

RAI Spotlight

Final PPS Regulation Issued

On August 4, 2017, a final rule was published in the Federal Register at <https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16256.pdf> outlining Fiscal Year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs). It revises and rebases the market basket index by updating the base year from 2010 to 2014, thus using more recent data for the rate calculations. Based on the changes contained within this final rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by \$370 million, or 1.0% from payments in FY 2017.

CMS also used this rule to finalize changes to the Quality Reporting Program (QRP). Under the SNF QRP, SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year. This is already in place, beginning October 1, 2017 (<https://>

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html). In this rule, CMS is finalizing its replacement of the current pressure ulcer measure with an updated version of that measure (Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury), and adopting four new measures that address functional status beginning with the FY 2020 program year (October 1, 2019). These new measures include Change in Self-Care Score, Change in Mobility Score, Discharge Self-Care Score and Discharge Mobility Score.

The SNF Value-Based Purchasing Program (VBP) has adopted scoring and operational policies for its first year (FY 2019) and has specified measures and program features. This SNF PPS final rule includes additional Program

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MDS Updates and Phase 2 Teleconference

Date: October 12, 2017
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: MDS Updates and Phase 2
Handouts: Power Point slides will be available about October 11 on the DOH Message Board at

<https://sais.health.pa.gov/commonpoc/Login/Login.aspx>

Call in number: 1-888-694-4728 or 1-973-582-2745

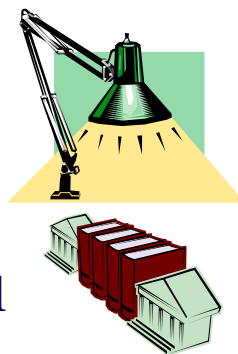
Conference ID Number: 75872041

Company Name: Myers and Stauffer Moderator: Cathy Petko

Presenter: Lisa Bingaman

A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

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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Section S Update Teleconference Q & As



On July 13, 2017, a training teleconference was provided on Section S Updates. The following questions were received:

Q. If a resident is admitted receiving an antipsychotic regularly, a gradual dose reduction (GDR) cannot be completed before the Admission assessment is required. We must code N045A = 1 Yes, Antipsychotics received on a routine basis, and then code N045B = 0 saying that a GDR has not been attempted. Before the quarterly is completed, a GDR is performed but then the resident is switched to a different antipsychotic medication. Should we report the GDR for the first medication?

A. Since the teleconference, the revised version of the RAI Manual has been released so there is a clearer answer to your question. Refer to pages N-11 through N-13 which give comprehensive instructions for the completion of this section. Two areas of guidance that may help you make a decision are:

- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section, and
- If multiple dose reductions have been attempted since admission/entry or reentry or the prior OBRA assessment, record the date of the most recent reduction attempt in N0450C Date of last attempted GDR.

Q. The assessments have gotten longer and longer but the completion dates have remained the same.

A. The requirement for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or

Revised RAI Manual Released

On August 31, 2017, CMS released the revised LTC Facility RAI User's Manual v. 1.15 that is effective October 1, 2017. (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>) As usual, they made available not only the revised pages for the manual but the Track Changes file which makes it quicker to identify the changes that have been made.

The following changes are of particular interest:

- For examples 3 and 5 on pages A-35 and A-36, the correction is made to clarify that even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H Is this a SNF Part A PPS Discharge Assessment? be coded as 1, Yes.

Medicaid certified long-term care facilities. Completion and submission requirements are found beginning on page 2-16 of the RAI Manual. You are correct; there have been no changes.

Q. For the new Section S0113, Prior Living Situation, what do we code for a resident who was living with a spouse or other family member such as a daughter?

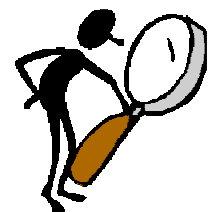
A. You have to evaluate if the person in the home is a caregiver or not. If they are not a caregiver, then the answer would be 99.

Q. When a resident covered by Medical Assistance is hospitalized and returns to the SNF to be covered by Medicare Part A, how do we answer S9080A, Is the resident Medical Assistance for MA Case-Mix?

A. According to the instructions for Section S on page 2-8 of the Resident Data Reporting Manual, the resident is not considered to be MA for MA Case-Mix if any portion of the day of care is paid by Medicare Part A. When the Medicare Part A stay ends, modify S9080A on the latest assessment to indicate that the resident is now MA for MA Case-Mix and enter the date of change in S9080B.

Q. How do you get the slides for Sections N, O and P?

A. Go onto the Message Board for the Department of Health (<https://sais.health.pa.gov/commonpoc/Login/Login.aspx>). There is no need to sign in, just click on the drop down box and select Nursing Care Facilities.



- On page G-8, a new ADL Self-Performance Rule of 3 Algorithm has been inserted.
- On pages G-9 and G-10, there are new clarifications about coding Transfers.
- Extensive clarifications are presented on pages GG-1 to GG-39 Functional Abilities and Goals.
- New items have been added to Section N Medications including N0410H Days Opioid medication was received and N0450 Antipsychotic Medication Review. Coding instructions for these new items begin on page N-7 and continue through page N -13.
- On pages O-42 and O-45, the manual indicates that CMS no longer requires completion of O0600 Physician Examinations and O0700 Physician Orders. **Note: Pennsylvania does require the completion of these items for the RUG-III classification for Medical Assistance.**

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New Long-Term Care Survey Process

With so many changes in rules and regulations concerning care in nursing facilities and skilled nursing facilities, it is not surprising that the Long Term Care Survey Process would also change. In the past, two forms of the survey process have been used: the traditional survey used in about half the states including Pennsylvania and the Quality Improvement Survey (QIS) used in the rest of the country.

Incorporating the changes required by the Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities final rule published on October 4, 2016 (<https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016->

[23503.pdf](https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf)), CMS is implementing a new survey process across the country on November 28, 2017. CMS has prepared a presentation on this new survey available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>. Select New Long Term Care Survey Process under Downloads.



Revised Appendix PP

CMS is endeavoring to provide information to assist facilities and surveyors to come into compliance with final rule on Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities (<https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf>). It has released the updated State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities which is effective November 28, 2017 (<https://>

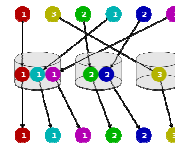
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf). Besides incorporating changes included in the rule, Appendix PP is organized according to the new F-tag designations for easier reference to the changes.



Alternative Resident Classification

On May 4, 2017, an advance notice of proposed rulemaking was published presenting an alternate resident classification system to the RUG-IV system (<https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08519.pdf>). To aid reviewers in understanding the potential changes, CMS has issued the RCS-I Model Calculation Worksheet for SNFs (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/Downloads/RCS_I_Logic-508_Final.pdf) which makes possible the classification of an individual resident using MDS and clinical record data.

In addition, CMS has released a provider specific impact analysis file which details the estimated impact of the RCS-I model on Medicare Part A payments to each SNF in the country. Go to <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/therapyresearch.html> and select Provider Specific Impact Analysis. The provider and resident data is for fiscal year 2014 and represents estimated payments under RCS-I assuming no changes in provider behavior or resident case-mix.

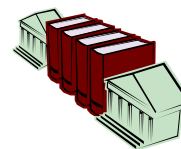


Final PPS Regulation Issued (cont'd)

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proposals:

- The Program will include one readmission measure for each year;
- The Secretary will reduce the adjusted Federal per diem rate applicable to each SNF in a fiscal year by 2 percent to fund the value-based incentive payments for that fiscal year;

- The total amount of value-based incentive payments that can be made to SNFs' in a fiscal year will be 60 percent of the total amount withheld from SNFs' Medicare payments for that fiscal year. The Program will pay SNFs ranked in the lowest 40 percent less than the amount they would otherwise be paid in the absence of the SNF VBP; and
- Both public and confidential facility performance reporting will be conducted.





Community Health Choices (CHC) and Continuity of Care

CHC is Pennsylvania's mandatory managed care program for individuals who are 21 years of age or older and eligible for both Medicaid and Medicare (dual eligibles) and individuals who are 21 years of age or older and eligible for Medicaid long-term services and supports because they need the level of care provided by a nursing facility. This care may be provided in the home, community, or nursing facility.

It is being implemented in phases: in the Southwest on January 1, 2018; in the Southeast on July 1, 2018; and in all other zones on January 1, 2019. A listserv has been established for ongoing 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.

CHC includes provisions to help maintain continuity of care and avoid interruptions of service for participants when they are first enrolled, as well as when choosing to switch from one managed care organization to another.

Recently on the ListServ, there was information provided about CHC and continuity of care with Nursing Facility Services.

- Upon implementation: If the CHC participant resides in a nursing facility in the CHC zone, the participant will be permitted to continue receiving care at that facility until he/she either leaves the facility or is disenrolled from CHC, or if the facility drops out of the Medicaid program.
- After implementation date: Participants admitted to a facility after implementation will receive the standard 60-day continuity of care protections.
- Other considerations: A change in CHC-MCO, a temporary hospitalization, or therapeutic leave does not interfere with or terminate the continuity of care period as long as the participant remains a resident of the facility. The CHC-MCO in which the participant is enrolled must enter into an agreement with the nursing facility to make payments for care during the continuity of care period.

Extended Quality Reporting Program Modification Date 2018

Nursing facilities are required to submit data for the Quality Reporting Program (QRP) according to certain deadlines. CMS has identified errors in calculating the various quality measures that will affect payment. To assure accurate calculations, all data for assessment based measures required in the SNF QRP in CY2017 will remain open to modifica-

tions until May 15, 2018. The details can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Update-SNF-Review-and-Correct-Report-Confidential-Feedback-Report-Issues-August-2017.pdf>.



Training Videos

On October 4, 2016, CMS published the final rule on Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities (<https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf>). This final rule revises the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs.

The changes are extensive and diverse. CMS is implement-

ing them in three phases: Phase 1 had to be implemented by November 28, 2016; Phase 2 by November 28, 2017; and Phase 3 by November 28, 2019. To aid facilities in this transition process, CMS has produced a series of training videos at https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSLTCSME_VID. Most of them are labeled "Incomplete" but there is extensive information provided on the various topics.

CASPER Manual



The CASPER system serves as a link between CMS and nursing facilities. Some reports are simply placed in the CASPER files, e.g., Final Validation Reports; others can be requested by the facility. To assist facilities, CMS has added Chapter 13 SNF Quality Reporting Program (QRP) to the CASPER Manual (https://www.qtso.com/download/guides/casper/cspr_sec13_mds_prvdr.pdf). This will assist facilities in obtaining and interpreting some of the reports connected with the QRP.



Revised RAI Manual Released (cont'd)

(Continued from page 2)

- Another addition to the MDS for October 1, 2017 is Section P0200 Alarms. Instructions for this section are found on pages P-8 through P-10.

Discussion of the upcoming changes will be included in the teleconference on October 12, 2017, but obtaining and reading the revised manual will be important for each individual.