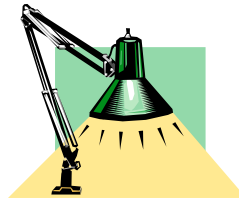


RAI Spotlight



SNF: Final Rule FY 2020

On July 30, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a final rule [CMS-1718-F] for Fiscal Year (FY) 2020 Medicare payment rates and quality programs for skilled nursing facilities (SNFs). This final rule is part of continuing efforts to strengthen the Medicare program by better aligning payment rates for these facilities with the costs of providing care and increasing transparency so that patients are able to make informed choice.

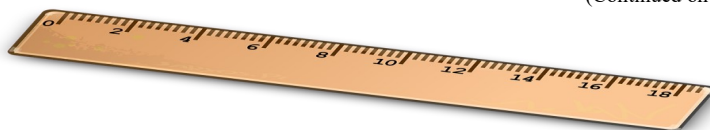
CMS projects aggregate payments to SNFs will increase by \$851 million, or 2.4 percent, for the FY 2020, which begins October 1, 2019. This estimated increase is attributable to a 2.8 percent market basket increase factor with a 0.4 percentage point reduction for the multi-factor productivity adjustment.

The Final Rule discusses three major provisions:

SNF Prospective Payment System (PPS)

The Patient Driven Payment Model (PDPM) will be effective October 1, 2019 under the SNF Prospective Payment System (PPS) for classifying patients in a covered Medicare Part A SNF stay. The PDPM utilizes ICD-10 codes to classify SNF patients into certain payment groups. Each year, the ICD-10 codes and guidelines are revised in a variety of non-substantive ways, such as a single code being split into two more specific codes. To help ensure SNFs have the most up-to-date ICD-10 code information as soon as possible, in the clearest and most useful format, CMS is finalizing a sub-regulatory process for making non-substantive changes to the list of ICD-10 codes used to classify patients into clinical categories under the PDPM.

(Continued on page 4)



MDS Section: G/GG Teleconference

Date: October 10, 2019

Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)

Topic: MDS Section: G/GG Teleconference

Handouts: Power Point slides will be available about October 9 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: 8061175

Company Name: Myers and Stauffer

Presenter: Kerry Weaver

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

Kiera Price
RAI Coordinator
1-717-547-3118
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August 2019

Questions about the RAI?

Please submit them to
qa-mds@pa.gov

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MDS/RAI Changes and PDPM Policy Updates Teleconference Q & A



On July 11, 2019 a training conference was provided on MDS/RAI Changes and PDPM Policy Updates. No questions were received.

PPS: Transition from RUGS to PDPM

The transition between RUG-IV and PDPM will be a “hard” transition. Meaning, that the two systems will not run concurrently at any point. The RUG-IV payment system will be retired effective September 30, 2019 and the PDPM system will begin October 1, 2019. All days of service on or prior to September 30, 2019 will be billed under RUG-IV, while all days of service beginning October 1, 2019 will be billed under PDPM. Therefore all Medicare A/PPS residents in a facility over the transition will need both a RUG-IV and PDPM HIPPS code generated from an MDS assessment. To generate these HIPPS codes each resident admitted prior to October 1, 2019 is required to have a 5-day assessment completed with an ARD of September 30, 2019 at the latest to generate a RUG-IV HIPPS code and a *transitional* IPA assessment with an ARD of October 1 through 7, 2019 to generate the HIPPS code for PDPM.

This *transitional* IPA will begin payment on October 1, 2019 despite the date chosen for an ARD. This applies only to this *transitional* IPA. Also applying only to this *transitional* IPA, is the Variable per-diem adjustment schedule which will begin on October 1, 2019 for all residents in the facility continuing on a PPS stay under PDPM.

“Our dilemma is that we hate change and love it at the same time; what we really want is for things to remain the same but get better..”-*Sydney J. Harris*

MDS Section GG: Training Opportunities

The Centers for Medicare & Medicaid Services has released a series of short videos to assist providers with coding select Section GG items on the OASIS, IRF-PAI, LTCH CARE Data Set, and the MDS. These videos, ranging from 4-12 minutes, are designed to provide targeted guidance using simulated patient scenarios.



To access the videos, click on the links below:

- [Coding GG0110. Prior Device Use with Information from Multiple Sources \(3:58\)](#)
- [Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility \(11:56\)](#)
- [Coding GG0130B. Oral Hygiene \(4:25\)](#)
- [Coding GG0170C. Lying to Sitting on side of bed \(4:33\)](#)

From <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html>

Infection Prevention Training

The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) collaborated on the development of a free on-line training course in infection prevention and control for nursing home staff in the long-term setting

The training provides approximately 19 hours of continuing education credits as well as a certificate of completion.

The “Nursing Home Infection Preventionist Training Course” is located on the CDC’s TRAIN website. https://www.train.org/cdctrain/training_plan/3814.

Entire memo available here. [QSO19-10-NH \[PDF, 122KB\]](#)
This memo supersedes memo Quality, Safety & Oversight policy memorandum QSO 18-15-NH.

Pennsylvania: MDS Updates for October 1, 2019

Pennsylvania will not be requiring the use of the Optional State Assessment Item Set for the Minimum Data Set (MDS) for October 1, 2019. Pennsylvania will continue, as is the current process, using the OBRA and Required/Scheduled PPS assessments to determine Medicaid Case-Mix.

Background

CMS is implementing a new “Patient Driven Payment Model” (PDPM) for Skilled Nursing Facility (SNF) fee-for-service Medicare reimbursement effective October 1, 2019.

CMS will be eliminating MDS assessments that are not needed to support the PDPM. This change means less-frequent assessments will be available October 1, 2019 when calculating the case mix index (CMI) for Pennsylvania NF rates. If Pennsylvania chose to continue the additional assessments, Pennsylvania would have to implement the Optional State Assessment (OSA) Item set for the MDS.

Additionally, there will be no changes to Section S of the MDS with October 1, 2019 Resident Data Reporting Manual.

Community HealthChoices-Provider Relationships

Community HealthChoices (CHC) is Pennsylvania’s mandatory managed care program for individuals who are dually-eligible for Medicare and Medicaid and individuals 21 years of age or older with physical disabilities. Managed care is new for long-term services and supports, but Pennsylvania has provided physical and behavioral health care through a managed care model for many years.

This transition will create questions. Please reference the fact sheet for information about how care providers will work with CHC’s managed care organizations to deliver quality care to CHC Participants.

CHC is live in the Southwest and Southeast, and DHS is preparing for implementation in the remainder of the state on January 1, 2020. Make sure you and your coworkers have the information you need about CHC. Take the 30-minute online training at <http://www.healthchoices.pa.gov/providers/about/community/index.htm>.



If you have other questions about CHC, view the comprehensive question and answer document online at http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_274784.pdf.

If you have any questions, please visit www.HealthChoices.pa.gov or email RA-PWCHC@pa.gov

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.



Medicare Beneficiary Identifier

The Medicare Beneficiary Identifier (MBI) uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. These letters are excluded to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”). Read MLN Matters Article [New MBI: Get It, Use It](#) for other helpful information, such as how to get the MBI, and what to do if an MBI changes.

Protect your patients’ identities, and use the MBI now. Claims you submit with the Health Insurance Claim Number (HICN) will be rejected, with a few [exceptions](#) and reject all eligibility transactions starting **January 1, 2020**.

Don’t have an MBI?

- Ask your patients for their card. If they did not get a new card, give them the Get Your New Medicare Card flyer in [English](#) or [Spanish](#). Use your Medicare Administrative Contractor’s look up tool. [Sign up](#) for the Portal to use the tool.
- Check the remittance advice. It returns the MBI on the remittance advice for every claim with a valid and active HICN.

SNF Final Rule FY 2020 Continued

(Continued from page 1)

Various PAC settings permit therapists to furnish therapy to their patients in three different modes: individual, concurrent, and group. For more consistent therapy definitions across care settings, CMS is adopting the same definition of group therapy that is used in the IRF PPS: group therapy consists of two to six patients doing the same or similar activities. As PDPM implementation takes place, CMS believes aligning the group therapy definition serves to improve the agency's consistency in payment policies across PAC settings.

SNF Value-Based Purchasing Program (VBP) Finalized Policy Changes

The SNF VBP Program began rewarding SNFs with incentive payments based on their quality measure performance on October 1, 2018. The program currently scores SNFs on an all-cause measure of hospital readmissions, and in the future, will transition to a measure of potentially preventable hospital readmissions. As required by statute, the program reduces SNFs' Medicare payments by two percentage points, then redistributes approximately 60% of those funds as incentive payments.

The final rule also includes an update to the public reporting requirements to ensure that CMS publishes accurate performance information for low-volume SNFs and a new 30-day deadline for Phase One Review and Corrections requests.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

The SNF QRP is authorized by section 1888(e)(6) of the Social Security Act and applies to freestanding SNFs, any SNF affiliated with acute care facilities, and all non-critical access hospital (CAH) swing-bed rural hospitals. Under the SNF QRP, SNFs that fail to submit required quality data to CMS will be subject to a 2 percentage point reduction to the applicable fiscal year's annual market basket percentage update.

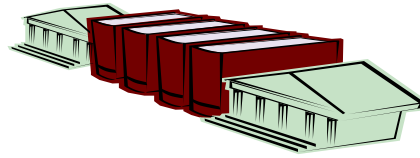
Manuals with Recent Revisions

PBJ Provider User Guide V3.0.1 (UPDATED 6/19)

This manual explains how to connect to the PBJ system and submit data. It also defines error messages and descriptions, identifying errors by number, severity, error message, and error description. The description section includes potential corrective actions for providers to take to resolve the errors. <https://qtso.cms.gov/reference-and-manuals/pbj-provider-users-guide>

CASPER Reporting User's Guide for PBJ Providers (UPDATED 6/19)

This user's guide provides information and instructions pertaining to the CASPER Reporting application. Section 12, Payroll Based Journal (PBJ) Reports, address the staffing and census reports available to providers, including the Employee Report, the Census Report, the Staffing Summary Report, and the PBJ Submitter Final File Validation Report. <https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-pbj-providers>



As part of CMS' commitment to improve the interoperability of health information and their ongoing efforts to increase quality and safety in SNF operations, CMS is adopting two new quality measures in FY 2020 to assess whether certain health information is provided by the SNF at the time of transfer or discharge. The two measures are: 1) Transfer of Health Information to the Provider-Post-Acute Care and 2) Transfer of Health Information to the Patient-Post-Acute Care.

For more information:

Final Rule: <https://www.federalregister.gov/documents/2019/08/07/2019-16485/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

SNF PPS: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPFS/index.html>

SNF QRP: <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> and <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html>

SNF VBP: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.html>

