May 30, 2018

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An Informational Bulletin Brought To You By Polaris Group

CMS Proposed New Patient-Driven Payment Model

On April 27, 2018, the Centers for Medicare and Medicaid Services (CMS) announced a proposal to replace the Resource Utilization Groups (RUGs) payment system with a new model for Medicare payment of skilled nursing care. Although it is similar to last year's proposed Resident Classification System (RCS), CMS made some refinements and renamed it the Patient-Driven Payment Model (PDPM). CMS believes the new model will save money and improve care by reducing administrative burden and tying payment to patient conditions rather than services provided. The new payment system would go into effect on October 1, 2019 (FY 2020).

Key components of the proposed PDPM:

- The basic structure of the payment model follows last year's RCS proposal, but with modifications and streamlining based on public comments and stakeholder input.
- Under the proposed PDPM, there would be five case mix related components to the rate: physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillary (NTA), along with a sixth component for non-case mix related costs.
- The proposed PDPM would separately identify and adjust the case mix components, using primarily minimum data set (MDS) data, for the varied needs and characteristics of a resident's care. The case mix components would then be combined with the non-case mix component to form the full SNF prospective payment system (PPS) per diem rate for that resident. The intent is to base as much of the rate as possible on patient characteristics instead of service provision.
- While PT and OT will be separate components, these components will always result in the same case-mix group; however, the PT and OT case-mix payment levels differ. Clinical Categories for the PT and OT components would be based on the primary reason for SNF care (based on ICD-10-CM diagnoses coded on the MDS), further modified by functional impairment sub-groupings to be scored based on Section GG of the MDS. The functional grouping would include new metrics in calculating activities of daily living (ADL) and expand the payment system beyond the four late-loss ADLs. Unlike RCS, cognitive function is no longer included as a grouping factor for the PT and OT components, which streamlines the number of groups.
- The proposed SLP component will be determined by three characteristics; the primary clinical reason for SNF care (Acute-Neurologic or Non-Neurologic), the presence of a swallowing disorder or mechanically altered diet and the third characteristic is cognitive status or SLP comorbidity present. SLP components have been streamlined resulting in 12 case-mix payment groups.
- The proposed Nursing component would be based on a modified traditional RUG IV methodology. PDPM proposes using Section GG of the MDS to determine a function score. The nursing components have been streamlined resulting in 25 case-mix payment groups.
- Non-therapy ancillaries (NTA) would be paid based on six groups derived from a comorbidity score calculated from the MDS.
- The proposed PDPM will have variable per diem adjustment factors based on the length of stay for PT, OT, and NTA payment categories. This change is intended to better calibrate costs to a patient's stay over an episode of care, recognizing that some per diem costs are higher in the early days of a length of stay and are lower nearer to discharge.
- The proposed PDPM has an interrupted stay policy, which would require completion of a new MDS if there were a readmission to the hospital that is longer than three days and/or admission to a different SNF during the episode. This new policy would not trigger a reset of the variable per diem adjustment clock noted above, meaning that those overall length of stay incentives remain intact regardless of the presence of an interrupted stay.
- In the proposed rule, CMS would no longer be using therapy minutes to determine reimbursement, any changes in a resident's therapy minutes will no longer impact reimbursement, therefore, CMS is proposing a new MDS assessment schedule.

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- ☑ 5-Day scheduled PPS Assessment- All covered Part A days until Part A discharge (unless an IPA is completed).
- ☑ Interim Payment Assessment - significant change that meets both criteria
- ☑ PPS Discharge Assessment – all residents discharged from Medicare Part A

- CMS would require a discharge assessment for all residents who are discharged from Medicare Part A. In addition, CMS would add 2 new therapy-reporting requirements to the discharge assessment, the first aimed at documenting therapy minutes and each therapy mode used, and a second focused on days for each discipline and mode of therapy. CMS hopes that monitoring both minutes and days will allow it to get a better handle on the daily intensity of services provided.
- The proposed PDPM would limit concurrent and group therapy to 25% for each discipline.

May 2018 OIG Updates

Examining Healthcare Coalitions' Partnerships with Non-Hospital-Based Facilities in Community Preparedness Efforts

Healthcare Coalitions (HCCs) are groups of public and private health care organizations, emergency preparedness planners, responders, and other types of health officials in specified jurisdictions. HCCs receive funding through the Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP). HPP guidance states that HCCs should create jurisdictional emergency response plans that take into consideration the needs of vulnerable populations. Many vulnerable populations depend on non-hospital-based facilities, for monitoring and care during and after disasters. However, prior OIG work found that non-hospital-based health care facilities commonly lacked comprehensive emergency response plans.

Prompted in part by this work, CMS implemented new emergency preparedness requirements that apply to all facilities receiving Medicare or Medicaid reimbursement. While HPP and CMS emergency preparedness requirements are components of different programs managed by different agencies, the implementation of each is affected by the other. The HPP directs HCCs to leverage the CMS-required emergency response plans of its partners, especially those that serve vulnerable populations. At the same time, some non-hospital-based facilities may depend on the expertise and resources of HCC partners to meet CMS emergency preparedness requirements. The OIG will examine the extent to which HCCs ensure "a successful whole community response" by integrating non-hospital-based facilities into their emergency preparedness activities and technological strategies. The OIG will also assess ASPR's oversight and support including its coordination with CMS-of HCCs' integration of non-hospital-based facilities

Five Star Technical User's Guide Updated

April 2018, CMS updated the Five Star Technical User's Guide

CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. The Nursing Home Compare Web site features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. The Five-Star Quality Rating System Technical Users' Guide provides in-depth descriptions of the ratings and the methods used to calculate them. CMS updated the Five-Star Rating System Technical Users Guide April 2018.

Summary of updates:

- Beginning with the April 2018 update of the Nursing Home Compare website and the Five-Star Quality Rating System, the Centers for Medicare and Medicaid Services (CMS) is replacing the existing staffing measures (derived from the CMS-671 form and case-mix based on RUG-III) with staffing reported through the payroll-based journal (PBJ) system, resident census derived from MDS assessments, and case-mix based on RUG-IV. These changes as they affect the Five-Star Quality Rating System are described in detail in the Staffing Domain section of this document.

For a copy of the CMS Five Star Technical User's Guide; http://polaris-group.com/news_releases.asp

LTCSP Procedure Guide and Training Updated

CMS updated the Long Term Care Survey Process (LTCSP) Procedure Guide effective May 6, 2018.

The LTCSP Procedure Guide provides instruction on the procedural and software steps necessary for completing the LTCSP. Use the Procedure Guide for all standard surveys of SNFs and NFs, whether freestanding, distinct parts, or dually participating. The LTCSP steps are organized into seven parts: 1) offsite preparation; 2) facility entrance; 3) initial pool process; 4) sample selection; 5) investigation; 6) ongoing and other survey activities; and 7) potential citations.

For a copy of the CMS LTCSP Procedure Guide; http://polaris-group.com/news_releases.asp

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question: For section A of the MDS – if residents get new Medicare cards with new numbers – are we to use the new numbers

Answer: Once a new Medicare number is received, your system should be updated. Since the new Medicare cards will be mailed at different times, there will be a transition period where either current MCN or new MCN will be accepted. See CMS Instructions below:

There will be a transition period when you can use either the HICN or the MBI to exchange data and information with us. **The transition period will start April 1, 2018, and run through December 31, 2019.** However, your systems must be ready to accept the new MBI by April 1, 2018. It's especially important that you're ready for people who are new to Medicare in April 2018 and later because they'll only get a card with the MBI.

Question: We have a facility that we just purchased. They have a resident that speaks Farsi and have used the family to translate for the MDS interview sections. Is this acceptable?

Answer: The family may serve as interpreter. See RAI guidelines below for section A1100:

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the resident is unable to respond, a family member or significant other should be asked.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, ask for preferred language.
5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Coding Instructions for A1100A

• **Code 0, no:** if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status.

• **Code 1, yes:** if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.

2018 WEBINAR TRAININGS
Polaris Group is pleased to offer the following
CEU approved live Webinars

	Date
New GG & SNFQRP QMs Training ****Hot New Topic***	
Introduction to New MDS, GG & SNFQRP Measures for Oct 1, 2018	6/12
Supervisory Skills Training Series	
"SUPER" Supervisor - Part 1: Communication Skills to Improve	6/5
Supervisory Skills - Part 2: Coaching to Improve Staff Performance	6/7
RUG-IV Training Series	
RUG-IV Qualifiers & MDS Coding - Part 1	6/6
COT, EOT, SOT Combinations & More! - Part 2	6/18
PPS Systems & Management - Part 3	6/19
5 Star Training	
Overcome 5 Star Anxiety	6/14
Part B Therapy Training	
Part B Therapy Programs - Clinical	6/27

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

POLARIS GROUP LTC TRAINING INSTITUTE

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Training Workshops for LTC
Current 2018 Dates & Locations:

Advanced Billing for SNFs
August 21-23 Las Vegas, NV
October 16-18 Orlando, FL

SNF Medicare & PPS Compliance
November 13-15 New Orleans, LA

SNF Billing Training
June 19-21 Orlando, FL
September 18-20 Dallas/Ft. Worth, TX

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