

RAI Spotlight



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FY 2022 SNF-PPS FINAL RULE

On July 29, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating Medicare payment policies and rates for skilled nursing facilities under the Skilled Nursing Facility (SNF) prospective payment system (PPS) for FY 2022. Additionally, this final rule includes several policies that update the SNF Quality Reporting Program (QRP) and the SNF Value-Based Program (VBP) for FY 2022.

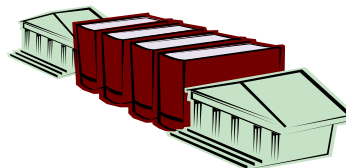
FY 2022 Updates to the SNF Payment Rates

CMS estimates that the aggregate impact of the payment policies in this final rule would result in an increase of approximately \$410 million in Medicare Part A payments to SNFs in FY 2022. This estimate reflects a \$411 million increase from the update to the payment rates of 1.2%, which is based on a 2.7% SNF market basket update, less a 0.8 percentage point forecast error adjustment and a 0.7 percentage point productivity adjustment, and a \$1.2 million decrease due to the proposed reduction to the SNF PPS rates to account for the recent blood-clotting factors exclusion.

Methodology for Recalibrating the PDPM Parity Adjustment

When finalizing PDPM, CMS stated that this new payment model would be implemented in a budget neutral manner, meaning that the transition to this new payment model would not result in an increase or decrease in aggregate SNF spending. Since PDPM implementation, available data suggest an unintended increase in payments of approximately 5% in FY 2020. CMS has conducted the data analysis to recalibrate the parity adjustment used to achieve budget neutrality under PDPM. CMS acknowledges that the COVID-19 public health emergency could have affected the data used in these analyses. A parity adjustment has not been put in place for FY 2022.

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Teleconference Information

Date: October 14, 2021
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: **The Importance of Accurate MDS Diagnosis Coding**
Handouts: Power Point slides will be available on or about October 13th on the DOH Message Board at <https://sais.health.pa.gov/commonpoc/Login/Login.aspx>

Call in number: 1-(844)-833-3230 or 1-(442)-275-1811
Conference ID Number: 2275278

- Company Name: Myers and Stauffer Presenter: Kerry Weaver
- A recording of this conference will be posted on the NFRP Homepage, under MDS resources following the presentation. <https://nfrp.panfsubmit.com/>

Additional questions: qa-mds@pa.gov

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Questions about the RAI?

Please submit them to
qa-mds@pa.gov

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Teleconference FAQ's

On July 8, 2021 a training teleconference was provided on RAI Chapter 2 Basics. The following questions were received:

Q. I am still a little confused about when to use a significant correction assessment vs. a modification of the assessment that needs correcting if an item is miscoded. Can you clarify?

A. *When any significant error is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, you must do both, submit a modification request record to correct the existing record, **and** perform a new Significant Correction to Prior Assessment [or Significant Change in Status Assessment if applicable] and update the care plan.*

Refer to Chapter 5 of the RAI User's Manual for complete instructions on submitting a Significant Correction record.

LONG TERM CARE Admission and Discharge Transmittal (MA 103)

The Office of Long-term Living would like to remind all Medicaid-enrolled skilled nursing facilities of the need for completion of the MA-103 form.

The Long Term Care (LTC) Admission and Discharge Transmittal (MA 103) **MUST be sent to the County Assistance Office (CAO) within three days of admission or discharge.** The MA 103 is to be completed by the facility or the resident's attending physician in the following situations:

1. When a medical assistance (MA) applicant is admitted to a nursing facility or converts to MA.
2. When it is determined that a resident no longer needs the services provided by your facility.
3. When the resident expires.

The original completed copy of the form labeled "Resident's Clinical Record" must be retained in the resident's clinical record.

It is imperative that this form is completed accurately



Q. My question is, what do you do for the required interviews that would not have been completed for a Quarterly MDS, when during the completion process, it is determined a Significant Change Assessment is needed, i.e.: Preferences for Customary Routine and Activities? Dash them?

A. *Without out changing the ARD you would have to enter dashes for any item that you have "no information" for. I would suggest making a note in the medical record as to why these areas were dashed and do the interview outside of the look-back and follow-up as needed despite not being able to include the information on the MDS.*

and submitted timely to ensure the individual receives the required services while in a facility.

Please note: This form is not needed if an individual is only seeking respite care or enters the hospital without discharge from the LTC facility.

You may contact the local CAO for any questions or concerns.

A listserv has been established for on-going updates on the CHC program. It is titled OLTL-COMMUNITY-HEALTHCHOICES, please visit the ListServ Archives page at <http://listserv.dpw.state.pa.us> to update or register your email address.



CMS Training Opportunities

SNF Section K: Height, Weight, and Nutritional Approaches Web-Based Training

This [web-based training course](#) for Skilled Nursing Facility (SNF) providers covers assessment and coding of K0200: Height and Weight and K0500: Nutritional Approaches.

Visit the [SNF Quality Reporting Program Training](#) webpage for more information.

MDS PASRR Section Reminder

All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).

Please make certain MDS items A1500, 1510 and 1550 are completed in order to identify these residents on the MDS

A1500: Preadmission Screening and Resident Review (PASRR)

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission , Annual, *SCSA*, Significant Correction to Prior Comp. Assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:

- PASRR Level I screening did not result in a referral for Level II screening, or
- Level II screening determined that the resident does not have a serious *MI* and/or *ID/DD* or related conditions, or
- PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or *ID/DD* or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.

Code 9, not a Medicaid-certified unit: if bed is not in a Medicaid-certified nursing home.

A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission, Annual, *SCSA*, Significant Correction to Prior Comp. Assessment).
2. Check all that apply.

Coding Instructions

- **Code A, Serious mental illness:** if resident has been diagnosed with a serious mental illness.
- **Code B, Intellectual Disability:** if resident has been diagnosed with *ID/DD*.
- **Code C, Other related conditions:** if resident has been diagnosed with other related conditions.

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status

Steps for Assessment

1. If resident is 22 years of age or older on the *ARD*, complete only if A0310A = 01 (Admission).
2. If resident is 21 years of age or younger on the *ARD*, complete if A0310A = 01, 03, 04, or 05 (Admission , Annual, *SCSA*, Significant Correction to Prior Comp. Assessment).

Coding Instructions

- Check all conditions related to *ID/DD* status that were present before age 22.
- When age of onset is not specified, assume that the condition meets this criterion AND likely to continue indefinitely.
- **Code A:** if Down syndrome is present.
- **Code B:** if autism is present.
- **Code C:** if epilepsy is present.
- **Code D:** if other organic condition related to *ID/DD* is present.
- **Code E:** if an *ID/DD* condition is present but the resident does not have any of the specific conditions listed.
- **Code Z:** if *ID/DD* condition is not present.

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New Blood Clotting Factor Exclusion from SNF Consolidated Billing

The Consolidated Appropriations Act, 2021 requires that certain specified blood clotting factors used for the treatment of patients with hemophilia and other bleeding disorders be excluded from the consolidated billing requirements under the SNF PPS for services furnished on or after October 1, 2021.

Changes in PDPM ICD-10 Code Mappings

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.

In response to stakeholder feedback, CMS made several changes to the PDPM ICD-10 code mappings.

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

The SNF QRP is a pay-for-reporting program. SNFs that do not meet reporting requirements may be subject to a two-percentage point reduction in their annual update.

CMS adopted two new measures:

- **Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring Hospitalization Measure**

CMS adopted a new claims-based measure, SNF HAI, to the SNF QRP, beginning with the FY 2023 SNF QRP. The SNF HAI measure uses Medicare fee-for-service (FFS) claims data to estimate the rate of HAIs that are acquired during SNF care and result in hospitalization. Some of the HAIs identified in this measure include sepsis, urinary tract infection, and pneumonia. The goal of the measure is to be able to assess those SNFs that have notably higher rates of HAIs that are acquired during SNF care and result in hospitalization.

- **COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure**

CMS adopted the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure beginning with the FY 2023 SNF QRP. This measure will require SNFs to report on COVID-19 HCP vaccination of their staff in order to assess whether SNFs are taking steps to limit the spread of COVID-19 among their HCP, reduce the risk of transmission within their facilities, and help sustain the ability of SNFs to continue serving their communities. SNFs must report the vaccination data through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network beginning October 1, 2021.

And updated the specifications for another measure:

Transfer of Health (TOH) Information to the Patient-PAC Quality Measure

CMS updated the denominator for the Transfer of Health (TOH) Information to the Patient-Post Acute Care (PAC) quality measure. In the past, the measure denominators for both the TOH Information to the Patient-PAC and the TOH Information to the Provider-PAC measures include patients discharged home under the care of an organized home health service organization or hospice. In order to avoid counting the patient in both TOH measures, CMS is removing patients discharged home under the care of an organized home health service organization or hospice from the definition of the denominator for the TOH Information to the Patient-PAC measure.

In addition, CMS made a modification to the public reporting of SNF quality measures:

- **Public Reporting of Quality Measures with Fewer than Standard Numbers of Quarters Due to COVID-19 PHE Exemptions**

Due to the COVID-19 PHE, CMS granted an exception to the SNF QRP reporting requirements from Q1 2020 and Q2 2020. This exception affected the standard number of quarters that CMS currently uses to display SNF QRP data. CMS updated the number of quarters used for public reporting to account for this exception.

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

The SNF VBP Program rewards SNFs with incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by performance on a single measure of hospital readmissions. All SNFs paid under Medicare's SNF PPS are included in the SNF VBP Program.

- **Measure Suppression and Special Scoring Policies for the SNF VBP Program**

CMS will suppress the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) for the FY 2022 SNF VBP Program Year because circumstances caused by the PHE for COVID-19 have significantly affected the measure and the ability to make fair, national comparisons of SNFs' performance scores. As part of a special scoring policy for FY 2022, CMS will assign a performance score of zero to all participating SNFs. CMS will reduce the otherwise applicable federal per diem rate for each SNF by two percent and award SNFs 60% of that withhold, resulting in a 1.2% payback percentage to those SNFs. Finally, SNFs that qualify for the low-volume adjustment will continue to receive 100 percent of that 2 percent withhold.

The final rule (CMS-1746-F) can be downloaded from the *Federal Register* at: <https://www.federalregister.gov/public-inspection/current>.

