



An Informational Bulletin Brought To You By Polaris Group

## Skilled Nursing Facility Quality Reporting Data Submission Deadline

The IMPACT Act of 2014 mandated the establishment of the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). As finalized in the Fiscal Year (FY) 2016 SNF PPS final rule, beginning with FY 2018 and each subsequent FY, the Secretary will reduce the market basket update (also known as the Annual Payment Update, or APU) by 2 percentage points for any SNF that does not comply with the quality data submission requirements with respect to that FY.

The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16. This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016. **Providers have until May 15, 2017, to correct and/or submit their quality data for the FY 2018 reporting year.** Providers must submit all data necessary to calculate SNF QRP measures on at least 80% of the MDS assessments submitted to be in compliance with FY 2018 SNF QRP requirements.

SNF QRP data is submitted through MDS 3.0 via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. The implementation of the SNF QRP does not change requirements related to the submission of MDS 3.0 data through CMS' QIES ASAP system.

List of the current MDS SNF measures for FY 2018:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)
- Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Claims-based measures are also included in the SNF QRP. These measures are calculated through Medicare Fee-For-Service claims data and do not require SNFs to submit any additional data to CMS.

List of the claims-based measures for FY 2018:

- Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
- Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure

As a reminder, it is recommended that providers run the applicable CMS CASPER validation reports prior to each quarterly reporting deadline to ensure that all required data has been submitted. Providers are also encouraged to verify all facility information prior to submission, including their CCN and facility name. Only successful submissions will count toward your Annual Payment Update requirement.

To read the complete CMS Quick Reference Guide for the Skilled Nursing Facility Quality Reporting Program (SNF QRP): <http://www.polaris-group.com/>

### CMS Payroll Journal Updates

The Affordable Care Act requires Long Term Care facilities to electronically submit direct care staffing information based on payroll and other auditable data. The Centers for Medicare and Medicaid Services (CMS) developed the Payroll-Based Journal (PBJ) system for facilities to submit staffing and census information. The first mandatory reporting period began July 1, 2016.

On April 21, 2017 CMS Published a Survey and Certification Memo for providers with current updates to the PBJ system.

- **Nursing Home Compare Website and the Five Star Quality Rating System:** Currently, the data submitted is not being used to calculate a staffing measure on the Nursing Home Compare website, or being used to calculate a rating in the Five Star Quality Rating System. CMS intends to use the data to calculate staffing measures for the Five Star Quality



Rating System in 2018, and will communicate with providers in advance of any postings. At this time, the data is being used to inform stakeholders of the level of staffing data submitted by each facility. The website currently includes icons next to each facility to reflect whether that facility has submitted data by the last deadline of February 14, 2017. Icons will continue to be used to indicate whether a facility has, or has not submitted data by the next deadline of May 15, 2017 (for hours worked between January 1, 2017 through March 31, 2017). Additionally, providers that have not submitted any data for two consecutive deadlines (May 15 and February 14) will have their overall and staffing star ratings suppressed until data is received. CMS strongly encourages providers to submit data throughout the quarter, and not wait until the last 24 hours before the deadline. Data must be submitted successfully to be considered timely. Once a facility uploads their data file, they need to check their final Validation Report, which can be accessed in the Certification and Survey Provider Enhanced Reporting (CASPER) folder, to verify that the data was successfully submitted. It may take up to 24 hours to receive the validation report, so providers must allow for time to correct any errors and resubmit, if necessary.

- Data Specification Updates:** CMS is making two changes to make it easier for providers to submit data, reduce burden, and improve accuracy. First, some providers experienced difficulty submitting the hire, termination, and rehire dates for employees. CMS has now made it optional to submit this data. For those that wish to continue to submit this information, they have altered the system so that it can be submitted more easily. This information was originally intended to be used to calculate rates of tenure and turnover. However, based on analyses of the data submitted, and the challenges providers have experienced, CMS now intends to calculate these rates using the actual hours worked by staff each day. In addition, CMS is converting three types of labor categories from mandatory to optional submission. These categories are Dental Services (Job Title Code 32), Podiatry Services (Job Title Code 33), and Vocational Services (Job Title Code 35). CMS will provide advance notice to providers for any future changes to the optional or mandatory status of these or any other labor categories.

To read the complete CMS S&C Memo: <http://www.polaris-group.com/>

## OIG Releases Compliance Tool

The office of the Inspector General (OIG) released a document on March 27, 2017, Measuring Compliance Program Effectiveness. This Compliance tool brings together many compliance ideas identified from a roundtable discussion held in January 2017. The OIG, along with staff from the Department of Health and Human Services (HHS) and compliance professionals, met to discuss ways to measure the effectiveness of a compliance program. The list of compliance program elements and program metrics contained in the report are a result of the group's discussion. The purpose of the list is to give providers as many ideas as possible, and be broad enough to help any type of health care organization.

To read the complete OIG Compliance Tool: <http://www.polaris-group.com/>

## CMS Updates ABN for Part B SNF Services

The Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by providers, physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.

Skilled nursing facilities (SNFs) must use the ABN for items/services expected to be denied under Medicare Part B only.

The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. While there are no changes to the form itself, providers should take note of the newly incorporated expiration date on the form. With the 2016 Paperwork Reduction Act (PRA) submission, a non-substantive change has been made to the ABN. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed. **The effective date for use of this ABN form is 6/21/2017.**



**Polaris Group Solution Center  
Hotline Q&A  
“Where No Question Goes Unanswered!”**

**Question:**

We had a resident who was out of the facility on a LOA with the family and fell and broke her arm. Do I have to record that in the fall section of the MDS?

**Answer:**

Yes. According to the RAI Manual under Page J-30 it says “review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home You could complete a discharge return expected assessment/end of stay, then treat as readmit. (This would assume the resident was out of the facility over 25 hours)”.

**Question:**

We had a resident that discharged off Medicare Part A but remained in the building. The 7 day COT checkpoint was the same day they discharged off Medicare Part A. Do I have to do the COT and can I combine it with the SNF Part A PPS Discharge Assessment?

**Answer:**

The COT would be required and can't be combined with the SNF Part A PPS Discharge Assessment. The RAI says on page 2-55: “If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met. If the date listed in A2400C is on Day 7 of the COT observation period, then the SNF must complete both the COT OMRA and the Part A PPS Discharge Assessment. These assessments must be completed separately”.

**Question:**

I have a resident who went off Medicare Part A on 3/27/17 but she is staying in the building so do I do a NPE item set? What would the ARD date and the Medicare end date be?

**Answer:**

Yes, you need to do the NPE item set (SNF Part A PPS



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	<u>Date</u>
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Traditional Survey Prep, Process & Management Part 1	5/4
Traditional Survey Process Part 2	5/5
<b><u>Care Area Assessments Training</u></b>	
Care Area Assessments/How To “Work The CAAs”	5/8
<b><u>PEPPER Training</u></b>	
Using New FY16 PEPPER to Support Auditing & Monitoring Efforts	5/10
<b><u>Medicare Training Series</u></b>	
Medicare Part A Basics	5/22
Medicare Documentation & Skilling Criteria	5/24
Denial Letters & Expedited Review Notices for LTC	5/25
<b><u>Medicare Denials Management Training Series</u></b>	
Additional Development Requests & Appeals Part 1	5/23
Responding to Denials & Appeals Part 2	5/31
Systems to Prevent ADRs in the First Place Part 3	6/1

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For further information, please contact the Webinar  
Department at: 800-275-6252 ext. 250  
or register online at: [www.polaris-group.com](http://www.polaris-group.com)*



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<b><u>Surviving MAC/RAC/ZPIC Audits</u></b> November 8-9 Orlando, FL	<b><u>Advanced Billing for SNFs</u></b> August 22-24 Las Vegas, NV November 14-16 Tampa, FL

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