

This provision includes the frequency, scope, and number of assessments required.

(b) *Assessment schedule.* In accordance with the methodology described in § 413.337(c) related to the adjustment of the Federal rates for case-mix, SNFs must submit assessments according to an assessment schedule. This schedule must include performance of an initial Medicare assessment with an assessment reference date that is set for no later than the 8th day of posthospital SNF care, and such other interim payment assessments as the SNF determines are necessary to account for changes in patient care needs.

(c) *Noncompliance with assessment schedule.* CMS pays a default rate for the Federal rate when a SNF fails to comply with the assessment schedule in paragraph (b) of this section. The default rate is paid for the days of a patient's care for which the SNF is not in compliance with the assessment schedule.

[63 FR 26309, May 12, 1998, as amended at 64 FR 41682, July 30, 1999; 84 FR 38832, Aug. 7, 2019]

§ 413.345 Publication of Federal prospective payment rates.

CMS publishes information pertaining to each update of the Federal payment rates in the FEDERAL REGISTER. This information includes the standardized Federal rates, the resident classification system that provides the basis for case-mix adjustment, and the factors to be applied in making the area wage adjustment. This information is published before May 1 for the fiscal year 1998 and before August 1 for the fiscal years 1999 and after.

[82 FR 36634, Aug. 4, 2017]

§ 413.348 Limitation on review.

Judicial or administrative review under sections 1869 or 1878 of the Act or otherwise is prohibited with regard to the establishment of the Federal rates. This prohibition includes the methodology used in the computation of the Federal standardized payment rates, the case-mix methodology, and the development and application of the wage index. This prohibition on judicial and

administrative review also extends to the methodology used to establish the facility-specific rates but not to determinations related to reasonable cost in the fiscal year 1995 cost reporting period used as the basis for these rates.

§ 413.350 Periodic interim payments for skilled nursing facilities receiving payment under the skilled nursing facility prospective payment system for Part A services.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, SNFs receiving payment under the PPS for Part A services do not receive interim payments during the cost reporting year, and receive payment only following submission of a bill. Paragraph (d) of this section provides for accelerated payments in certain circumstances.

(b) *Periodic interim payments.* (1) An SNF receiving payment under the prospective payment system may receive periodic interim payments (PIP) for Part A SNF services under the PIP method subject to the provisions of § 413.64(h). To be approved for PIP, the SNF must meet the qualifying requirements in § 413.64(h)(3). Moreover, as provided in § 413.64(h)(5), contractor approval is conditioned upon the contractor's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* The contractor estimates an SNF's prospective payments net of estimated beneficiary coinsurance and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year. If an SNF has payment experience under the prospective payment system, the contractor estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final settlement.

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(3) *Termination of PIP*—(i) *Request by the SNF*. An SNF receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the contractor*. An contractor terminates PIP if the SNF no longer meets the requirements of § 413.64(h).

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system*. For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the contractor determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6). The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an SNF receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Accelerated payments*—(1) *General rule*. Upon request, an accelerated payment may be made to an SNF that is receiving payment under the prospective payment system and is not receiving PIP under paragraph (b) of this section if the SNF is experiencing financial difficulties because of the following:

(i) There is a delay by the contractor in making payment to the SNF.

(ii) Due to an exceptional situation, there is a temporary delay in the SNF's preparation and submittal of bills to the contractor beyond its normal billing cycle.

(2) *Approval of payment*. An SNF's request for an accelerated payment must be approved by the contractor and CMS.

(3) *Amount of payment*. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment*. Recovery of the accelerated payment is made by

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recoupment as SNF bills are processed or by direct payment by the SNF.

[64 FR 41682, July 30, 1999]

§ 413.355 Additional payment: QIO reimbursement for cost of sending records electronically or by photocopy and mailing.

An additional payment is made to a skilled nursing facility in accordance with § 476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[85 FR 59025, Sept. 18, 2020]

§ 413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

(a) *Participation start date*. Beginning with the FY 2018 program year, a SNF must begin reporting data in accordance with paragraph (b) of this section no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the SNF as operating in the CMS designated data submission system. For purposes of this section, a program year is the fiscal year in which the market basket percentage described in § 413.337(d) is reduced by two percentage points if the SNF does not report data in accordance with paragraph (b) of this section.

(b) *Data submission requirement*. (1) Except as provided in paragraph (c) of this section, and for a program year, SNFs must submit to CMS data on measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Social Security Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Social Security Act, in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the SNF QRP based on one or more of the following factors:

(i) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better resident outcomes.