

## **SNF PPS FY 2022 Final Rule: Learn the Facts Behind the Headlines Q&A**

**Q1:** I understand they were going to hold some of the changes until 2023, is this correct?

**A1:** There are two primary big-ticket items that will be “held” until 2023. The first is the proposed 5% parity adjustment that would restore budget neutrality to the current PDPM relative to SNF spending under the RUG IV 66 model. CMS proposed several methods to accomplish this, see slides 21 – 23. However, due to comments made by stakeholders with regard to these proposals, CMS indicated in the final rule that, “...we believe it is imperative that we act in a well-considered but expedient manner once excess payments are identified. Additionally, as stated earlier..., our analysis of FY 2020 data found that even after removing beneficiaries using a PHE-related waiver or with a COVID-19 diagnosis from our data set, the observed inadvertent increase in SNF payments since PDPM was implemented was approximately the same. We will continue to monitor all available data and take that into consideration, in combination with the feedback and recommendations received, for developing the FY 2023 SNF PPS proposed rule.” From comments that CMS made on the Open-Door Forum it appears as if this delay will only last until the rule making process once again takes up this discussion next spring. Look for some type of parity adjustment to take place

The second item that has, “held” is the Value Based incentive multiplier and payment based on the Value-Based Purchasing rehospitalization improvement and achievement score rankings. This year, because of COVID-19, CMS has elected to suppress the ranking system for incentive purposes, reduce payments by 2% but then pay everyone, except low volume facilities, 1.2%. See slides 46-57 for a full discussion of how CMS intends to move forward with this process. CMS has also indicated that they will evaluate future FY incentives based on suppression measure they have developed to determine if similar action may be warranted in future years.

**Q2:** Is the 1.2 % the overall rate (includes all the rural/urban, market etc...) or is that separate?

**A2:** The 1.2% Market basket update affects the base PDPM rates that may be found on slide 6 of the presentation. Those rates essentially reflect a 1.2% update to the rates that were in effect for FY 2021 reduced slightly by the exclusion of blood clotting factors from consolidated billing requirements. These rates are then case mix adjusted for each of the PDPM payment categories, see slides 7 and 8. The wage index, which reflects a facility’s designation as urban or rural, affects the labor related portion of each of the rates associated with the 5 PDPM payment categories. Wage index adjustments are addressed starting on slide 9 of the presentation.

**Q3:** What can SNFs do in order for CMS to reflect their wage index into their calculations?

**A3:** One way is to continue to express concerns to CMS through the comment process in the proposed rule each spring. This is what CMS has indicated in this year’s final rule related to this issue and is similar to remarks they have made in past rule making cycles. “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 the 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.”*

**Q5:** Can you clarify use of CVA ICD-10 and coding in MDS? If a CVA occurred in last 60 days, can we use that on MDS? or only sequelae?

**A5:** We generally do not want to use acute codes in SNF however we now know CVA is lifelong based on new research. We would still want to meet criteria for 'active' in section I however yes a prior stroke could be the primary reason for stay if there are significantly residual impacts on function. Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. The FY 2022 ICD-10 guidelines which may be found at <https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf> indicate that, “These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67. Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the ICD-10-CM Official Guidelines for Coding and Reporting dominant or nondominant side is affected.”

**Q6:** SPADEs goes into effect ?

**A6:** Standardized Patient Assessment Data Elements are already in effect. These are the result of the IMPACT ACT and the resulting Quality Reporting Program (SSF QRP). The SNF QRP requires SNFs to submit QM and SPADEs to CMS. For a given data submission period, the MDS assessments submitted by a SNF must meet the APU minimum submission threshold of no less than 80 percent of the MDS assessments having 100 percent completion of the required SNF QRP data elements. These are the data elements needed to calculate the SNF QRP QMs and are defined as standardized data elements. As for the SPADES that were to go into effect in the fall of 2020, CMS has delayed implementation of these for 2 full fiscal years after the COVID-19 PHE is ended.

**Q7:** What is the name of the "dry run" report in CASPER?

**A7:** It is called the “SNF HAI Confidential Dry Run Report”. It is an excel spreadsheet that can be downloaded from your CASPER folder.

**Q8:** Can you help me to understand how the QRP for COVID vaccinations differs from the current reporting?

**A8:** To meet the reporting requirements for the COVID-19 Vaccination Coverage among HCP measure, a SNF will have to report the cumulative number of HCP eligible to work in the SNF for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. SNFs will have to report data for the measure at least one week per month and could self-select the week. For

SNFs that report more than 1 week per month, the last week of the reporting month will be used. This will be a QRP measure that will affect the annual APU by 2% if not reported as specified. SNFs are required to begin reporting this data for this measure through the Centers for Disease Control and Prevention National Healthcare Safety Network beginning October 1, 2021. CMS will publicly report the COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the October 2022 Care Compare refresh or as soon as technically feasible using data collected for Q4 2021 (October 1, 2021 through December 31, 2021). See the technical specifications for the QRP vaccination measure at <https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpccoverage-508.pdf>. The current reporting is required weekly and carries with it survey citations and possible CMPs for non-compliance and is not publicly reported. See the interim final rule and requirements at <https://www.cms.gov/files/document/qso-21-19-nh.pdf>

**Q9:** Are contract therapy staff included in the vac measure?

**A9:** Yes, but optional. From the technical specification for this measure located at <https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpccoverage-508.pdf> the following is indicated.

#### **Denominator Details**

*Denominator data are to be collected for three required categories of HCP and can also be collected for a fourth optional category:*

- 1. Employees (required): This includes all persons receiving a direct paycheck from the reporting facility (i.e., on the facility's payroll), regardless of clinical responsibility or patient contact.*
- 2. Licensed independent practitioners (LIPs) (required): This includes physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the reporting facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility's payroll.*
- 3. Adult students/trainees and volunteers (required): This includes medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.*
- 4. Other contract personnel (optional): Contract personnel are defined as persons providing care, treatment, or services at the facility through a contract who do not fall into any of the other - denominator categories.**

Remember that reporting vac data for contract therapists **is required** for the current COVID-19 Vaccine Immunization Requirements for Residents and Staff per the interim final rule issued on May 11, 2021. See <https://www.cms.gov/files/document/qso-21-19-nh.pdf>

**Q10:** clarification....Current reporting into NHSN for COVID vaccinations?

**A10:** See <https://www.cms.gov/files/document/qso-21-19-nh.pdf> This is the interim final rule issued on May 11, 2021 and details these reporting requirements.

**Q11:** Any Telehealth related changes for rehab services?

**A11:** Great question! Current telehealth allowances for Part A will continue until end of PHE which was reviewed in July for 90 more days. Most of the telehealth regs will be out in the MPFS rule which will outline specific CPT codes to be placed in for permanent use.

**Q12:** Can you clarify the Covid 19 vaccine and how this will impact facilities? If staff/residents have accepted or declined the vaccine?

**A12:** I assume you are referring to the reporting requirements. If that is the case, again these reporting requirements are required for SNF QRP which is only a reporting requirement and will affect the APU per QRP requirements. As for the interim final rule that is referenced in Q9 and 10, non-compliance with these reporting requirements carries survey citations and possible CMPs. Both of these currently are reporting vaccination data only and do not require staff to be vaccinated. They are intended 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 throughout the COVID-19 PHE and beyond.

**Q13:** Did you say that we would get monetary penalties for COVID vaccines?

**A13:** CMPs are possible for non-compliance with regard to vaccination reporting requirements that are found in the interim final rule. This may be accessed at <https://www.cms.gov/files/document/qso-21-19-nh.pdf>

**Q14:** Has CMS already started gathering reporting Covid vaccines for APU determinations (at least 1week/month)? If not, when does that start?

**A14:** While nursing homes are currently reporting vaccination data based on the requirements in the interim final rule referenced in Q9 and Q10, for QRP reporting purposes CMS has finalized that SNFs will report the vaccination data through the Centers for Disease Control and Prevention National Healthcare Safety Network beginning October 1, 2021. CMS will publicly report the COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the October 2022 Care Compare refresh or as soon as technically feasible using data collected for Q4 2021 (October 1, 2021 through December 31, 2021). A SNF's HCP COVID-19 vaccination coverage rate will be displayed based on one quarter of data. Provider preview reports would be distributed in July 2022.

**Q15:** Have you calculated what the incentive multiplier would be for the 1.2% payback for SNF VBP for all SNFS?

**A15:** CMS noted on the most recent SNF Open Door Forum, held on 8/5/2021, that they did not have the SNF VBP incentive multiplier available at the time of the call, so unfortunately that data is currently unavailable.

**Q16:** On SNF VBP - so if you scored below 1 point on the CASPER SNF VBP report released end of July, disregard that because CMS is giving back 1.2% across the board to all SNF?

**A16:** Essentially yes. For FY 2022 CMS will assign each eligible SNF's performance score of zero for the program year to mitigate the effect that the distorted measure results would otherwise have on SNF's performance scores and incentive payment multipliers. They will also reduce each eligible SNF's adjusted Federal per diem rate by the applicable percent (2 percent) and then further adjust the resulting amounts by a value-based incentive payment amount equal to 60 percent of the total 2%

reduction resulting in a 1.2 percent payback for the FY 2022 program year. CMS sees this as the most equitable way to reduce the impact of the withhold in light of their determination to award a performance score of zero to all SNFs.

**Q17:** We had 1 facility that received the 2% reduction because of dashing height/weight. We had a COVID unit that was receiving outside patients. I wish CMS would reconsider how long the exemption was. These patients were very ill and required a lot of care. Due to isolation and COVID protocols we couldn't get this information. We don't have bed scales. We were doing our best in this Pandemic to care for these patients. COVID didn't end on 6/30/2020- which is when the exemption was lifted. I hope this is reviewed.

**A17:** I agree that the way that CMS decided to approach this issue. i.e., only calculating compliance for Q3 and Q4 of 2020, made it more likely that a provider might experience non-compliance. In fact, I made this point to CMS on the recent SNF LTC ODF and asked that they consider favorably those facilities who were compliant for the full 12 months. I work with three providers that had the same issue related to height/weight. These items are related to the covariate of low BMI for the skin integrity measure. The facilities I work with were compliant for the full 12 months which make this more difficult to swallow. Remember that you do have the opportunity to file a reconsideration/appeal with CMS. If you believe you have been identified for this payment reduction in error, you have the right to request a re-consideration of this decision. Reconsideration requests will only be accepted via email no later than 11:59:59 pm local time zone, August 13, 2021 at the following address: [SNFQRPreconsiderations@cms.hhs.gov](mailto:SNFQRPreconsiderations@cms.hhs.gov). The letter that facilities received related to non-compliance has more detailed instructions related to filing a reconsideration.

**Q18:** SNF VBP confidential report will show what facility would have been without covid? Will they receive a different one with the suppression methodology as well?

**A18:** What CMS indicated in the final rule is that they will provide each SNF with its SNF readmission measure rate in confidential feedback reports so that the SNF is aware of the observed changes to its measure rates. They will also publicly report the FY 2022 SNF readmission measure rates on the [Provider Data Catalogue](#) with appropriate caveats noting the limitations of the data due to the PHE for COVID-19.

**Q19:** Where can we locate benchmark data for those quality measures that have this data?

**A19:** Benchmark data may be located in four places depending on exactly what you are looking for. These are your CASPER Facility Level QM reports, CASPER 5-Star Preliminary reports, Care Compare and the [Provider Data Catalogue](#).