portion of the case-mix adjusted per diem rate, we would multiply the total case-mix adjusted per diem rate, which is the sum of all five case-mix adjusted components into which a patient classifies, and the non-case-mix component rate, by the FY 2021 labor-related share percentage provided in Table 7. The remaining portion of the rate would be the non-labor portion. Under the previous RUG–IV model, we included tables which provided the case-mix adjusted RUG–IV rates, by RUG–IV group, broken out by total rate, labor portion and non-labor portion, such as Table 9 of the FY 2019 SNF PPS final rule (83 FR 39175). However, as we discussed in the FY 2020 final rule (84 FR 38738), under PDPM, as the total rate is calculated as a combination of six different component rates, five of which are case-mix adjusted, and given the sheer volume of possible combinations of these five case-mix adjusted components, it is not feasible to provide tables similar to those that existed in the prior rulemaking.

Therefore, to aid stakeholders in understanding the effect of the wage index on the calculation of the SNF per diem rate, we have included a hypothetical rate calculation in Table 8.

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage adjustment had not been made. For FY 2021 (federal rates effective October 1, 2020), we would apply an adjustment to fulfill the budget neutrality requirement. We would meet this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor. Our budget neutrality calculations are described in section III.D.1.d. of this final rule.

A discussion of the comments we received regarding the SNF PPS wage index, including the wage index budget neutrality calculation, along with our responses, appears in section III.D.1 of this final rule.

5. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, section 1888(h) of the Act requires the Secretary to reduce the adjusted federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished during a fiscal year by 2 percent, and to adjust the resulting rate for a SNF by the value-based incentive payment amount earned by the SNF based on the SNF's performance score for that fiscal year under the SNF VBP Program. To implement these requirements, we finalized in the FY 2019 SNF PPS final rule the addition of § 413.337(f) to our regulations (83 FR 39178).

Please see section III.D.3. of this final rule for a further discussion of our policies for the SNF VBP Program.

6. Adjusted Rate Computation Example

Tables 8, 9, and 10 provide examples generally illustrating payment calculations during FY 2021 under PDPM for a hypothetical 30-day SNF stay, involving the hypothetical SNF XYZ, located in Frederick, MD (Urban CBSA 23224), for a hypothetical patient who is classified into such groups that the patient's HIPPS code is NHNC1. Table 8 shows the adjustments made to the federal per diem rates (prior to application of any adjustments under the SNF VBP program as discussed previously) to compute the provider's case-mix adjusted per diem rate for FY 2021, based on the patient's PDPM classification, as well as how the variable per diem (VPD) adjustment factor affects calculation of the per diem rate for a given day of the stay. Table 9 shows the adjustments made to the case-mix adjusted per diem rate from Table 8 to account for the provider's wage index. The wage index used in this example is based on the FY 2021 SNF PPS wage index that appears in Table A available on the CMS website at *http://*

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. Finally, Table 10 provides the case-mix and wage index adjusted per-diem rate for this patient for each day of the 30-day stay, as well as the total payment for this stay. Table 10 also includes the VPD adjustment factors for each day of the patient's stay, to clarify why the patient's per diem rate changes for certain days of the stay. As illustrated in Table 10, SNF XYZ's total PPS payment for this particular patient's stay would equal $20,390.17.

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TABLE 8: PDPM Case-Mix Adjusted Rate Computation Example

Per Diem Rate Calculation				
Component	**Component Group**	**Component Rate**	**VPD Adjustment Factor**	**VPD Adj. Rate**
PT	N	$91.82	1.00	$91.82
OT	N	$86.63	1.00	$86.63
SLP	H	$66.24	1.00	$66.24
Nursing	N	$167.65	1.00	$167.65
NTA	C	$150.14	3.00	$450.42
Non-Case-Mix	-	$96.85	-	$96.85
Total PDPM Case-Mix Adj. Per Diem				$959.61

TABLE 9: Wage Index Adjusted Rate Computation Example

PDPM Wage Index Adjustment Calculation						
HIPPS Code	PDPM Case-Mix Adjusted Per Diem	Labor Portion	Wage Index	Wage Index Adjusted Rate	Non-Labor Portion	Total Case Mix and Wage Index Adj. Rate
NHNC1	$959.61	$684.20	0.9834	$672.84	$275.41	$948.25

TABLE 10: Adjusted Rate Computation Example

Day of Stay	NTA VPD Adjustment Factor	PT/OT VPD Adjustment Factor	Case Mix and Wage Index Adjusted Per Diem Rate
1	3.0	1.0	$948.25
2	3.0	1.0	$948.25
3	3.0	1.0	$948.25
4	1.0	1.0	$651.53
5	1.0	1.0	$651.53
6	1.0	1.0	$651.53
7	1.0	1.0	$651.53
8	1.0	1.0	$651.53
9	1.0	1.0	$651.53
10	1.0	1.0	$651.53
11	1.0	1.0	$651.53
12	1.0	1.0	$651.53
13	1.0	1.0	$651.53
14	1.0	1.0	$651.53
15	1.0	1.0	$651.53
16	1.0	1.0	$651.53
17	1.0	1.0	$651.53
18	1.0	1.0	$651.53
19	1.0	1.0	$651.53
20	1.0	1.0	$651.53
21	1.0	0.98	$648.00
22	1.0	0.98	$648.00
23	1.0	0.98	$648.00
24	1.0	0.98	$648.00
25	1.0	0.98	$648.00
26	1.0	0.98	$648.00
27	1.0	0.98	$648.00
28	1.0	0.96	$644.47
29	1.0	0.96	$644.47
30	1.0	0.96	$644.47
Total Payment			$20,390.17

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C. Additional Aspects of the SNF PPS

1. SNF Level of Care—Administrative Presumption

The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system discussed in section III.B.3. of this final rule. This approach includes an administrative presumption that utilizes a beneficiary's correct assignment, at the outset of the SNF stay, of one of the case-mix classifiers designated for this purpose to assist in making certain SNF level of care determinations.

In accordance with § 413.345, we include in each update of the federal payment rates in the **Federal Register** a discussion of the resident classification system that provides the basis for case-mix adjustment. We also designate those specific classifiers under the case-mix classification system that represent the required SNF level of care, as provided in 42 CFR 409.30. This designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial Medicare assessment are automatically classified as meeting the SNF level of care definition up to and including the

assessment reference date (ARD) for that assessment.

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. This presumption recognizes the strong likelihood that those beneficiaries who are assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html* (where such designations appear in the paragraph entitled ''Case Mix Adjustment''), and would publish such designations in rulemaking only to the extent that we actually intend to propose changes in them. Under that approach, the set of case-mix classifiers designated for this purpose under PDPM was finalized in the FY 2019 SNF PPS final rule (83 FR 39253) and is posted on the SNF PPS website (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html*), in the paragraph entitled ''Case Mix Adjustment.''

However, we note 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, 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. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations where the sole classifier that triggers the presumption is itself assigned through the receipt of services that are subsequently determined to be not reasonable and necessary. Moreover, we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the ARD of the initial Medicare assessment.

We did not receive any comments regarding the proposed rule's discussion of the administrative level of care presumption. As previously stated in this final rule, the set of case mix classifiers designated for this purpose under PDPM is posted on the SNF PPS website (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html*).

2. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA 1997) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297).

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_2018-10-01.pdf.* In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113, enacted November 29, 1999) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual high-cost, low probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *www.cms.gov/transmittals/downloads/ab001860.pdf.*

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate additional, individual services for exclusion within each of these four specified service categories. In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA do not designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: They must fall within one of the four service categories specified in the BBRA; and they also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion as essentially affording the flexibility to revise the list of excluded codes in response to changes of major

significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791).

In the proposed rule, we specifically invited public comments identifying 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 our criteria for exclusion from SNF consolidated billing. We stated in the proposed rule that we may consider excluding a particular service if it meets our criteria for exclusion as specified previously. We requested that commenters identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, we stated in the proposed rule that, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, October 1, 2020). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

A discussion of the comments we received regarding SNF consolidated billing, along with our responses, appears below.

Comment: Several commenters cited the COVID–19 Public Health Emergency (PHE) as justification for excluding services from consolidated billing that would not otherwise qualify for such exclusion.

Response: We appreciate these concerns and recognize the unique circumstances of the COVID–19 PHE. However, excluding services from SNF consolidated billing that would not otherwise meet the statutory conditions for exclusion would require congressional action.

Comment: A commenter requested that CMS consider whether application of 42 CFR 411.8(b)(4), (Services paid for by a Government entity) ''would enable payment for COVID–19 testing under Medicare Part B for patients currently covered in a Medicare Part A stay.''

Response: We are not sure we understand what the commenter is asking, however, we note that § 411.8(b)(4) does not address exceptions to the SNF consolidated billing requirement.

Comment: Some commenters suggested that CMS should consider removing antiviral, antibiotic, and other expensive non-chemotherapy medications from consolidated billing and allowing such services to be separately billable. A commenter stated these medications are oftentimes more expensive than the already excluded chemotherapy medications. Another commenter stated that the high cost of newer pharmaceutical agents is a barrier in allowing patients to access their Part A SNF benefits, suggesting that SNF facilities may be hesitant to accept eligible patients if these patients will require high cost medications. The commenter requested that CMS add these agents, including their administration costs, to the excluded list under Consolidated Billing. Examples of such medications include: Dalbavancin; Daptomycin; Ceftolozane-tazobactam; and Oritavancin.

Response: We have responded to similar recommendations in past rulemaking cycles. The issue of establishing a broader exclusion that would encompass expensive non-chemotherapy drugs was addressed in the SNF PPS final rule for FY 2017 (81 FR 51985, August 5, 2016), and again in the final rule for FY 2019 (83 FR 39180, August 8, 2018), which explained that existing law does not provide for such an expansion.

Comment: Some commenters reiterated recommendations made in previous rulemaking cycles for exclusions from consolidated billing of certain Part-D-only oral chemotherapy drugs.

Response: We note that such drugs have been recommended for exclusion during previous rulemaking cycles. For the reasons discussed previously in prior rulemaking, the particular drugs cited in these comments remain subject to consolidated billing. In the FY 2020 SNF PPS final rule (84 FR 38743 through 38744), we stated that because the particular drugs at issue here would not be covered under Part B, the applicable provisions at section 1888(e)(2)(A) of the Act do not provide a basis for excluding them from consolidated billing. Moreover, as noted in the FY 2006 SNF PPS final rule (70 FR 45049) and the FY 2020 SNF PPS final rule (84 FR 38744), expanding the existing statutory drug coverage available under Part B to include such drugs is not within our authority.

Comment: A commenter requested that CMS consider excluding the chemotherapy medications Alkeran (Melphalan) and Bicnu (Carmustine) from consolidated billing, due to the high cost of daily treatments.

Response: Both Melphalan and Carmustine already appear on the SNF PPS exclusion list in Major Category III.A (Chemotherapy), under codes J9245 and J9050, respectively.

Comment: A commenter suggested that CMS should ''conduct a broad review of new chemotherapy drugs and their costs to determine whether any additions should be made to the exclusion list, as new drugs are being added regularly and do not always have their own HCPCS code.''

Response: We routinely review a list of upcoming HCPCS code revisions (additions, modifications, and deletions) for the coming calendar year to determine whether additions should be made in the consolidated billing exclusion list. As discussed in the FY 2015 SNF PPS final rule (79 FR 45642, August 5, 2014), the approach that Congress adopted to identify the individual chemotherapy drugs being designated for exclusion consisted of listing them by HCPCS code in the statute itself (section 1888(e)(2)(A)(iii)(II) of the Act). Thus, a chemotherapy drug's assignment to its own specific code has always served as the mechanism of designating it for exclusion, as well as the means by which the claims processing system is able to recognize that exclusion. Accordingly, the assignment of a chemotherapy drug to its own code is a necessary prerequisite to consider that service for exclusion from consolidated billing under the SNF PPS.

Comment: A commenter suggested that CMS exclude portable X-ray services from Skilled Nursing Facility Consolidated Billing (SNF CB).

Response: As explained in the final rule for FY 2001 (65 FR 46790), we have the statutory authority to designate additional service codes for exclusion only when they fall within one of the four categories originally specified in the BBRA and set forth at section

1888(e)(2)(A)(iii) of the Act: That is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices. We do not have statutory authority to create a new category of excluded items, such as for diagnostic imaging services. Excluding portable x-ray services from SNF CB would require congressional action, as existing law does not provide for such an exclusion.

3. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this final rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. As discussed in the FY 2019 SNF PPS final rule (83 FR 39235), revisions were made to the swing bed assessment to support implementation of PDPM, effective October 1, 2019. A discussion of the assessment schedule and the MDS effective beginning FY 2020 appears in the FY 2019 SNF PPS final rule (83 FR 39229 through 39237). The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

A commenter submitted the following comment related to the proposed rule's discussion of payment for SNF-level swing-bed services. A discussion of that comment, along with our response, appears below.

Comment: One commenter suggested that exempting the swing-bed services of CAHs from the SNF PPS creates a discrepancy in payment for comparable services between the CAH and any area SNFs which are not so exempted, to the SNF's disadvantage. The commenter urged CMS to seek statutory authority either to pay for CAH swing-bed services under the SNF PPS, or to adjust Medicare payments for those rural SNFs located in the same geographic area as a swing-bed CAH.

Response: As we noted previously in the final rule for FY 2020 (84 FR 38745, August 7, 2019) in response to a similar comment, as originally enacted in section 4432 of the BBA 1997, the SNF PPS applied uniformly to *all* providers of extended care services under Part A, including SNFs themselves along with swing-bed CAHs as well as rural (non-CAH) swing-bed hospitals. However, the Congress subsequently enacted legislation in section 203 of the BIPA that specifically excluded swing-bed CAHs from the SNF PPS (see section 1888)(e)(7)(C) of the Act), thus establishing that swing-bed CAHs are to be exempted from the SNF PPS while leaving this payment methodology in place for the other facilities, including rural SNFs. Accordingly, we cannot adjust Medicare payments for rural SNFs located in the same geographic area as a swing-bed CAH to provide for similar payments.

4. Revisions to the Regulation Text

We proposed to make certain revisions in the regulation text itself. Specifically, we proposed to update the example used in illustrating the application of the SNF level of care's ''practical matter'' criterion that appears at 42 CFR 409.35(a), as well as to correct an erroneous cross-reference that appears in the swing-bed payment regulations at 42 CFR 413.114(c)(2), as discussed further below.

The statutory SNF level of care definition set forth in section 1814(a)(2)(B) of the Act provides that the beneficiary must need and receive skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis.

Section 409.35(a) provides that in making a ''practical matter'' determination, consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. In this context, in evaluating whether a given non-inpatient alternative is more economical than inpatient SNF care, the regulation provides that the availability of Medicare payment for those services may not be a factor.

In illustrating this point, the existing regulation text at § 409.35(a) uses as an example the previous annual caps on Part B payment for outpatient therapy services. It indicates that Medicare's nonpayment for services that exceed the cap would not, in itself, serve as a basis for determining that needed care can only be provided in a SNF. To reflect the recent repeal of the Part B therapy caps in section 50202 of the BBA 2018, we proposed to revise the regulation text by rewording the example used to illustrate this point in a manner that omits its reference to the repealed therapy cap provision. Specifically, we proposed to revise the regulation text on this point to provide as an example that the unavailability of Medicare payment for *outpatient* therapy due to the beneficiary's nonenrollment in Part B cannot serve as a basis for finding that the needed care can only be provided on an *inpatient* basis in a SNF.

In addition, we proposed to make a minor technical correction to the regulation text in § 413.114(c), which discusses historical swing-bed payment policies that were in effect for cost reporting periods beginning prior to July 1, 2002. Specifically, we proposed to revise § 413.114(c)(2) to remove an erroneous cross-reference to a non-existent § 413.55(a)(1), and to substitute in its place the correct cross-reference to the regulations on reasonable cost reimbursement at § 413.53(a)(1).

We received one comment supporting our proposed revisions to the regulation text. We appreciate this comment and after considering the comment received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing our proposed revisions to the regulation text without modification.

D. Other Issues

1. Changes to SNF PPS Wage Index

a. Core-Based Statistical Areas (CBSAs) for the FY 2021 SNF PPS Wage Index

(1) Background

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We proposed to continue this practice for FY 2021, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate

and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data under the IPPS also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. As in previous years, we proposed to continue to use, as the basis for the SNF PPS wage index, the IPPS hospital wage data, unadjusted for occupational mix, without taking into account geographic reclassifications under section 1886(d)(8) and (d)(10) of the Act, and without applying the rural floor under section 4410 of the BBA 1997 and the outmigration adjustment under section 1886(d)(13) of the Act. For FY 2021, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2016 and before October 1, 2017 (FY 2017 cost report data).

The applicable SNF PPS wage index value is assigned to a SNF on the basis of the labor market area in which the SNF is geographically located. In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Area (MSA) and the creation of micropolitan statistical areas and combined statistical areas. In adopting the Core-Based Statistical Areas (CBSA) geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No. 13–01 established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided minor updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. In addition, on August 15, 2017, OMB issued Bulletin No. 17–01 which announced a new urban CBSA, Twin Falls, Idaho (CBSA 46300). As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), and as we noted in the proposed rule, this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03 which superseded the August 15, 2017 OMB Bulletin No. 17–01. Subsequently, on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of OMB Bulletin No. 18–04 may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.* (We note that on March 6, 2020, OMB issued OMB Bulletin 20–01 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*)), which, as discussed later in this section, was not issued in time for development of the FY 2021 SNF PPS proposed rule.) As we discussed in the proposed rule (85 FR 20928), while OMB Bulletin No. 18–04 is not based on new census data, it includes some material changes to the OMB statistical area delineations, including some new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart. In the FY 2021 SNF PPS proposed rule, we proposed to adopt the updates to the OMB delineations announced in OMB Bulletin No. 18–04 effective beginning in FY 2021 under the SNF PPS. As noted previously, the March 6, 2020 OMB Bulletin 20–01 was not issued in time for development of the FY 2021 SNF PPS proposed rule. We intend to propose any updates from this bulletin in the FY 2022 SNF PPS proposed rule.

As we stated in the proposed rule, to implement these changes for the SNF PPS beginning in FY 2021, it is necessary to identify the revised labor market area delineation for each affected county and provider in the country. We further stated that the revisions OMB published on September 14, 2018 contain a number of significant changes. For example, we stated that under the revised OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would split apart. We discuss these changes in more detail later in this final rule.

b. Implementation of Revised Labor Market Area Delineations

We typically delay implementing revised OMB labor market area delineations to allow for sufficient time to assess the new changes. For example, as discussed in the FY 2014 SNF PPS proposed rule (78 FR 26448) and final rule (78 FR 47952), we delayed implementing the revised OMB statistical area delineations described in OMB Bulletin No. 13–01 to allow for sufficient time to assess the new changes. In the proposed rule (85 FR 20929), we stated that we believe it is important for the SNF PPS to use the latest labor market area delineations available as soon as is reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We also stated in the proposed rule that we further believe that using the delineations reflected in OMB Bulletin No. 18–04 will increase the integrity of the SNF PPS wage index system by creating a more accurate representation of geographic variations in wage levels. As we stated in the proposed rule, we have reviewed our findings and impacts relating to the revised OMB delineations set forth in OMB Bulletin No. 18–04, and find no compelling reason to further delay implementation. As we explained in the proposed rule, because we believe we have broad authority under section

1888(e)(4)(G)(ii) of the Act to determine the labor market areas used for the SNF PPS wage index, and because we believe the delineations reflected in OMB Bulletin No. 18–04 better reflect the local economies and wage levels of the areas in which hospitals are currently located, we proposed to implement the revised OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, for the SNF PPS wage index effective beginning in FY 2021. In addition, we proposed to implement a 1-year transition policy under which we would apply a 5 percent cap in FY 2021 on any decrease in a hospital's wage index compared to its wage index for the prior fiscal year (FY 2020) to assist providers in adapting to the revised OMB delineations (if we were to finalize the implementation of such delineations for the SNF PPS wage index beginning in FY 2021). This transition is discussed in more detail later in this final rule.

(a) Micropolitan Statistical Areas

As discussed in the FY 2006 SNF PPS proposed rule (70 FR 29093 through 29094) and final rule (70 FR 45041), we considered how to use the Micropolitan Statistical Area definitions in the calculation of the wage index. OMB defines a ''Micropolitan Statistical Area'' as a CBSA ''associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000'' (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), we determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's SNF PPS rural wage index (see 70 FR 29094 and 70 FR 45040 through 45041).

Thus, the SNF PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in non-MSA areas, and the statewide rural wage index is assigned to SNFs located in those areas. Because Micropolitan Areas tend to encompass smaller population centers and contain fewer hospitals than MSAs, we determined that if Micropolitan Areas were to be treated as separate labor market areas, the SNF PPS wage index would have included significantly more single-provider labor market areas. As we explained in the FY 2006 SNF PPS proposed rule (70 FR 29094), recognizing Micropolitan Areas as independent labor markets would generally increase the potential for dramatic shifts in year-to-year wage index values because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of an area. Dramatic shifts in an area's wage index from year-to-year are problematic and create instability in the payment levels from year-to-year, which could make fiscal planning for SNFs difficult if we adopted this approach. For these reasons, we adopted a policy to include Micropolitan Areas in the state's rural wage area for purposes of the SNF PPS wage index, and have continued this policy through the present.

We stated in the proposed rule (85 FR 20929) that we believe the best course of action would be to continue the policy established in the FY 2006 SNF PPS final rule and include Micropolitan Areas in each state's rural wage index. These areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). As discussed in the proposed rule, we do not believe it would be appropriate to calculate a separate wage index for areas that typically may include only a few hospitals for the reasons discussed in the FY 2006 SNF PPS proposed rule, and as discussed earlier in this final rule. Therefore, in conjunction with our proposal to implement the revised OMB labor market delineations beginning in FY 2021 and consistent with the treatment of Micropolitan Areas under the IPPS, we proposed to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of the state's rural wage index.

(b) Urban Counties That Will Become Rural Under the Revised OMB Delineations

As previously discussed, we proposed to implement the revised OMB statistical area delineations based upon OMB Bulletin No. 18–04 beginning in FY 2021. In the FY 2021 SNF PPS proposed rule (85 FR 20929), we indicated that a total of 34 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered to be located in a rural area, beginning in FY 2021, if we adopted these revised OMB delineations. In the proposed rule, we listed the 34 urban counties, as set forth in Table 11, that would be rural if we finalized our proposal to implement the revised OMB delineations.

TABLE 11: Urban Counties That Would Become Rural

FIPS County Code	County/County Equivalent	State	Current CBSA	CBSA Name
01127	Walker	AL	13820	Birmingham-Hoover, AL
12045	Gulf	FL	37460	Panama City, FL
13007	Baker	GA	10500	Albany, GA
13235	Pulaski	GA	47580	Warner Robins, GA
15005	Kalawao	HI	27980	Kahului-Wailuku-Lahaina, HI
17039	De Witt	IL	14010	Bloomington, IL
17053	Ford	IL	16580	Champaign--Urbana, IL
18143	Scott	IN	31140	Louisville/Jefferson County, KY-IN
18179	Wells	IN	23060	Fort Wayne, IN
19149	Plymouth	IA	43580	Sioux City, IA-NE-SD
20095	Kingman	KS	48620	Wichita, KS
21223	Trimble	KY	31140	Louisville/Jefferson County, KY-IN
22119	Webster	LA	43340	Shreveport-Bossier City, LA
26015	Barry	MI	24340	Grand Rapids-Wyoming, MI
26159	Van Buren	MI	28020	Kalamazoo-Portage, MI
27143	Sibley	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI
28009	Benton	MS	32820	Memphis, TN-MS-AR
29119	Mc Donald	MO	22220	Fayetteville-Springdale-Rogers, AR-MO
30037	Golden Valley	MT	13740	Billings, MT
31081	Hamilton	NE	24260	Grand Island, NE
38085	Sioux	ND	13900	Bismarck, ND
40079	Le Flore	OK	22900	Fort Smith, AR-OK
45087	Union	SC	43900	Spartanburg, SC
46033	Custer	SD	39660	Rapid City, SD
47081	Hickman	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN
48007	Aransas	TX	18580	Corpus Christi, TX
48221	Hood	TX	23104	Fort Worth-Arlington, TX
48351	Newton	TX	13140	Beaumont-Port Arthur, TX
48425	Somervell	TX	23104	Fort Worth-Arlington, TX
51029	Buckingham	VA	16820	Charlottesville, VA
51033	Caroline	VA	40060	Richmond, VA
51063	Floyd	VA	13980	Blacksburg-Christiansburg-Radford, VA
53013	Columbia	WA	47460	Walla Walla, WA
53051	Pend Oreille	WA	44060	Spokane-Spokane Valley, WA

We proposed that, for purposes of determining the wage index under the SNF PPS, the wage data for all hospitals located in the counties listed in Table 11 would be considered rural when calculating their respective state's rural wage index under the SNF PPS. We stated in the proposed rule that we recognize that rural areas typically have lower area wage index values than urban areas, and SNFs located in these counties may experience a negative impact in their SNF PPS payment due to the proposed adoption of the revised OMB delineations. A discussion of the proposed wage index transition policy appears later in this final rule.

Furthermore, we stated in the proposed rule that for SNF providers currently located in an urban county that would be considered rural should this proposal be finalized, we would utilize the rural unadjusted per diem rates, found in Table 4 of the proposed rule, as the basis for determining payment rates for these facilities beginning on October 1, 2020.

(c) Rural Counties That Will Become Urban Under the Revised OMB Delineations

As previously discussed, we proposed to implement the revised OMB statistical area delineations based upon OMB Bulletin No. 18–04 beginning in FY 2021. In the proposed rule (85 FR 20931), we indicated that analysis of these OMB statistical area delineations shows that a total of 47 counties (and county equivalents) that are currently located in rural areas would be located in urban areas if we finalize our proposal to implement the revised OMB delineations. In the proposed rule (85 FR 20932), we listed the 47 rural counties that would be urban, as set forth in Table 12, if we finalize our proposal to implement the revised OMB delineations.

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TABLE 12: Counties That Would Gain Urban Status

FIPS County Code	County/County Equivalent	State Name	New CBSA	New CBSA Name
01063	Greene	AL	46220	Tuscaloosa, AL
01129	Washington	AL	33660	Mobile, AL
05047	Franklin	AR	22900	Fort Smith, AR-OK
12075	Levy	FL	23540	Gainesville, FL
13259	Stewart	GA	17980	Columbus, GA-AL
13263	Talbot	GA	17980	Columbus, GA-AL
16077	Power	ID	38540	Pocatello, ID
17057	Fulton	IL	37900	Peoria, IL
17087	Johnson	IL	16060	Carbondale-Marion, IL
18047	Franklin	IN	17140	Cincinnati, OH-KY-IN
18121	Parke	IN	45460	Terre Haute, IN
18171	Warren	IN	29200	Lafayette-West Lafayette, IN
19015	Boone	IA	11180	Ames, IA
19099	Jasper	IA	19780	Des Moines-West Des Moines, IA
20061	Geary	KS	31740	Manhattan, KS
21043	Carter	KY	26580	Huntington-Ashland, WV-KY-OH
22007	Assumption	LA	12940	Baton Rouge, LA
22067	Morehouse	LA	33740	Monroe, LA
25011	Franklin	MA	44140	Springfield, MA
26067	Ionia	MI	24340	Grand Rapids-Kentwood, MI
26155	Shiawassee	MI	29620	Lansing-East Lansing, MI
27075	Lake	MN	20260	Duluth, MN-WI
28031	Covington	MS	25620	Hattiesburg, MS
28051	Holmes	MS	27140	Jackson, MS
28131	Stone	MS	25060	Gulfport-Biloxi, MS
29053	Cooper	MO	17860	Columbia, MO
29089	Howard	MO	17860	Columbia, MO
30095	Stillwater	MT	13740	Billings, MT
37007	Anson	NC	16740	Charlotte--Concord-Gastonia, NC-SC
37029	Camden	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC
37077	Granville	NC	20500	Durham-Chapel Hill, NC
37085	Harnett	NC	22180	Fayetteville, NC
39123	Ottawa	OH	45780	Toledo, OH
45027	Clarendon	SC	44940	Sumter, SC
47053	Gibson	TN	27180	Jackson, TN
47161	Stewart	TN	17300	Clarksville, TN-KY
48203	Harrison	TX	30980	Longview, TX
48431	Sterling	TX	41660	San Angelo, TX
51097	King and Queen	VA	40060	Richmond, VA
51113	Madison	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	Southampton	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	Franklin City	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	Jackson	WV	16620	Charleston, WV
54065	Morgan	WV	25180	Hagerstown-Martinsburg, MD-WV
55069	Lincoln	WI	48140	Wausau-Weston, WI
72001	Adjuntas	PR	38660	Ponce, PR
72083	Las Marias	PR	32420	Mayagüez, PR

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We proposed that, for purposes of calculating the area wage index under the SNF PPS, the wage data for hospitals located in the counties listed in Table 12 would be included in their new respective urban CBSAs. As we explained in the proposed rule (85 FR 20933), typically, SNFs located in an urban area would receive a wage index value higher than or equal to SNFs located in their state's rural area. A discussion of the proposed wage index transition policy appears later in this final rule. Furthermore, we stated that

for SNFs currently located in a rural county that would be considered urban should this proposal be finalized, we would utilize the urban unadjusted per diem rates found in Table 3 of the proposed rule, as the basis for determining the payment rates for these facilities beginning October 1, 2020.

(d) Urban Counties That Will Move to a Different Urban CBSA Under the Revised OMB Delineations

As we stated in the FY 2021 SNF PPS proposed rule (85 FR 20933), in addition to rural counties becoming urban and urban counties becoming rural, some urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the revised OMB delineations. Further, we stated that in other cases, adopting the revised OMB delineations would involve a change only in CBSA name and/or number, while the CBSA continues to encompass the same constituent counties. For example, we noted that CBSA 19380 (Dayton, OH) would experience both a change to its number and its name, and become CBSA 19430 (Dayton-Kettering, OH), while all of its three constituent counties would remain the same. We stated that we would consider these proposed changes (where only the CBSA name and/or number would change) to be inconsequential changes with respect to the SNF PPS wage index. In the proposed rule, we listed the CBSAs where there would be a change in CBSA name and/or number only, as set forth in Table 13, if we adopt the revised OMB delineations.

TABLE 13: Urban CBSAs With Change to Name and/or Number

Current CBSA Code	Current CBSA Title	New CBSA Code	New CBSA Title
10540	Albany, OR	10540	Albany-Lebanon, OR
11500	Anniston-Oxford-Jacksonville, AL	11500	Anniston-Oxford, AL
12060	Atlanta-Sandy Springs-Roswell, GA	12060	Atlanta-Sandy Springs-Alpharetta, GA
12420	Austin-Round Rock, TX	12420	Austin-Round Rock-Georgetown, TX
13460	Bend-Redmond, OR	13460	Bend, OR
13980	Blacksburg-Christiansburg-Radford, VA	13980	Blacksburg-Christiansburg, VA
14740	Bremerton-Silverdale, WA	14740	Bremerton-Silverdale-Port Orchard, WA
15380	Buffalo-Cheektowaga-Niagara Falls, NY	15380	Buffalo-Cheektowaga, NY
19380	Dayton, OH	19430	Dayton-Kettering, OH
24340	Grand Rapids-Wyoming, MI	24340	Grand Rapids-Kentwood, MI
24860	Greenville-Anderson-Mauldin, SC	24860	Greenville-Anderson, SC
25060	Gulfport-Biloxi-Pascagoula, MS	25060	Gulfport-Biloxi, MS
25540	Hartford-West Hartford-East Hartford, CT	25540	Hartford-East Hartford-Middletown, CT
25940	Hilton Head Island-Bluffton-Beaufort, SC	25940	Hilton Head Island-Bluffton, SC
28700	Kingsport-Bristol-Bristol, TN-VA	28700	Kingsport-Bristol, TN-VA
31860	Mankato-North Mankato, MN	31860	Mankato, MN
33340	Milwaukee-Waukesha-West Allis, WI	33340	Milwaukee-Waukesha, WI
34940	Naples-Immokalee-Marco Island, FL	34940	Naples-Marco Island, FL
35660	Niles-Benton Harbor, MI	35660	Niles, MI
36084	Oakland-Hayward-Berkeley, CA	36084	Oakland-Berkeley-Livermore, CA
36500	Olympia-Tumwater, WA	36500	Olympia-Lacey-Tumwater, WA
38060	Phoenix-Mesa-Scottsdale, AZ	38060	Phoenix-Mesa-Chandler, AZ
39140	Prescott, AZ	39150	Prescott Valley-Prescott, AZ
43524	Silver Spring-Frederick-Rockville, MD	23224	Frederick-Gaithersburg-Rockville, MD
44420	Staunton-Waynesboro, VA	44420	Staunton, VA
44700	Stockton-Lodi, CA	44700	Stockton, CA
45940	Trenton, NJ	45940	Trenton-Princeton, NJ
46700	Vallejo-Fairfield, CA	46700	Vallejo, CA
47300	Visalia-Porterville, CA	47300	Visalia, CA
48140	Wausau, WI	48140	Wausau-Weston, WI
48424	West Palm Beach-Boca Raton-Delray Beach, FL	48424	West Palm Beach-Boca Raton-Boynton Beach, FL

However, we stated in the proposed rule (85 FR 20934) that in other cases, if we adopted the revised OMB delineations, counties would shift between existing and new urban CBSAs, changing the constituent makeup of the CBSAs. We explained that, in one type of change, CBSAs would split into multiple new CBSAs. For example, we noted that CBSA 35614 (New York Jersey City White Plains, NY NJ) has counties splitting off into new CBSAs, such as CBSA 35154 (New Brunswick Lakewood, NJ). Further, we explained that in other cases, a CBSA would lose one or more counties to another urban CBSA. For example, we noted that Kendall County, IL, that is currently in CBSA 16974 (Chicago Naperville Arlington Heights, IL) is moving to CBSA 20994 (Elgin, IL).

In the proposed rule (85 FR 20936), we listed the urban counties that would move from one urban CBSA to another newly proposed or modified CBSA, as set forth in Table 14, if we adopt the revised OMB delineations.

TABLE 14: Urban Counties That Would Move From One Urban CBSA to Another

FIPS County Code	County Name	State	Current CBSA	Curent CBSA Title	New CBSA Code	New CBSA Title
17031	Cook	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17043	Du Page	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17063	Grundy	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17093	Kendall	IL	16974	Chicago-Naperville-Arlington Heights, IL	20994	Elgin, IL
17111	Mc Henry	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17197	Will	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
34023	Middlesex	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34025	Monmouth	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34029	Ocean	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34035	Somerset	NJ	35084	Newark, NJ-PA	35154	New Brunswick-Lakewood, NJ
36027	Dutchess	NY	20524	Dutchess County-Putnam County, NY	39100	Poughkeepsie-Newburgh-Middletown, NY
36071	Orange	NY	35614	New York-Jersey City-White Plains, NY-NJ	39100	Poughkeepsie-Newburgh-Middletown, NY
36079	Putnam	NY	20524	Dutchess County-Putnam County, NY	35614	New York-Jersey City-White Plains, NY-NJ
47057	Grainger	TN	28940	Knoxville, TN	34100	Morristown, TN
54043	Lincoln	WV	26580	Huntington-Ashland, WV-KY-OH	16620	Charleston, WV
72055	Guanica	PR	38660	Ponce, PR	49500	Yauco, PR
72059	Guayanilla	PR	38660	Ponce, PR	49500	Yauco, PR
72111	Penuelas	PR	38660	Ponce, PR	49500	Yauco, PR
72153	Yauco	PR	38660	Ponce, PR	49500	Yauco, PR

We stated in the proposed rule that if SNFs located in these counties move from one CBSA to another under the revised OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values. A discussion of the wage index transition policy appears later in this final rule.

Commenters submitted the following comments related to the proposed changes discussed above that would result from adopting the revised OMB delineations. A discussion of these comments, along with our responses, appears below.

Comment: Most commenters concurred with adopting the revised OMB delineations. However, several commenters suggested that CMS delay adopting the revised OMB delineations until after the public health emergency related to COVID–19 has ended.

Response: We appreciate the comments concurring with the proposed adoption of the revised OMB delineations. As we stated in the proposed rule (85 FR 20929), we believe that the updated OMB delineations increase the integrity of the SNF PPS wage index by creating a more accurate representation of variations in area wage levels. As such, we believe that the revised OMB delineations would help ensure more accurate and appropriate payments as compared to the current OMB delineations. With regard to the comments that would seek a delay in adopting the revised delineations until after the COVID–19 related public health emergency is over, given that the revised OMB delineations would help ensure more accurate payments than under the current OMB delineations, we believe it is important to adopt the revised delineations as soon as possible. Nothing about the COVID–19 related emergency would diminish the importance of ensuring that payments are as accurate as possible. Moreover,

for providers that would experience an increase in payment under the revised OMB delineations, this means that they are currently being underpaid relative to the reported wage data in their geographic area. Ensuring that providers are not underpaid may even be of greater importance during this type of emergency situation. Therefore, we do not believe that a delay in implementation would be appropriate.

Comment: One commenter suggested that the adoption of the New Brunswick-Lakewood, NJ CBSA would result in a reduction in reimbursement for the four New Jersey counties that would make up the new CBSA and recommended that CMS delay finalizing the proposal to implement the new OMB delineations.

Response: We appreciate the detailed concerns sent in by the commenter regarding the impact of implementing the New Brunswick-Lakewood, NJ CBSA designation on their specific counties. While, we understand the commenter's concern regarding the potential financial impact, we believe that implementing the revised OMB delineations will create more accurate representations of labor market areas and result in SNF wage index values being more representative of the actual costs of labor in a given area. Moreover, we believe that providers located in labor market areas that will experience a decline in wage index under the revised OMB delineations currently are being paid in excess of what the reported wage and labor data for their area would suggest is appropriate. We believe that the OMB standards for delineating Metropolitan and Micropolitan Statistical Areas are appropriate for determining area wage differences and that the values computed under the revised delineations will result in more appropriate payments to providers by more accurately accounting for and reflecting the differences in area wage levels. Furthermore, as explained in section III.D.1.c. of this final rule, we are implementing a wage index transition for FY 2021 under which we will apply a 5 percent cap on any decrease in a hospital's wage index compared to its wage index for FY 2020 to assist providers in adapting to the revised OMB delineations. For these reasons, we do not believe that a delay in implementation would be appropriate.

Comment: One commenter recommended that CMS take this time, during which we are already making and contemplating changes to the SNF PPS more broadly and to the wage index more specifically, to consider creating a SNF-specific wage index, as opposed to continuing to rely on hospital data as the basis for the SNF wage index.

Response: We appreciate the commenter's suggestion as to the development of a SNF specific wage index. However, to date, the development of a SNF-specific wage index has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. In addition, adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are inpatient hospitals. Therefore, while we continue to believe that the development of such an audit process could improve SNF cost reports in such a manner as to permit us to establish a SNF-specific wage index, we do not believe this undertaking is feasible at this time. While we continue to review all available data and contemplate potential methodological approaches for a SNF-specific wage index in the future, we continue to believe that in the absence of the appropriate SNF-specific wage data, using the pre-reclassified, pre-rural floor hospital inpatient wage data (without the occupational mix adjustment) is appropriate and reasonable for the SNF PPS.

After considering the comments received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing our proposal to adopt the revised OMB delineations contained in OMB Bulletin 18–04 as proposed, without modification.

c. Transition Policy for FY 2021 Wage Index Changes

As discussed in the FY 2021 SNF PPS proposed rule (85 FR 20936), we believe that adopting the revised OMB delineations would result in SNF PPS wage index values being more representative of the actual costs of labor in a given area. However, we stated that we also recognize that some SNFs (42 percent) would experience decreases in their area wage index values as a result of this proposal, though just over 2 percent of providers would experience a significant decrease (that is, greater than 5 percent) in their area wage index value. We further stated that we also realize that many SNFs (54 percent) would have higher area wage index values after adopting the revised OMB delineations.

To mitigate the potential impacts, we have in the past provided for transition periods when adopting revised OMB delineations. For example, we proposed and finalized budget neutral transition policies to help mitigate negative impacts on SNFs following the adoption of the new CBSA delineations based on the 2010 decennial census data in the FY 2015 SNF PPS final rule (79 FR 45644 through 45646). Specifically, we implemented a 1-year 50/50 blended wage index for all SNFs due to our adoption of the revised delineations. This required calculating and comparing two wage indexes for each SNF since that blended wage index was computed as the sum of 50 percent of the FY 2015 SNF PPS wage index values under the FY 2014 CBSA delineations and 50 percent of the FY 2015 SNF PPS wage index values under the FY 2015 new OMB delineations. While we believed that using the new OMB delineations would create a more accurate payment adjustment for differences in area wage levels, we also recognized that adopting such changes may cause some short-term instability in SNF PPS payments. In the FY 2021 SNF PPS proposed rule (85 FR 20937), we recognized that similar instability may result from the proposed adoption of the revised OMB delineations discussed in the proposed rule. For example, we noted that SNFs currently located in CBSA 35614 (New York-Jersey City-White Plains, NY-NJ) that would be located in new CBSA 35154 (New Brunswick-Lakewood, NJ) under the proposed changes to the CBSA-based labor market area delineations would experience a nearly 17 percent decrease in the wage index as a result of that the proposed change. Therefore, consistent with past practice, we proposed a transition policy to help mitigate any significant negative impacts that SNFs may experience if we were to adopt the revised OMB delineations for FY 2021. Specifically, for FY 2021, as a transition, we proposed to apply a 5-percent cap on any decrease in an SNF's wage index from the SNF's wage index from the prior fiscal year. We stated that this transition would allow the effects of adopting the revised OMB delineations to be phased in over 2 years, where the estimated reduction in an SNF's wage index would be capped at 5 percent in FY 2021 (that is, no cap would be applied to any reductions in the wage index for the second year (FY 2022)).

We considered using a 50/50 blend for the transition, similar to the transition we finalized in the FY 2015 SNF PPS final rule, as described previously in this final rule. However, we stated in the proposed rule (85 FR 20937) that, given that a majority of SNFs would experience an increase in their area wage index values as a result of the revised OMB delineations, and given that a blended option would affect all SNF providers, we believe it would be more appropriate to allow SNFs that would experience an increase in wage index values to receive the full benefit of their increased wage index value (which is intended to reflect accurately the higher labor costs in that area), while mitigating any significant negative wage index impacts that may be experienced by a minority of SNFs. We explained that by utilizing a cap on negative impacts, this restricts the transition to only those with negative impacts and allows providers who would experience positive impacts to receive the full amount of their wage index increase. Thus, we stated that we believe a 5 percent cap on the overall decrease in an SNF's wage index value would be an appropriate transition for FY 2021. We further stated that we believe 5 percent is a reasonable level for the cap because it would effectively mitigate any significant decreases in an SNF's wage index for FY 2021, while balancing the importance of ensuring that area wage index values accurately reflect relative differences in area wage levels. Additionally, we noted that a cap on significant wage index decreases provides a certain degree of predictability in payment changes for providers and allows providers time to adjust to any significant decreases they may face in FY 2022, after the transition period has ended.

Furthermore, consistent with the requirement at section 1888(e)(4)(G)(ii) of the Act that wage index adjustments must be made in a budget neutral manner, we proposed that this 5 percent cap on the decrease in an SNF's wage index would not result in any change in estimated aggregate SNF PPS payments by applying a budget neutrality factor to the unadjusted federal per diem rates. Our methodology for calculating the budget neutrality factor is discussed further in section III.D.1.d. of this final rule.

In the proposed rule, we stated that this transition policy would be for a 1-year period, going into effect October 1, 2020, and continuing through September 30, 2021. That is, we stated that no cap would be applied to any reductions in the wage index for FY 2022.

Commenters submitted the following comments related to the proposed transition methodology. A discussion of these comments, along with our responses, appears below.

Comment: Many commenters supported the proposed transition methodology. A few commenters including MedPAC suggested alternatives to the 5 percent cap transition policy. MedPAC suggested that the 5 percent cap limit should apply to both increases and decreases in the wage index so that no provider would have its wage index value increase or decrease by more than 5 percent for FY 2021. Finally, several commenters recommended that CMS consider implementing a 5 percent cap, similar to that which we proposed for FY 2021, for years beyond the implementation of the revised OMB delineations, either until no providers experience more than a 5 percent decline in any given year, or by permanently imposing a 5 percent cap on wage index declines.

Response: We appreciate the comments supporting this proposed transition methodology. Further, we appreciate MedPAC's suggestion that the 5 percent cap should also be applied to increases in the wage index. However, as we discussed in the proposed rule, the purpose of the proposed transition policy, as well as those we have implemented in the past, is to help mitigate the significant negative impacts of certain wage index changes, not to curtail the positive impacts of such changes, and thus we do not believe it would be appropriate to apply the 5 percent cap on wage index increases as well. To the extent that a provider's wage index would increase under the revised OMB delineations, this means that the provider is currently being paid less than their reported wage data suggests is appropriate. We believe the proposed transition would help ensure these providers do not receive a wage index adjustment that is lower than appropriate and that payments are as accurate as possible. Finally, with regard to the comments recommending that we consider implementing this type of transition in future years, either on a permanent basis or only until providers no longer experience more than a 5 percent decline in any given year, we believe that this would undermine the goal of the wage index, which is to improve the accuracy of SNF payments. Applying such a cap each year would only serve to further delay improving the accuracy of SNF payments by continuing to pay certain providers more than their wage data suggest is appropriate. Therefore, while we believe that a transition is necessary to help mitigate some initial significant negative impacts from the revised OMB delineations, we also believe this mitigation must be balanced against the importance of ensuring accurate payments.

After considering the comments received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing, without modification, the proposed transition methodology, which places a 5 percent cap on any decrease in a SNF's FY 2021 wage index, from its FY 2020 wage index. The wage index applicable to FY 2021 is set forth in Table A available on the CMS website at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Table A provides a crosswalk between the FY 2021 wage index for a provider using the current OMB delineations in effect in FY 2020 and the FY 2021 wage index using the revised OMB delineations, as well as the transition wage index values.

d. Budget Neutrality Adjustments for Changes to the SNF PPS Wage Index

Section 1888(e)(4)(G)(ii) of the Act requires that we apply the wage index adjustment in a budget neutral manner such that aggregate SNF PPS payments will be neither greater than nor less than aggregate SNF PPS payments without the wage index adjustment. Under this provision, we determine a wage index adjustment budget neutrality factor that is applied to the federal per diem rates to ensure that any changes to the area wage index values would not result in any change (increase or decrease) in estimated aggregate SNF PPS payments. Accordingly, we proposed to apply a wage index budget neutrality factor in determining the federal per diem rates, and we also proposed a methodology for calculating this budget neutrality factor.

For FY 2021, we proposed to adjust the SNF PPS unadjusted federal per diem rates to account for the estimated effect of the wage index adjustments discussed in the proposed rule on estimated aggregate SNF PPS payments. As we stated in the proposed rule (85 FR 20937), under our established methodology, we have historically applied a single budget neutrality factor to ensure that any changes to the wage index are budget neutral. We explained that, in general, annual changes to the wage index include updates to the wage index values based on updated hospital wage data, labor-related share, and geographic labor-market area (that is, CBSA) designations, as applicable. For FY 2021, as discussed in the proposed

rule, we proposed to adopt revised OMB delineations and proposed to apply a 5 percent cap on any decrease in a SNF's wage index. Therefore, for purposes of the wage index budget neutrality requirement under section 1888(e)(4)(G)(ii) of the Act, in determining the SNF PPS federal per diem rates, we proposed a budget neutrality factor for FY 2021, described later in this section of the preamble, that accounts for all of these proposed changes to the SNF PPS wage index. We discuss below the methodology we proposed for calculating and applying the wage index budget neutrality factor for determining the FY 2021 federal per diem rates.

In the FY 2021 SNF PPS proposed rule (85 FR 20937 through 29038), we proposed to apply a budget neutrality factor to adjust the FY 2021 SNF PPS federal per diem rates to account for the estimated effect of the proposed changes to the wage index values based on updated hospital wage data and the adoption of the revised OMB delineations, and accounting for the proposed 5 percent cap on any decreases in a provider's area wage index value, on estimated aggregate SNF PPS payments using a methodology that is consistent with the methodology we have used in prior years (most recently, in the FY 2020 SNF PPS final rule (84 FR 38738)).

Specifically, we proposed to determine a budget neutrality factor for all updates to the wage index that would be applied to the SNF PPS federal per diem rate for FY 2021 using the following methodology:

- *Step 1*—Simulate estimated aggregate SNF PPS payments using the FY 2020 wage index values and FY 2019 SNF PPS claims utilization data.
- *Step 2*—Simulate estimated aggregate SNF PPS payments using the FY 2019 SNF PPS claims utilization data and the proposed FY 2021 wage index values based on updated hospital wage data and the proposed revised OMB delineations, assuming a 5 percent cap on any decreases in an area wage index (that is, in cases where a provider's FY 2021 area wage index value would be less than 95 percent of the provider's FY 2020 wage index value, we set the provider's FY 2021 wage index value to equal 95 percent of the provider's FY 2020 wage index value.)
- *Step 3*—Calculate the ratio of these estimated aggregate SNF PPS payments by dividing the estimated aggregate SNF PPS payments using the FY 2020 wage index values (calculated in Step 1) by the estimated aggregate SNF PPS payments using the proposed FY 2021 wage index values (calculated in Step 2) to determine the proposed budget neutrality factor for updates to the wage index that would be applied to the unadjusted federal per diem rates for FY 2021.

For the proposed rule (85 FR 20938), using the steps in the methodology previously described, we determined a proposed FY 2021 SNF PPS budget neutrality factor of 0.9982.

Accordingly, in section III.B. of the proposed rule, to determine the proposed FY 2021 SNF PPS federal per diem payment rates, we applied the proposed budget neutrality factor of 0.9982.

Commenters submitted the following comments related to the proposed wage index budget neutrality calculation. A discussion of these comments, along with our responses, appears below.

Comment: Several commenters requested that CMS consider waiving the portion of the wage index budget neutrality adjustment calculation accounting for changes to the wage index resulting from the proposed adoption of the revised OMB delineations, citing the current public health emergency as the basis for this request.

Response: We appreciate this comment and its relation to the current public health emergency. However, section 1888(e)(4)(G)(ii) of the Act requires that the wage index adjustment be done in such a manner as to not result in a change in aggregate payments. As such, we believe it is necessary and appropriate to calculate a budget neutrality factor that accounts for all wage index changes.

After considering the comments received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing, without modification, our proposed policies related to the SNF PPS wage index, including the proposed budget neutrality adjustment methodology. However, we note that in the FY 2021 SNF PPS proposed rule, the budget neutrality factor calculation was based on the wage and cost data available at the time of the proposed rule. The proposed FY 2021 budget neutrality factor was 0.9982. Based on more recent hospital cost report data available for this FY 2021 SNF PPS Final Rule, the final FY 2021 budget neutrality factor, which was used in calculating the final unadjusted FY 2021 federal per diem rates, is 0.9992.

2. Technical Updates to PDPM ICD–10 Mappings

In the FY 2019 SNF PPS final rule (83 FR 39162), we finalized the implementation of the Patient Driven Payment Model (PDPM), effective October 1, 2019. The PDPM utilizes International Classification of Diseases, Version 10 (ICD–10) codes in several ways, including to assign patients to clinical categories used for categorization under several PDPM components, specifically the PT, OT, SLP and NTA components. The ICD–10 code mappings and lists used under PDPM are available on the PDPM website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.*

Each year, the ICD–10 Coordination and Maintenance Committee, a federal interdepartmental committee that is chaired by representatives from the National Center for Health Statistics (NCHS) and by representatives from CMS, meets biannually and publishes updates to the ICD–10 medical code data sets in June of each year. These changes become effective October 1 of the year in which these updates are issued by the committee. The ICD–10 Coordination and Maintenance Committee also has the ability to make changes to the ICD–10 medical code data sets effective on April 1.

In the FY 2020 SNF PPS final rule (84 FR 38750), we outlined the process by which we maintain and update the ICD–10 code mappings and lists associated with the PDPM, as well as the SNF GROUPER software and other such products related to patient classification and billing, so as to ensure that they reflect the most up to date codes possible. Beginning with the updates for FY 2020, we apply nonsubstantive changes to the ICD–10 codes included on the PDPM code mappings and lists through a subregulatory process consisting of posting updated code mappings and lists on the PDPM website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.* Such nonsubstantive changes are limited to those specific changes that are necessary to maintain consistency with the most current ICD–10 medical code data set. On the other hand, substantive changes, or those that go beyond the intention of maintaining consistency with the most current ICD–10 medical code data set, will be proposed through notice and comment rulemaking. For instance, changes to the assignment of a code to a comorbidity list or other changes that amount to changes in policy are considered substantive changes that require notice and comment rulemaking.

We proposed several changes to the PDPM ICD–10 code mappings and lists. The proposed updated mappings and

lists were posted online at the SNF PDPM website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.* Our proposed changes are as follows.

Under the PDPM, we classify patients in clinical categories based on the primary SNF diagnosis. The clinical classification may change based on whether the patient had a major procedure during the prior inpatient stay that impacts the plan of care as captured in items J2100 through J5000 on the MDS. In the current ICD–10 to clinical category mapping being used in FY 2020, ICD–10 codes associated with certain cancers that could require a major procedure (specifically, C15 through C26.9, C33 through C39.9, C40.01 through C40.02, C40.11 through C40.12, C40.21 through C40.22, C40.31 through C40.32, C40.81 through C40.82, C40.91 through C41.9, C45.0 through C45.9, C46.3 through C46.9, C47.0, C47.11 through C47.12, C47.21 through C47.22, C47.3 through C48.8, C49.0, C49.11 through C49.12, C49.21 through C49.A9, C50.011 through C50.012, C50.021 through C50.022, C50.111 through C50.112, C50.121 through C50.122, C50.211 through C50.212, C50.221 through C50.222, C50.311 through C50.312, C50.321 through C50.322, C50.411 through C50.412, C50.421 through C50.422, C50.511 through C50.512, C50.521 through C50.522, C50.611 through C50.612, C50.621 through C50.622, C50.811 through C50.812, C50.821 through C50.822, C50.911 through C50.912, C50.921 through C50.922, C51.0 through C61, C62.01 through C62.02, C62.11 through C62.12, C62.91 through C68.9, C70.0 through C76.3, C76.41 through C76.42, C76.51 through C80.1, D37.09 through D39.9, D3A.00 through D3A.8, D40.0, D40.11 through D44.9, D48.3 through D48.4, D48.61 through D48.7, D49.0 through D49.7) do not include the option of a major procedure in the prior inpatient stay that may impact the plan of care. We proposed to add the surgical clinical category options of ''May be Eligible for the Non-Orthopedic Surgery Category'' or ''May be Eligible for One of the Two Orthopedic Surgery Categories'' to the clinical category mapping of the following diagnoses when a major procedure, as described previously, is identified on the MDS: C15 through C26.9, C33 through C39.9, C40.01 through C40.02, C40.11 through C40.12, C40.21 through C40.22, C40.31 through C40.32, C40.81 through C40.82, C40.91 through C41.9, C45.0 through C45.9, C46.3 through C46.9, C47.0, C47.11 through C47.12, C47.21 through C47.22, C47.3 through C48.8, C49.0, C49.11 through C49.12, C49.21 through C49.A9, C50.011 through C50.012, C50.021 through C50.022, C50.111 through C50.112, C50.121 through C50.122, C50.211 through C50.212, C50.221 through C50.222, C50.311 through C50.312, C50.321 through C50.322, C50.411 through C50.412, C50.421 through C50.422, C50.511 through C50.512, C50.521 through C50.522, C50.611 through C50.612, C50.621 through C50.622, C50.811 through C50.812, C50.821 through C50.822, C50.911 through C50.912, C50.921 through C50.922, C51.0 through C61, C62.01 through C62.02, C62.11 through C62.12, C62.91 through C68.9, C70.0 through C76.3, C76.41 through C76.42, C76.51 through C80.1, D37.09 through D39.9, D3A.00 through D3A.8, D40.0, D40.11 through D44.9, D48.3 through D48.4, D48.61 through D48.7, D49.0 through D49.7. We proposed to include one of the surgical clinical category options specified previously in this section for these codes because a major procedure for these codes in a prior inpatient stay could affect the plan of care. These proposed changes are outlined more specifically later in this section.

We proposed to include the surgical clinical category option ''May be Eligible for the Non-Orthopedic Surgery Category'' for cancer codes C15.3 through C26.9 which correspond to J2910 of the MDS and address cancers involving the gastrointestinal tract.

We proposed to include the surgical clinical category option ''May be Eligible for the Non-Orthopedic Surgery Category'' for cancer codes C33 through C39.9, which correspond to J2710 of the MDS and that address cancers involving the respiratory system.

We proposed to include the ''May be Eligible for One of the Two Orthopedic Surgery Categories'' option for codes C40.01 through C41.9 (with the exception of C410 Malignant neoplasm of bones of skull and face) for cancers involving the bones. We proposed to include the ''May be Eligible for the Non-Orthopedic Surgery Category'' option for code C410 Malignant neoplasm of bones of skull and face because this type of cancer is more likely to be treated by non-orthopedic than orthopedic surgery.

We proposed to include the ''May be Eligible for the Non-Orthopedic Surgery Category'' option for codes C46.3 through C46.9 for Kaposi's sarcoma because the cancers associated with those codes could require a major surgical procedure.

We proposed to include the ''May be Eligible for the Non-Orthopedic Surgery Category'' option for certain codes relating to neoplasms, specifically D37.09 through D39.9, D3A.00 through D3A.8, D40.0, D40.11 through D44.9, D48.3 through D48.4, D48.61 through D48.7, and D49.0 through D49.7, because these conditions sometimes require surgery.

In the FY 2020 ICD–10 to clinical category mapping, the ICD–10 code D75.A ''Glucose-6-phosphate dehydrogenase (G6PD) deficiency without anemia'' is assigned to the default clinical category of ''Cardiovascular and Coagulations'' to align with the other D75 codes. However, G6PD deficiency without anemia is generally asymptomatic and detected by testing. Compared to other blood diseases in the D75 code family, D75.A is very minor and likely asymptomatic. For this reason, we proposed to change the assignment of D75.A to ''Medical Management''.

Stakeholders have pointed out that in the FY 2020 ICD–10 clinical category mappings, certain fracture codes map to the surgical default clinical categories such as ''Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)'' or ''Major Joint Replacement or Spinal Surgery'' even if no surgery was performed. The specific codes mentioned were S32.031D, S32.19XD, S82.001D, and S82.002D through S82.002J. Given the concern raised by stakeholders, we proposed to change the default clinical category to ''Non-Surgical Orthopedic'', with the surgical option of ''May be Eligible for One of the Two Orthopedic Surgery Categories'', for the following codes mentioned by stakeholders: S32.031D, S32.19XD, S82.001D, and S82.002D through S82.002J. We will continue to address changes to the mapping of fracture codes on a case-by-case basis as they are raised by stakeholders. We further proposed to change the default clinical category of the following fracture codes to ''Return to Provider'' because these codes are unspecific and lack the level of detail provided by more specific codes as to whether the condition is on the right or left side of the body: S82.009A, S82.013A, S82.016A, S82.023A, S82.026A, S82.033A, S82.036A, and S82.099A.

A stakeholder pointed out that in the FY 2020 ICD–10 to clinical category mapping, the M48.00 through M48.08 spinal stenosis codes have a default clinical category mapping of ''Non-Surgical Orthopedic/Musculoskeletal'' and no surgical option, which does not allow for coding in cases where patients have spinal stenosis and spinal laminectomy surgery. For this reason, we proposed to add the surgical option of ''May be Eligible for One of the Two

Orthopedic Surgery Categories'' to M48.00 through M48.08 spinal stenosis codes.

In the FY 2020 ICD–10 to clinical category mapping, Z48 surgery aftercare codes map to the default clinical categories of ''Return to Provider'' or ''Medical Management'' even if a surgical procedure was indicated in J2100 of the MDS. Although Z48 codes are not very specific, we acknowledge that aftercare of some major non-orthopedic surgeries is coded through Z48 codes. Therefore, we proposed to add the surgical option of ''May be Eligible for the Non-Orthopedic Surgery Category'' to the following surgery aftercare codes: Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.288, Z48.290, Z48.298, Z48.3, Z48.811, Z48.812, Z48.813, Z48.815, Z48.816, and Z48.29, to promote more accurate clinical category assignment.

With regard to the NTA comorbidity to ICD–10 code mappings, in the FY 2020 NTA comorbidity mapping, ICD–10 codes T82.310A through T85.89XA for initial encounter codes map to the NTA comorbidity CC176 ''Complications of Specified Implanted Device or Graft''. This mapping is based on the Part C risk adjustment model condition category mapping, which only included ICD–10 codes for acute encounters for complications of internal devices. Stakeholder have requested that we add to the mappings the ICD–10 codes in this range with the seventh digit of D (subsequent encounter) or S (sequela) for subsequent care. We proposed to add codes in this range with the seventh digit of D (but not the seventh digit of S, because sequela can be coded years after the event and are likely not a reason for SNF treatment) for use in the ICD–10 code mapping to the NTA comorbidity CC176 ''Complications of Specified Implanted Device or Graft'' on the NTA conditions and extensive services list for the purpose of calculating the PDPM NTA score.

We invited comments on the proposed substantive changes to the ICD–10 code mappings discussed previously, as well as sought comments on additional substantive and non-substantive changes that stakeholders believe are necessary. A discussion of these comments, along with our responses, appears below.

Comment: A commenter requested an explanation as to how CMS plans to address new annual ICD–10–CM codes in the PDPM payment group mappings, stating that CMS described some changes to the mappings for 2020 ICD–10–CM codes, but did not describe how it plans to address 2021 codes or annual changes to ICD–10–CM codes. The commenter requested that CMS explain the process for mapping new codes, and state whether these will be available for comment through annual rule making.

Response: We described in the proposed rule the process by which we maintain and update the ICD–10 code mappings and lists associated with the PDPM. Specifically, we apply nonsubstantive changes to the ICD–10 codes included on the PDPM code mappings and lists through a subregulatory process consisting of posting updated code mappings and lists on the PDPM website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.* Such nonsubstantive changes are limited to those specific changes that are necessary to maintain consistency with the most current ICD–10 medical code data set. On the other hand, substantive changes, or those that go beyond the intention of maintaining consistency with the most current ICD–10 medical code data set, will be proposed through notice and comment rulemaking. For instance, changes to the assignment of a code to a comorbidity list or other changes that amount to changes in policy are considered substantive changes that require notice and comment rulemaking. This process is described in more detail in the portions of the FY 2020 SNF PPS final rule (84 FR 38750) pertaining to updates to the ICD–10 code mappings and lists.

Comment: A commenter noted that the list of Z48 surgery aftercare codes to which CMS proposes adding the surgical option of ''May be Eligible for the Non-Orthopedic Surgery Category'' in the proposed rule (Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.288, Z48.290, Z48.298, Z48.3, Z48.811, Z48.812, Z48.813, Z48.815, Z48.816, and Z48.29), contains seemingly duplicative references to code ''Z48.290'' and ''Z48.29''. The commenter inquired as to whether the duplicative ''Z48.29'' entry was erroneous and was supposed to be Z48.89, ''encounter for other specified surgical aftercare''.

Response: We note that Z48.29 is not duplicative of Z48.290; Z48.290, ''aftercare following bone marrow transplant'' is in fact a separate code under the heading of Z48.29, ''aftercare following other organ transplant.'' However, in the proposed rule, we inadvertently included both Z48.29 and Z48.290, as well as Z48.3 for aftercare following surgery for neoplasm, on the list of Z48 surgery aftercare codes to which we proposed to add the surgical option of ''May be Eligible for the Non-Orthopedic Surgery Category.'' Z48.29 is not a valid code because it requires a sixth character. According to ICD 10 coding guidance, ''Diagnosis codes are to be used and reported at their highest number of characters available. ICD–10–CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable'' (*https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf* pg. 14). The code Z48.29, ''encounter for aftercare following other organ transplant,'' is further subdivided into more specific codes. One of those codes is Z48.298, which is also aftercare following other organ transplant. Since the ICD–10 guidelines state that ''codes are to be used and reported at their highest number of characters available'' and the codes are duplicative in meaning, we are removing Z48.29 and keeping Z48.298. Code Z48.290 is for aftercare following a bone marrow transplant. Bone marrow transplants can be performed to treat patients with a variety of cancer and non-cancer indications. A bone marrow transplant is considered to be a medical procedure and therefore would not have the non-orthopedic surgery option. Bone marrow transplants involve injecting cells into a recipient rather than open surgery to replace an organ. Thus, bone marrow transplants differ from the other transplant codes involving open surgical procedures, so it would not be appropriate to include code Z48.290 in the category of non-orthopedic surgery which describes the provision of open surgical procedures and the care for patients after open surgical procedures. Finally, Z48.3 involves the aftercare of patients for neoplasm. There are specific codes for specific types of neoplasm. Z48.3 does not specify that the neoplasm is malignant. Furthermore, many of the most common neoplasms removed surgically are on the skin and do not require the same level of aftercare as open surgical procedures. Cancer aftercare can be coded more specifically using the C and D codes that we included in our proposal, which will ensure more appropriate payment. Thus, we are not including the Non-orthopedic surgery option for Z48.3. Therefore, the correct list of Z48 surgery aftercare codes to which we are adding the surgical option of ''May be Eligible for the Non-Orthopedic Surgery Category'' is as follows: Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.288, Z48.298, Z48.811, Z48.812, Z48.813, Z48.815, and Z48.816. This is consistent with the proposed updated mappings

and lists that were posted online at the SNF PDPM website at *https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/SNFPPS/PDPM* coincident with the release of the proposed rule. Finally, in response to the comment addressing code Z48.89 (the code that the commenter thought we might have meant instead of Z48.29), we note that we are not adding the surgical option of ''May be Eligible for the Non-Orthopedic Surgery Category'' to code Z48.89, which is ''encounter for other specified surgical aftercare''. This code provides inadequate information about the type of surgery, the illness that required surgery, and the type of aftercare. There are other codes that describe why the surgical aftercare is needed, for example Z48.21, ''aftercare following a heart transplant''. In order to obtain sufficient information to place a patient in the proper category, code Z48.89 is designated as Return to Provider, since other coding options exist to provide the needed information.

Comment: A commenter responded to CMS's proposal for codes C33 through C39.9 to include the surgical clinical category option, ''May be Eligible for the Non-Orthopedic Surgery Category'' which corresponds to J2710 on the MDS for cancers involving the respiratory system. The commenter encouraged CMS to consider allowing ICD–10 codes C38.0–C38.8, cancers of the heart, to map from J2700, Cardiopulmonary surgery (involving the heart or major blood vessels), as these codes may have a surgical procedure that would only be coded under J2700. The commenter also suggested CMS allow ICD–10 C37 to map from either J2710 or J2920, stating that ''C37 code should be allowed to map to the non-orthopedic surgery code when J2710 (Major surgery involving the respiratory system) has been correctly coded.'' In addition, the commenter stated that C37 is coded for cancer of the thymus, which may also need to map to a non-orthopedic surgery category based on the MDS coding of J2920, surgeries involving the endocrine organs.

Response: We would like to clarify that ''May be Eligible for the Non-Orthopedic Surgery Category'' does not correspond to J2710 only. As stated in the MDS RAI Manual Chapter 6, J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, and J2940 are all considered non-orthopedic surgery categories. Furthermore, the codes C37, C38.0—C38.8 have the option of being eligible for the non-orthopedic surgery category. Codes C38.0, C38.4 and C38.8 could map from J2700, cardiopulmonary surgery. C38.1, C38.2, C38.3 are too nonspecific as there are multiple malignancies that could form in these spaces and there are usually more specific codes for those malignancies. For example, C38.1 malignant neoplasm of anterior mediastinum includes the thymus and there is a more specific code, C37, malignancy of the thymus. Code C37 malignancy of the thymus could map from J2920. On the rare instance where a more specific code did not exist, codes C38.1, C38.2, and C38.3 could still map from J5000.

Comment: A commenter disagreed with the exclusion of ICD–10 code C410, ''Malignant neoplasm of the bones of skull and face,'' from the orthopedic surgery mappings, stating that cancers of the skull and face may require orthopedic surgery and should map to one of the two orthopedic surgery categories when a corresponding surgery is coded.

Response: Upon clinical investigation, we agree with the commenter that it is appropriate to include the ''May be Eligible for One of the Two Orthopedic Surgery Categories'' option for code C410, ''Malignant neoplasm of bones of skull and face,'' consistent with similar codes concerning neoplasms of bones in the face, such as C41.1, ''Malignant neoplasm of mandible.'' Based on clinician feedback, both orthopedic and non-orthopedic surgeries are possible in cases involving neoplasms of bones in the face, and non-orthopedic surgery is more common. However, the current PDPM grouper design only allows a code to be either orthopedic or non-orthopedic, and classification in the orthopedic surgery group results in a higher per diem rate than the non-orthopedic group. We anticipate that the need for orthopedic surgery and therapy should be rare but acknowledge that it is possible in such cases, and will monitor the use of the surgical option. Therefore, we will map code C410 to ''May be Eligible for One of the Two Orthopedic Surgery Categories'' with the rest of the codes in the range of C40.01 through C41.9.

Comment: A commenter suggested that codes related to malignant secondary (metastatic) cancer sites should be included in the list of ICD–10 cancer codes to which CMS is adding surgical clinical category options. The commenter suggested CMS consider including the following malignant secondary codes to the list of codes to which CMS should add surgical clinical category options and as SLP-related comorbidities: C78.39, secondary malignant neoplasm of other respiratory organs, which is used to code cancers that have metastasized to the laryngeal area (C32.0, C32.1, C32.2, C32.3, C32.9); and C79.89, secondary malignant neoplasm of other specified sites which is used to code cancers that have metastasized to oral cancers (C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.9, C09.9, C09.0, C09.1, C10.0, C10.1, C10.2, C10.3, C10.4, C10.9, C14.0, C14.2, C06.0 C05.0, C05.1, C05.2, C05.9, C06.2, C06.9).

Response: We included ''C76.51 through C80.1'' in the list of clinical category to ICD–10 code mappings to which we proposed adding the surgical clinical category options of ''May be Eligible for the Non-Orthopedic Surgery Category''' or ''May be Eligible for One of the Two Orthopedic Surgery Categories''; therefore, both C78.39, ''secondary malignancy of other respiratory organs,'' and C79.89, ''secondary malignancy of other digestive organs,'' are included in the proposed changes to the clinical category mappings. However, we decline to add these codes to the SLP comorbidities list. SLP treatment can help patients get used to the changes in their mouth after surgery, chemotherapy, or radiation. Codes C78.39 and C79.89 lack specificity and concern respiratory and digestive organs that do not generally indicate the need for SLP treatment. The oral cancer codes mentioned (for example, C00) are included instead, as they specify the location of the neoplasm (tonsil, gum, tongue, etc.) in organs that are closely associated with the need for SLP treatment.

Comment: Several commenters suggested additional changes to the ICD–10 code mappings and comorbidity lists that were outside the scope of this rulemaking. Multiple commenters suggested that CMS include the surgical option for several ''subsequent encounter'' ICD–10 codes that better describe the admission status of the SNF beneficiary than the currently permitted ''initial encounter'' ICD–10 codes; specifically, commenters identified several additional ''D'' seventh digit codes, as well as ''G, K, and P'' seventh digit codes that should include the surgical option. A commenter recommended that ICD–10 code G93.1, ''Anoxic brain damage,'' should map to the Neurologic category instead of Return to Provider. Another commenter stated that patients may need SNF care due to cytokine release syndrome related to chimeric antigen receptor T-cell therapy, which is receiving new codes in 2021 in the D89.831 to D89.839 range, and the commenter questioned how CMS proposes to map such codes. Finally, a commenter recommended that

CMS should add the H90.0 to H90.A32 hearing loss range of ICD–10 codes to the SLP comorbidities list; add the following neurodegenerative diagnoses to the SLP comorbidities list: Alzheimer's disease, Friedrich's ataxia, Huntington's disease, Lewy body disease, Parkinson's disease, spinal muscular atrophy; and add the following mild cognitive impairment code to the SLP comorbidities list: Mild cognitive impairment, so stated (mild neurocognitive disorder) G31.84.

Response: We note that such changes are outside the scope of this rulemaking, and will not be addressed in this rule. We will further consider the suggested changes to the ICD–10 code mappings and comorbidity lists and may implement them in the future as appropriate. To the extent that such changes are non-substantive, we may issue them in a future subregulatory update if appropriate; however, if such changes are substantive changes, in accordance with the update process established in the FY 2020 SNF PPS final rule, such changes must undergo full notice and comment rulemaking, and thus may be included in future rulemaking. See the discussion of the update process for the ICD–10 code mappings and lists in the FY 2020 SNF PPS final rule (84 FR 38750) for more information.

Comment: A commenter suggested that CMS implement an ''increased payment modifier for ICD–10 diagnoses that can be attributed to COVID–19 and its symptomology through the use of PDPM groupings that reflect the extraordinary costs to provide care during the pandemic.'' A commenter also encouraged CMS to add the COVID–19 diagnosis code, U07.01, to the NTA comorbidities mapping list, stating that while this code currently maps to the medical management clinical category when used as a primary reason for the SNF stay, it does not have reimbursement equivalent to the high associated costs for the care and management of this disease. Multiple commenters requested that CMS evaluate the cost of PPE, staff time, and resources associated with caring for COVID–19 residents and appropriately weigh the ICD–10 code in establishing ''points'' toward the cumulative patient totals under the NTA component of PDPM. One commenter recommended 5 points, citing the experience of their association members and expert panel members. Furthermore, to allow for adequate reimbursement in the future, commenters requested that CMS consider adding an NTA category for pandemic/epidemic type infection that would allow for timely reimbursement and allow CMS to add new ICD–10–CM codes to the mapping as needed. Another commenter suggested that the use of ICD–10 code U07.2 should be permitted on the MDS as an alternative method to document a patient is being treated for COVID–19, to eliminate delays in treatment where testing is limited, and that this U07.2 code should be mapped the same as the COVID–19 diagnosis code U07.1, stating that this will allow for better tracking of resource utilization by patients that are being treated for COVID–19 but had a false-negative test or patients that have encountered other issues or limited testing. Finally, a commenter expressed concern that the new COVID–19 code cannot be applied to dates prior to April 1, 2020 and suggested that CMS allow a placeholder primary reason for SNF stay/comorbidity checkboxes on the MDS.

Response: We appreciate these concerns and recognize the unique circumstances of the coronavirus public health emergency. However, with regard to the use of the U07.2 code, this code has not yet been adopted by the CDC and is not allowed to be used per CDC guidance. With regard to the COVID–19 code, U07.1, being inapplicable to dates prior to April 1, the CDC has provided coding guidelines for COVID–19 cases before April 1, 2020. With regard to weighting the costs of COVID–19 in the NTA component, we note that we do not currently have enough post-April data at this time to estimate the cost, and may consider this in future rulemaking. Finally, we note that the commenters' suggestions to create additional NTA categories, add code U7.01 to the NTA comorbidities mapping, and other substantive changes to the ICD–10 code mappings and lists, as well as suggestions for ''an increased payment modifier'' are outside the scope of this rulemaking. We will continue to consider these comments and may address them in future rulemaking. We refer readers to our previous discussion regarding our established process for considering changes to the ICD–10 code mappings and lists (see FY 2020 SNF PPS final rule (84 FR 38750)).

Comment: A commenter expressed concern that CMS had not yet taken action to expand the list of conditions on the NTA comorbidity list to include several additional conditions such as Parkinson's disease and serious mental illness such as schizophrenia. The commenter suggested that CMS consider potential updates to the NTA comorbidity list on an annual basis.

Response: We will consider potential updates to the NTA comorbidity list on an ongoing basis consistent with our established process for considering changes to the ICD–10 code mappings and lists (see FY 2020 SNF PPS final rule (84 FR 38750)). We note that Parkinson's (MDS I5300) and schizophrenia (HCC 57) were both considered for inclusion in the NTA comorbidity list that has assigned points for each condition which would contribute to NTA score calculation, but were eventually excluded from the comorbidity list due to small coefficient estimates, meaning that they did not represent an apparent significant increase in relative resource utilization as compared to other conditions found on the NTA comorbidity list.

Comment: Multiple commenters noted support for the proposed changes to the ICD–10 code mappings in general. Specifically, commenters noted support for the CMS proposals to: Add certain ICD–10 codes with the subsequent encounter ''D'' seventh digit for use in the ICD-code mapping to the NTA comorbidity CC176; move certain ICD–10 fracture codes which do not identify whether the condition is on the right or left side to ''Return to Provider''; and add the surgical option of ''May be Eligible for One of the Two Orthopedic Surgery Categories'' to ICD–10 codes M48.00 to M48.08. One commenter stated appreciation for CMS reviewing ICD–10 mapping in correlation with MDS Section J2100 to J5000 and ''urge(d) the agency to correct prior total joint and surgery mapping to facilitate the appropriate assignment of the primary reason for SNF stay.''

Response: We thank commenters for their support of our proposed changes. Regarding the comment concerning correcting prior total joint and surgery mapping, we will consider this change in the future consistent with the established process for considering changes to the ICD–10 code mappings and lists (see FY 2020 SNF PPS final rule (84 FR 38750)).

After considering the comments received, for the reasons set forth in this final rule and in the FY 2021 SNF PPS proposed rule, we are finalizing our proposed changes to the ICD–10 code mappings and lists with the modifications discussed above. As we previously stated, any substantive and non-substantive changes requested by commenters that are outside the scope of this rulemaking will be taken under consideration for potential future implementation consistent with the update process for the ICD–10 code mappings and lists established in the FY 2020 SNF PPS final rule (84 FR 38750).

3. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

a. Background

Section 215(b) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) authorized the SNF VBP Program (the ''Program'') by adding section 1888(h) to the Act. As a prerequisite to implementing the SNF VBP Program, in the FY 2016 SNF PPS final rule (80 FR 46409 through 46426), we adopted an all-cause, all-condition hospital readmission measure, as required by section 1888(g)(1) of the Act, and discussed other policies to implement the Program such as performance standards, the performance period and baseline period, and scoring. In the FY 2017 SNF PPS final rule (81 FR 51986 through 52009), we adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs, as required by section 1888(g)(2) of the Act, adopted policies on performance standards, performance scoring, and sought comment on an exchange function methodology to translate SNF performance scores into value-based incentive payments, among other topics. In the FY 2018 SNF PPS final rule (82 FR 36608 through 36623), we adopted additional policies for the Program, including an exchange function methodology for disbursing value-based incentive payments. Additionally, in the FY 2019 SNF PPS final rule (83 FR 39272 through 39282), we adopted more policies for the Program, including a scoring adjustment for low-volume facilities. In the FY 2020 SNF PPS final rule (84 FR 38820 through 38825), we also adopted additional policies for the Program, including a change to our public reporting policy and an update to the deadline for the Phase One Review and Correction process.

The SNF VBP Program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Section 1888(h)(1)(B) of the Act requires that the SNF VBP Program apply to payments for services furnished on or after October 1, 2018. We believe the implementation of the SNF VBP Program is an important step towards transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely rewarding volume.

For additional background information on the SNF VBP Program, including an overview of the SNF VBP Report to Congress and a summary of the Program's statutory requirements, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46409 through 46426); the FY 2017 SNF PPS final rule (81 FR 51986 through 52009); the FY 2018 SNF PPS final rule (82 FR 36608 through 36623); the FY 2019 SNF PPS final rule (83 FR 39272 through 39282); and the FY 2020 SNF PPS final rule (84 FR 38820 through 38825).

b. Measures

(1) Background and Update of the the SNF VBP Program Measure Name in Our Regulations

For background on the measures we have adopted for the SNF VBP Program, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46419), where we finalized the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) that we are currently using for the SNF VBP Program. We also refer readers to the FY 2017 SNF PPS final rule (81 FR 51987 through 51995), where we finalized the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) that we will use for the SNF VBP Program instead of the SNFRM as soon as practicable, as required by statute. We intend to submit the measure for NQF endorsement review during the Fall 2021 cycle, and to assess transition timing of the SNFPPR measure to the SNF VBP Program after NQF endorsement review is complete.

In the FY 2020 SNF PPS final rule (84 FR 38821 through 38822), we adopted a policy changing the name of the SNFPPR to Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge. We adopted this change to differentiate the SNF VBP Program's measure of potentially preventable hospital readmissions from a similar measure specified for use in the SNF QRP, which uses a 30-day post-SNF discharge readmission window. We did not propose any updates to this measure policy in the FY 2021 SNF PPS proposed rule.

However, consistent with this finalized policy, we proposed to amend the definition of ''SNF Readmission Measure'' under 42 CFR 413.338(a)(11) to reflect the updated Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure name.

We welcomed public comments on this proposal to amend the regulation text to reflect the updated measure name.

Comment: Several commenters supported the proposal to amend the regulation text to reflect the updated Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure name. One commenter stated that this change will help the public differentiate this measure from a similar measure under the SNF QRP, which uses a 30-day post-SNF discharge readmission period.

Response: We thank the commenters for their support.

After consideration of the comments, we are finalizing our proposal to amend the definition of ''SNF Readmission Measure'' under 42 CFR 413.338(a)(11) to reflect the updated Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure name as proposed.

c. SNF VBP Performance Period and Baseline Period

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46422) for a discussion of our considerations for determining performance periods under the SNF VBP Program. In the FY 2019 SNF PPS final rule (83 FR 39277 through 39278), we adopted a policy whereby we will automatically adopt the performance period and baseline period for a SNF VBP program year by advancing the performance period and baseline period by 1 year from the previous program year. Under this policy, the FY 2023 performance period will be FY 2021, and the baseline period will be FY 2019. We did not propose any changes to this policy in the FY 2021 SNF PPS proposed rule.

d. Performance Standards

(1) Background

We refer readers to the FY 2017 SNF PPS final rule (81 FR 51995 through 51998) for a summary of the statutory provisions governing performance standards under the SNF VBP Program and our finalized performance standards policy, as well as the numerical values for the achievement threshold and benchmark for the FY 2019 program year. We published the final numerical values for the performance standards for the FY 2020 SNF VBP Program year in the FY 2018 SNF PPS final rule (82 FR 36613) and published the final numerical values for the performance standards for the FY 2021 SNF VBP Program year in the FY 2019 SNF PPS final rule (83 FR 39276). We also adopted a policy allowing us to correct the numerical values of the performance standards in the FY 2019 SNF PPS final rule (83 FR 39276 through 39277). We did not propose any changes to these policies in the FY 2021 SNF PPS proposed rule.

(2) Codification of the SNF VBP Performance Standards Correction Policy

In the FY 2019 SNF PPS final rule (83 FR 39276 through 39277), we finalized a policy to correct numerical values of performance standards for a program year in cases of errors. We also finalized that we will only update the numerical values for a program year one time, even if we identify a second error, because we believe that a one-time correction will allow us to incorporate new information into the calculations without subjecting SNFs to multiple updates. We stated that any update we make to the numerical values based on a calculation error will be announced via the CMS website, listservs, and other available channels to ensure that SNFs are made fully aware of the update. We did not propose any changes to these policies in the FY 2021 SNF PPS proposed rule.

We proposed to amend the definition of ''Performance standards'' at § 413.338(a)(9) of our regulations, consistent with these policies finalized in the FY 2019 SNF PPS final rule, 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.

We welcomed public comments on this proposal to codify the performance standards correction policy finalized in the FY 2019 SNF PPS final rule (83 FR 39276 through 39277).

Comment: Several commenters supported the proposal to codify the amended definition of ''Performance standards'', consistent with the policies finalized in the FY 2019 SNF PPS final rule, to reflect CMS' ability to update the numerical values of performance standards if it determines there is an error that affects the achievement threshold or benchmark.

Response: We thank the commenters for their support.

After consideration of the comments, we are finalizing the amendment to the definition of ''Performance standards'' at § 413.338(a)(9) of our regulations as proposed.

(3) Performance Standards for the FY 2023 Program Year

Based on the baseline period of FY 2019 for the FY 2023 program year, we estimated in the proposed rule that the performance standards would have the numerical values noted in Table 15 (85 FR 20941). We stated that these values represented estimates based on the most recently-available data, and that we would update the numerical values in this final rule.

The final FY 2023 SNF VBP Program year performance standards have the numerical values noted in Table 15.

TABLE 15: Final FY 2023 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79270	0.83028

e. SNF VBP Performance Scoring

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52000 through 52005) for a detailed discussion of the scoring methodology that we have finalized for the Program. We also refer readers to the FY 2018 SNF PPS final rule (82 FR 36614 through 36616) for discussion of the rounding policy we adopted. We also refer readers to the FY 2019 SNF PPS final rule (83 FR 39278 through 39281), where we adopted: (1) A scoring policy for SNFs without sufficient baseline period data, (2) a scoring adjustment for low-volume SNFs, and (3) an extraordinary circumstances exception policy.

We did not propose any updates to SNF VBP scoring policies in the FY 2021 SNF PPS proposed rule.

f. SNF Value-Based Incentive Payments

We refer readers to the FY 2018 SNF PPS final rule (82 FR 36616 through 36621) for discussion of the exchange function methodology that we have adopted for the Program, as well as the specific form of the exchange function (logistic, or S-shaped curve) that we finalized, and the payback percentage of 60 percent. We adopted these policies for FY 2019 and subsequent fiscal years.

We also discussed the process that we undertake for reducing SNFs' adjusted federal per diem rates under the Medicare SNF PPS and awarding value-based incentive payments in the FY 2019 SNF PPS final rule (83 FR 39281 through 39282).

For estimates of FY 2021 SNF VBP Program incentive payment multipliers, we encourage SNFs to refer to FY 2020 SNF VBP Program performance information, available at *https://data.medicare.gov/Nursing-HomeCompare/SNF-VBP-Facility-LevelDataset/284v-j9fz.* Our previous analysis of historical SNF VBP data shows that the Program's incentive payment multipliers appear to be relatively consistent over time. As a result, we believe that the FY 2020 payment results represent our best estimate of FY 2021 performance at this time.

We did not propose any updates to SNF VBP payment policies in the FY 2021 SNF PPS proposed rule.

g. Public Reporting on the Nursing Home Compare Website or a Successor Website

(1) Background

Section 1888(g)(6) of the Act requires the Secretary to establish procedures to make SNFs' performance information on SNF VBP Program measures available to the public on the Nursing Home Compare website or a successor website, and to provide SNFs an opportunity to review and submit corrections to that information prior to its publication. We began publishing SNFs' performance information on the SNFRM in accordance with this directive and the statutory deadline of October 1, 2017.

Additionally, section 1888(h)(9)(A) of the Act requires the Secretary to make available to the public certain information on SNFs' performance under the SNF VBP Program, including SNF performance scores and their ranking. Section 1888(h)(9)(B) of the Act requires the Secretary to post aggregate information on the Program, including the range of SNF performance scores and the number of SNFs receiving value-based incentive payments, and the range and total amount of those payments.

In the FY 2017 SNF PPS final rule (81 FR 52009), we discussed the statutory requirements governing public reporting of SNFs' performance information under the SNF VBP Program. In the FY 2018 SNF PPS final rule (82 FR 36622 through 36623), we finalized our policy to publish SNF measure performance information under the SNF VBP Program on Nursing Home Compare after SNFs have an opportunity to review and submit corrections to that

information under the two-phase Review and Correction process that we adopted in the FY 2017 SNF PPS final rule (81 FR 52007 through 52009) and for which we adopted additional requirements in the FY 2018 SNF PPS final rule. In the FY 2018 SNF PPS final rule, we also adopted requirements to rank SNFs and adopted data elements that we will include in the ranking to provide consumers and stakeholders with the necessary information to evaluate SNFs' performance under the Program (82 FR 36623).

(2) Codification of the Data Suppression Policy for Low-Volume SNFs

In the FY 2020 SNF PPS final rule (84 FR 38823 through 38824), we adopted a data suppression policy for low-volume SNF performance information. Specifically, we finalized our proposal to suppress the SNF information available to display as follows: (1) If a SNF has fewer than 25 eligible stays during the baseline period for a program year, we will not display the baseline risk-standardized readmission rate (RSRR) or improvement score, though we will still display the performance period RSRR, achievement score, and total performance score if the SNF had sufficient data during the performance period; (2) if a SNF has fewer than 25 eligible stays during the performance period for a program year and receives an assigned SNF performance score as a result, we will report the assigned SNF performance score and we will not display the performance period RSRR, the achievement score, or improvement score; and (3) if a SNF has zero eligible cases during the performance period for a program year, we will not display any information for that SNF. We did not propose any changes to this policy in the FY 2021 SNF PPS proposed rule.

However, to ensure that SNFs are fully aware of this public reporting policy, we proposed in the FY 2021 SNF PPS proposed rule (85 FR 20942) to codify it at § 413.338(e)(3)(i), (ii), and (iii) of our regulations.

We welcomed public comment on this proposal to codify the data suppression policy for low-volume SNFs policy finalized in the FY 2020 SNF PPS final rule (84 FR 38823 through 38824).

Comment: A commenter supported the proposal to codify language around the data suppression policy for low-volume SNFs, as finalized in the FY 2020 SNF PPS final rule (84 FR 38823 through 38824).

Response: We thank the commenter for its support.

After consideration of the comments, we are finalizing our proposal to codify our data suppression policy at § 413.338(e)(3)(i), (ii), and (iii) of our regulations as proposed.

(3) Public Reporting of SNF VBP Performance Information on Nursing Home Compare or a Successor Website

Section 1888(h)(9)(A) of the Act requires that the Secretary make available to the public on the Nursing Home Compare website or a successor website information regarding the performance of individual SNFs for a FY, including the performance score for each SNF for the FY and each SNF's ranking, as determined under section 1888(h)(4)(B) of the Act. Additionally, section 1888(h)(9)(B) of the Act requires that the Secretary periodically post aggregate information on the SNF VBP Program on the Nursing Home Compare website or a successor website, including the range of SNF performance scores, and the number of SNFs receiving value-based incentive payments and the range and total amount of those payments. In the FY 2018 SNF PPS final rule (82 FR 36622 through 36623), we finalized our policy to publish SNF measure performance information under the SNF VBP Program on Nursing Home Compare.

Our SNF VBP Program regulations currently only refer to the Nursing Home Compare website and do not account for the situation where a successor website replaces the Nursing Home Compare website. Therefore, we proposed in the FY 2021 SNF PPS proposed rule (85 FR 20942) to amend § 413.338(e)(3) of our regulations to reflect that we will publicly report SNF performance information on the Nursing Home Compare website or a successor website. CMS announced our website transition on a public internet blog in January 2020 (*https://www.cms.gov/blog/making-it-easier-compare-providers-and-care-settings-medicaregov*). We intend to update SNFs and other stakeholders through the internet and other widely used communication modes at a later date closer to the targeted transition date.

We welcomed public comments on this proposal.

Comment: Several commenters supported the proposal to publicly report SNF VBP performance information on Nursing Home Compare or a successor website, as current regulations account for displaying information only on Nursing Home Compare. One commenter noted that public reporting and accessibility of data is critical for Program evaluation and understanding quality trends.

Response: We thank the commenters for their support and agree that public reporting is important for the success of the Program.

After consideration of the comments, we are finalizing our proposal to amend § 413.338(e)(3) of our regulations to reflect that we will publicly report SNF performance information on the Nursing Home Compare website or a successor website as proposed.

h. Update and Codification of the Phase One Review and Correction Deadline

In the FY 2017 SNF PPS final rule (81 FR 52007 through 52009), we adopted a two-phase review and corrections process for SNFs' quality measure data that will be made public under section 1888(g)(6) of the Act and SNF performance information that will be made public under section 1888(h)(9) of the Act. We detailed the process for requesting Phase One corrections and finalized a policy whereby we would accept Phase One corrections to any quarterly report provided during a calendar year until the following March 31. In the FY 2020 SNF PPS final rule (84 FR 38824 through 38835), we updated this policy to reflect a 30-day Phase One Review and Correction deadline rather than through March 31st following receipt of the performance period quality measure quarterly report that we issue in June. In the FY 2021 SNF PPS proposed rule (85 FR 20942), we stated that we were now proposing to also apply this 30-day Phase One Review and Correction deadline to the baseline period quality measure report that we typically issue in December. We stated that this proposal would align the Phase One Review and Correction deadlines for the quarterly reports that contain the underlying claims and measure rate information for the baseline period or performance period. We stated that under this proposal, SNFs would have 30 days following issuance of those reports to review the underlying claims and measure rate information. We stated that should a SNF believe that any of the information is inaccurate, it may submit a correction request within 30 days following issuance of the reports. We also stated that although these reports are typically issued in December (baseline period information) and June (performance period information), the issuance dates could vary. We stated that if the issuance dates of these reports are significantly delayed or need to be shifted for any reason, we would notify SNFs through routine communication channels including, but not limited to memos, emails, and notices on the CMS SNF VBP website.

We also proposed to codify this policy in our regulations by amending the

''Confidential feedback reports and public reporting'' paragraph at § 413.338(e)(1). We welcomed public comments on these proposals.

Comment: A few commenters supported the proposal to apply a 30-day Phase One Review and Correction deadline to the baseline period quality measure quarterly reports typically issued in December. One commenter stated that this proposal aligns this Review and Correction process with the 30-day deadline that was implemented for the June performance period quality measure quarterly reports in the FY 2020 SNF PPS final rule.

Response: We thank the commenters for their support and agree that this policy aligns with the 30-day Phase Two Review and Correction deadline under the Program. As stated above in the proposal, SNFs would have 30 days following issuance of the baseline period quality measure quarterly reports to review the underlying claims and measure rate information. Should a SNF believe that any of the information is inaccurate, it may submit a correction request within 30 days following issuance of the reports.

Comment: A commenter did not support the proposed 30-day Phase One Review and Correction deadline for baseline period quality measure quarterly reports and stated that the time for review and corrections of these data should be 60–90 days. The commenter was concerned that the 30-day timeframe is not a long enough time period for many facilities to review their data for accuracy and submit correction requests to CMS as necessary.

Response: Our intention with this proposal was to align all Review and Correction deadlines within the SNF VBP Program and specifically to set all Review and Correction deadlines to 30 days following the date we provide the applicable report. The deadline for Review and Correction submissions for baseline period quality measure quarterly reports currently differs from other Review and Correction deadlines within the SNF VBP Program; it currently extends to the March 31st following the date we provide these reports. All other Review and Correction deadlines for the SNF VBP Program are 30 days following the date we provide the applicable report. We believe aligning all Review and Correction deadlines within the Program would be clearer and easier for SNFs to track.

Our proposal would not preclude SNFs from submitting correction requests prior to receipt of their quarterly report if they believe that an error has occurred, after reviewing data from quarterly reports delivered prior to the baseline period quality measure quarterly report. Under current program operations, a particular year of data is used first as a performance period and later as a baseline period, thus SNFs have the opportunity to familiarize themselves with the particular year of data when it is used for the performance period, prior to receiving baseline period quality measure quarterly reports that represent the same data collection period.

We also believe that SNFs have accumulated extensive experience with the SNF VBP Program's quarterly report system, as well as the finalized Review and Corrections processes. We will continue to conduct outreach and education to ensure that SNFs are fully aware of the Program's operational deadlines, and we will be as clear as possible about the respective Review and Correction deadlines when delivering each quarterly report to SNFs.

After consideration of the comments, we are finalizing our proposal to update the Phase One Review and Correction deadline and to codify that policy in our regulations by amending the ''Confidential feedback reports and public reporting'' at § 413.338(e)(1) as proposed.

IV. Collection of Information Requirements

This final rule does not impose any new or revised ''collection of information'' requirements or burden. For the purpose of this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of OMB's Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) implementing regulations. Since this rule does not impose any new or revised collection of information requirements or burden, the rule is not subject to the requirements of the PRA.

V. Economic Analyses

A. Regulatory Impact Analysis

1. Statement of Need

This final rule updates the FY 2020 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach on these issues.

2. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA, September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) as further discussed below. Also, the rule has been reviewed by OMB.

3. Overall Impacts

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2020 (84 FR 38728). We estimate that the aggregate impact will be an increase of approximately $750 million in payments to SNFs in FY 2021, resulting from the SNF market basket update to the payment rates. We note that these impact numbers do not incorporate the SNF VBP reductions that we estimate will total $199.54 million in FY 2021. We would note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, very susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and (e)(5) of the Act, we update the FY 2020 payment rates by a factor equal to the market basket index percentage change reduced by the MFP

adjustment to determine the payment rates for FY 2021. The impact to Medicare is included in the total column of Table 16. In finalizing the SNF PPS rates for FY 2021, we are finalizing a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the federal rates).

The annual update in this rule will apply to SNF PPS payments in FY 2021. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2021 SNF PPS payment impacts appear in Table 16. Using the most recently available data, in this case FY 2019, we apply the current FY 2020 wage index and labor-related share value to the number of payment days to simulate FY 2020 payments. Then, using the same FY 2019 data, we apply the FY 2021 wage index and labor-related share value to simulate FY 2021 payments. We tabulate the resulting payments according to the classifications in Table 16 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2020 payments to the simulated FY 2021 payments to determine the overall impact. The breakdown of the various categories of data Table 16 follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).
- The second column shows the number of facilities in the impact database.
- The third column shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The total impact of this change is 0.0 percent; however, there are distributional effects of the change.
- The fourth column shows the impact on the wage index of adopting the revised OMB delineations, discussed in section III.D.1.a. of this final rule. The total impact of this change is 0.0 percent; however, there are distributional effects of the change.
- The fifth column shows the effect of all of the changes on the FY 2021 payments. The update of 2.2 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 2.2 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 16, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes in this final rule, rural providers will experience a 2.4 percent increase in FY 2021 total payments.

TABLE 16: Impact to the SNF PPS for FY 2021

Provider Characteristics	# Providers	Update Wage Data	Update OMB Delineation	Total Change
Group				
Total	15,078	0.0%	0.0%	2.2%
Urban	10,951	0.0%	0.0%	2.2%
Rural	4,127	0.1%	0.1%	2.4%
Hospital-based urban	380	0.3%	0.1%	2.6%
Freestanding urban	10,571	0.0%	0.0%	2.2%
Hospital-based rural	245	0.1%	0.1%	2.4%
Freestanding rural	3,882	0.1%	0.1%	2.4%
Urban by region				
New England	775	-1.1%	-0.1%	1.0%
Middle Atlantic	1,470	0.9%	0.1%	3.2%
South Atlantic	1,868	-0.1%	-0.1%	2.0%
East North Central	2,118	0.0%	-0.1%	2.1%
East South Central	536	-0.3%	-0.1%	1.8%
West North Central	921	-0.7%	-0.1%	1.3%
West South Central	1,323	-0.1%	0.0%	2.1%
Mountain	527	-0.7%	0.0%	1.5%
Pacific	1,407	0.0%	0.1%	2.2%
Outlying	6	0.0%	-0.1%	2.1%
Rural by region				
New England	126	0.1%	-0.1%	2.3%
Middle Atlantic	194	0.6%	-0.1%	2.8%
South Atlantic	462	-0.1%	0.2%	2.3%
East North Central	908	0.5%	0.1%	2.8%
East South Central	452	-0.2%	0.1%	2.1%
West North Central	1,020	-0.2%	0.1%	2.1%
West South Central	666	-0.1%	0.1%	2.2%
Mountain	207	-0.2%	-0.1%	1.9%
Pacific	92	1.0%	-0.1%	3.1%
Ownership				
For profit	10,729	0.0%	0.0%	2.2%
Non-profit	3,469	0.0%	0.0%	2.2%
Government	880	0.1%	0.1%	2.3%

Note: The Total column includes the FY 2021 2.2 percent market basket increase factor. Additionally, we found no SNFs in rural outlying areas.

5. Impacts for the SNF VBP Program

The estimated impacts of the FY 2021 SNF VBP Program are based on historical data and appear in Table 17. We modeled SNF performance in the Program using SNFRM data from FY 2016 as the baseline period and FY 2018 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621), though we note that the 60 percent payback percentage for FY 2021 will adjust to account for the low-volume scoring adjustment that we adopted in the FY 2019 SNF PPS final rule (83 FR 39278 through 39280). We estimate that the low-volume scoring adjustment would increase the 60 percent payback percentage for FY 2021 by approximately 2.25 percentage points (or $11.91 million), resulting in a payback percentage for FY 2021 that is 62.25 percent of the estimated $528.63 million in withheld funds for that fiscal year. Based on the 60 percent payback percentage (as modified by the low-volume scoring adjustment), we estimate that we will redistribute approximately $329.09 million in value-based incentive payments to SNFs in FY 2021, which means that the SNF VBP Program is estimated to result in approximately $199.54 million in savings to the Medicare Program in FY 2021. We refer readers to the FY 2019 SNF PPS final rule (83 FR 39278 through 39280) for additional information about payment adjustments for low-volume SNFs in the SNF VBP Program.

Our detailed analysis of the estimated impacts of the FY 2021 SNF VBP Program follows in Table 17.

TABLE 17: SNF VBP Program Estimated Impacts for FY 2021

Characteristic	Number of facilities	Mean SNFRM Risk-Standardized Readmission Rate (%)	Mean performance score	Mean incentive multiplier	Percent of total SNF Medicare Part A FFS payment after applying incentives
Group					
Total	15,201	19.67	27.7397	0.99251	100.00
Urban	10,893	19.72	26.6713	0.99205	84.98
Rural	4,308	19.55	30.4412	0.99367	15.02
Hospital-based urban*	307	19.30	34.4100	0.99645	1.88
Freestanding urban*	10,545	19.73	26.4063	0.99191	83.07
Hospital-based rural*	208	19.15	38.7270	0.99781	0.49
Freestanding rural*	3,888	19.56	29.9215	0.99346	14.36
Urban by region					
New England	752	19.76	25.4730	0.99151	5.48
Middle Atlantic	1,468	19.47	29.2070	0.99355	16.07
South Atlantic	1,864	19.84	25.2768	0.99150	17.29
East North Central	2,087	19.82	24.5481	0.99085	13.66
East South Central	542	19.85	25.2002	0.99120	3.56
West North Central	927	19.72	27.2973	0.99194	4.10
West South Central	1,324	20.05	23.3211	0.98996	7.49
Mountain	527	19.11	34.3344	0.99643	3.68
Pacific	1,396	19.50	30.1656	0.99406	13.65
Outlying	6	20.16	17.5878	0.98708	0.00
Rural by region					
New England	129	19.13	32.5091	0.99497	0.67
Middle Atlantic	210	19.24	31.5817	0.99419	0.91
South Atlantic	493	19.72	27.3343	0.99248	2.22
East North Central	909	19.45	29.3109	0.99361	3.44
East South Central	515	19.81	26.1659	0.99182	2.33
West North Central	1,040	19.41	34.5946	0.99503	1.98
West South Central	708	20.02	25.6838	0.99105	2.21
Mountain	208	18.97	40.1353	0.99883	0.66
Pacific	95	18.53	43.9844	1.00106	0.60
Outlying	1	18.78	30.7950	0.98659	0.00
Ownership					
Government	948	19.37	33.8732	0.99539	3.48
Profit	10,656	19.76	26.2134	0.99171	74.39
Non-Profit	3,597	19.48	30.6447	0.99414	22.13

* The group category which includes hospital-based/freestanding by urban/rural excludes 253 swing-bed SNFs.

6. Alternatives Considered

As described in this section, we estimated that the aggregate impact for FY 2021 under the SNF PPS will be an increase of approximately $750 million in payments to SNFs, resulting from the SNF market basket update to the payment rates.

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY; accordingly, we are not pursuing alternatives for this process.

With regard to the alternatives considered related to the other provisions contained in this final rule, such as the adoption of revised OMB delineations and cap on wage index decreases discussed in section III.D.1. of this final rule, we discuss any alternatives considered within those sections.

7. Accounting Statement

As required by OMB Circular A–4 (available online at *https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/*), in Tables 18 and 19, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule for FY 2021. Tables 16 and 18 provide our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this final rule, based on the data for 15,078 SNFs in our database. Tables 17 and 19 provide our best estimate of the possible changes in Medicare payments under the SNF VBP as a result of the policies we have adopted for this program.

TABLE 18: Accounting Statement: Classification of Estimated Expenditures, from the 2020 SNF PPS Fiscal Year to the 2021 SNF PPS Fiscal Year

Category	Transfers
Annualized Monetized Transfers	$750 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

* The net increase of $750 million in transfer payments is a result of the market basket increase of 2.2 percent.

TABLE 19: Accounting Statement: Classification of Estimated Expenditures for the FY 2021 SNF VBP Program

Category	Transfers
Annualized Monetized Transfers	$329.09 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

*This estimate does not include the two percent reduction to SNFs' Medicare payments (estimated to be $528.63 million) required by statute.

8. Conclusion

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2020 (84 FR 38728). Based on the above, we estimate that the overall payments for SNFs under the SNF PPS in FY 2021 are projected to increase by approximately $750 million, or 2.2 percent, compared with those in FY 2020. We estimate that in FY 2021, SNFs in urban and rural areas will experience, on average, a 2.2 percent increase and 2.4 percent increase, respectively, in estimated payments compared with FY 2020. Providers in the urban Middle Atlantic region will experience the largest estimated increase in payments of approximately 3.2 percent. Providers in the urban New England region will experience the smallest estimated increase in payments of 1.0 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by reason of their non-profit status or by having revenues of $30 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as that term is used in the RFA, according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $30 million or less in any 1 year. (For details, see the Small Business Administration's website at *http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards*). In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This rule updates the SNF PPS rates contained in the SNF PPS final rule for FY 2020 (84 FR 38728). Based on the above, we estimate that the aggregate impact for FY 2021 will be an increase of $750 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 16 that all providers will experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2021 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2020 Report to Congress (available at *http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch8_sec.pdf*), MedPAC states that Medicare covers approximately 10 percent of total patient days in freestanding facilities and 18 percent of facility revenue (March 2020 MedPAC Report to Congress, 224). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 16. As indicated in Table 16, the effect on facilities is projected to be an aggregate positive impact of 2.2 percent for FY 2021. As the overall impact on the industry as a whole, and thus on small entities

specifically, is less than the 3 to 5 percent threshold discussed previously, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small entities for FY 2021.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. This final rule will affect small rural hospitals that: (1) Furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be a positive impact. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2020 (84 FR 38728)), the category of small rural hospitals is included within the analysis of the impact of this final rule on small entities in general. As indicated in Table 16, the effect on facilities for FY 2021 is projected to be an aggregate positive impact of 2.2 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small rural hospitals for FY 2021.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately $156 million. This final rule will impose no mandates on state, local, or tribal governments or on the private sector.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This final rule will have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

E. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, entitled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' It has been determined that this final rule is a transfer rule that does not impose more than *de minimis* costs and thus is not a regulatory action for the purposes of Executive Order 13771.

F. Congressional Review Act

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

G. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this year's final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed this year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons, we thought that the number of commenters on the proposed rule is a fair estimate of the number of reviewers of this final rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of the proposed rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $110.74 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it would take approximately 4 hours for the staff to review half of the proposed rule. For each SNF that reviews the rule, the estimated cost is $442.96 (4 hours × $110.74). Therefore, we estimate that the total cost of reviewing this regulation is $20,819.12 ($442.96 × 47 reviewers).

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 413

Diseases, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS

■ 1. The authority citation for part 409 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 409.35 is amended by revising paragraph (a) to read as follows:

§ 409.35 Criteria for ''practical matter''.

(a) *General considerations.* In making a ''practical matter'' determination, as required by § 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. For example, if a beneficiary can obtain daily physical therapy services on an outpatient basis, the unavailability of Medicare payment for those alternative services due to the beneficiary's non-enrollment in Part B may not be a basis for finding that the needed care can only be provided in a SNF.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

■ 3. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww.

§ 413.114 [Amended]

■ 4. Section 413.114 is amended in paragraph (c)(2) by removing the reference ''§ 413.55(a)(1)'' and adding in its place the reference ''§ 413.53(a)(1)''.

■ 5. Section 413.338 is amended by revising paragraphs (a)(9) and (11) and (e)(1) and (3) to read as follows:

§ 413.338 Skilled nursing facility value-based purchasing program.

(a) * * *

(9) *Performance standards* are the levels of performance that SNFs must meet or exceed to earn points under the SNF VBP Program for a fiscal year, and are announced no later than 60 days prior to the start of the performance period that applies to the SNF readmission measure for that fiscal year. Beginning with the performance standards that apply to FY 2021, if CMS discovers an error in the performance standard calculations subsequent to publishing their numerical values for a fiscal year, CMS will update the numerical values to correct the error. If CMS subsequently discovers one or more other errors with respect to the same fiscal year, CMS will not further update the numerical values for that fiscal year.

* * * * *

(11) *SNF readmission measure* means, prior to October 1, 2019, the all-cause all-condition hospital readmission measure (SNFRM) or the all-condition risk-adjusted potentially preventable hospital readmission rate (SNFPPR) specified by CMS for application in the SNF Value-Based Purchasing Program. Beginning October 1, 2019, the term *SNF readmission measure* means the all-cause all-condition hospital readmission measure (SNFRM) or the all-condition risk-adjusted potentially preventable hospital readmission rate (Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge measure) specified by CMS for application in the SNF Value-Based Purchasing Program.

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(e) * * *

(1) Beginning October 1, 2016, CMS will provide quarterly confidential feedback reports to SNFs on their performance on the SNF readmission measure. SNFs will have the opportunity to review and submit corrections for these data by March 31st following the date that CMS provides the reports, for reports issued prior to October 1, 2019. Beginning with the performance period quality measure quarterly report issued on or after October 1, 2019 that contains the performance period measure rate and all of the underlying claim information used to calculate the measure rate that applies for the fiscal year, SNFs will have 30 days following the date that CMS provides these reports to review and submit corrections for the data contained in these reports. Beginning with the baseline period quality measure quarterly report issued on or after October 1, 2020 that contains the baseline period measure rate and all of the underlying claim information used to calculate the measure rate that applies for the fiscal year, SNFs will have 30 days following the date that CMS provides these reports to review and submit corrections for the data contained in these reports. Any such correction requests must be accompanied by appropriate evidence showing the basis for the correction.

* * * * *

(3) CMS will publicly report the information described in paragraphs (e)(1) and (2) of this section on the Nursing Home Compare website or a successor website. Beginning with information publicly reported on or after October 1, 2019, the following exceptions apply:

(i) If CMS determines that a SNF has fewer than 25 eligible stays during the baseline period for a fiscal year but has 25 or more eligible stays during the performance period for that fiscal year, CMS will not publicly report the SNF's baseline period SNF readmission measure rate and improvement score for that fiscal year;

(ii) If CMS determines that a SNF is a low-volume SNF with respect to a fiscal year and assigns a performance score to the SNF under paragraph (d)(3) of this section, CMS will not publicly report the SNF's performance period SNF readmission measure rate, achievement score or improvement score for the fiscal year; and

(iii) If CMS determines that a SNF has zero eligible cases during the performance period with respect to a fiscal year, CMS will not publicly report any information for that SNF for that fiscal year.

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Dated: July 23, 2020.

Seema Verma

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 29, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2020–16900 Filed 7–31–20; 4:15 pm]

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