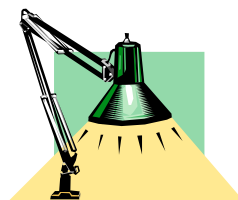
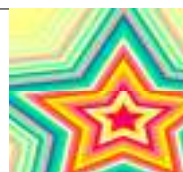


RAI Spotlight



5-Star Rating System Changes



The 5-Star Rating System, also known as Nursing Home Compare, has become an important tool in aiding the public to evaluate and compare nursing homes since it was put in place five years ago. The scale is based on the results of nursing home surveys, calculation of various Quality Measures and the level of staffing in the nursing home.

Recently there has been discussion that staffing measures and quality statistics (MDS data) are reported by the nursing homes themselves but not generally audited by the federal government.

To address this issue, beginning in 2015, CMS will implement the following improvements to the Nursing Home Five Star Quality Rating System (www.whitehouse.gov/the-press-office/2014/10/06/fact-sheet-administration-announces-new-executive-actions-improve-quality).

Nationwide Focused Survey Inspections: Effective January 2015, CMS and the states will implement focused survey inspections nationwide for a sample of nursing homes to enable better verification of both the staffing and quality measure information. PA was a pilot state this year for the focused MDS survey. A Survey and Certification Letter has been released with the details of this new process.

(www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-06.html)

Payroll-Based Staffing Reporting: CMS will implement a quarterly electronic reporting system that is auditable back to payrolls to verify staffing information.

Additional Quality Measures: CMS will increase both the number and type

(Continued on page 4)

RAI Coordinator
1-717-787-1816
qa-mds@pa.gov

Volume 9, Issue 2
November 2014

Questions about the RAI?

Please submit them to
qa-mds@pa.gov

Inside this issue:

<i>Changes in the MDS World Q & As</i>	2
<i>Nursing Facility Report Portal</i>	3
<i>New Goals Set for Use of Antipsychotic Medication</i>	3
<i>Building Respect for LGBT Older Adults</i>	3
<i>IMPACT Act of 2014</i>	4
<i>Announcements</i>	4

Section M Teleconference

Date: January 8, 2015
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Section M Skin Conditions
Handouts: Power Point slides will be available about January 5 on the DOH Message Board at

<http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp>

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

Conference ID Number: 32141523

Company Name: Myers and Stauffer Moderator: Cathy Petko
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





Changes in the MDS World Q & As

On October 9, 2014, a training teleconference was provided on Changes in the MDS World. The following questions were received.

Q. The flu vaccine was available in our area in August but our medical director does not want any vaccine administered until October. All current residents received the flu vaccine for the last flu season. How should we complete O0250B Date influenza vaccine received and/or O0250C If influenza vaccine not received, state reason?

A. For coding item O0250, "this year's influenza vaccination season" begins as soon as the vaccination is available from manufacturers. The CDC recommends that all residents should receive influenza vaccine annually before influenza season. In the majority of seasons, the vaccine will become available to LTC facilities beginning in September and vaccination should commence as soon as vaccine is available. Refer to www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm, and the coding tips on page O-8 of the RAI Manual.

If the vaccine was available but not offered to the resident, O0250A is coded 0, O0250B is skipped and O0250C is coded 5, Not offered. The NHA and/or the DON should work with the medical director to resolve this situation.

Q. How should A0310 and A0600 be coded if the resident's care is being paid by a Health Maintenance Organization (HMO) or Medicare Advantage (MA) plan?

A. A0310A Federal OBRA Reason for Assessment should be coded based on the assessment you are completing; OBRA assessments and tracking forms must be completed and submitted for HMO and MA residents. A0310B PPS Assessment is coded only if the resident is in a MC Part A stay so it should be coded 99 Not a PPS assessment. A0310C PPS OMRA should be coded 0 No. A0600A Social Security Number should be completed. A0600B Medicare Number (or comparable railroad insurance number) must not be completed with an HMO number; use only a Medicare (HIC) number or a Railroad Retirement Board number.

Be very clear exactly what the HMO or MA organization requires. Read the contract or talk with the organization. Some require no additional assessments, others want assessments completed at the 5 and 14-day intervals. Work with your vendor to meet the HMO or MA requirements without violating CMS instructions. Above all, do not submit assessments completed only for HMO or MA purposes.

Q. Our HMO does not require additional assessments. However, at a conference, they recommended that we do the PPS assessments anyway. Should they be completed but not submitted?

A. Sometimes at the beginning of a resident's stay, it is not entirely clear as to what payors may be involved, or if the

resident may be switching from one plan to another. Completing the PPS assessments may be seen as a protective measure in case it is discovered that the resident will be covered by MC Part A. Know your payors, and read contracts carefully to identify all requirements.

Q. What is a PSAE? This must be evaluated for MA residents; is an MA Pending resident considered to be MA for this evaluation?

A. PSAE is an acronym for Preventable Serious Adverse Event. If an MA Pending resident experiences a possible PSAE, document carefully but do not report it until the resident is determined to be eligible for MA and the event occurred while she was eligible for MA. You can read more about this on the OLTL PSAE site at <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/preventable/index.htm>.

Q. Both A1600 Entry Date and A1900 Admission date must be completed on an Entry tracker. When are these dates the same? When do they change?

A. When the resident first comes to your facility, these dates will be the same on the Entry tracker; it is the beginning both of the episode and the stay. If the resident is returning from a period of hospitalization, A1600 Entry Date would be the latest date of reentry. A1900 Admission Date would be unchanged; the episode doesn't end until the resident is Discharged Return Not Anticipated, Discharged Return Anticipated but stays out more than 30 days, or dies. If the resident returned after one of these events, it would be the beginning of a new episode so A1600 and A1900 would again be the same date.

Q. How should A0410 Unit Certification or Licensure Designation be coded for an HMO resident?

A. If the resident is in a Medicare or Medicaid certified bed, it must be coded 3 Unit is Medicare and/or Medicaid certified.

Q. Resident was in a Rehab RUG on the 5-day PPS assessment but placed in a Nursing RUG on the 14-day assessment. Can a COT be done seven days later to restore the Rehab RUG?

A. No. Both regulation and CMS interpretations say that it must be a COT that placed the resident in the Nursing RUG to allow completion of a COT after an assessment that did not classify into a Rehab RUG.

Q. The resident placed in a Nursing RUG on the 5-day, 14-day and 30-day assessment due to Index Maximization but was receiving therapy. Now on Day 37, therapy minutes have increased so she would place in a Rehab category. Can a COT be done?

A. The resident fails to meet the two criteria: she has never been classified in a Rehab category and a COT did not place her in a Nursing RUG. The 60-day assessment may place her in a Rehab RUG if she continues to receive sufficient therapy.



Nursing Facility Report Portal

In the past, CMI Reports were retrieved by selecting the MDS 2.0 link after logging into the Centers for Medicare and Medicaid Services (CMS) site to submit resident MDS records. Beginning with the November 1, 2014 Picture Date, the CMI Reports will no longer be available via the MDS 2.0 link on the CMS site.

Now, to access CMI Reports, you will use a secure file hosting system identified as the Nursing Facility Report Portal. The URL for this site is <https://cmi.panfsubmit.com>.

In November, a letter was sent to the Nursing Home Administrators (NHA) of all nursing facilities participating in the MA program. In it, there was an introduction to the new system, a sealed envelope containing the facility account user name and password, and an Individual User Account Maintenance Form with instructions.

In order to download CMI Reports, the user must have an individual account and password. To get this access, the potential user must take the following steps:

- Complete the form selecting Create New User Account;
- Have the form signed and dated by the NHA;
- Obtain a coversheet with facility letterhead; and
- Scan the two documents to create an electronic file.

Access the NFRP at <https://cmi.panfsubmit.com>.

- Click on *NFRP Login* and enter the facility account user-

name and password provided in the sealed envelope.

- Select the Requests folder.
- Click on the Browse button and select the scanned file.
- Click on Open; path and filename should appear in the Choose a File area.
- Click on the Upload button to complete the upload process.

The form will be reviewed for completeness by Myers and Stauffer.

- An Individual User account will be created.
- An email will be sent to the User's Company Email Address containing instructions to call the Myers and Stauffer help desk (717-541-5809) to receive their password information. The email will contain a PIN to confirm your credentials when you call the helpdesk to obtain your password.
- Using your email address as your User name and the password provided by the helpdesk, you may then connect with the NFRP, log in as yourself, and select Access CMI Reports.
- Click on the report of interest to open or save the file.
- Problems? Contact the help desk at 717-541-5809.

New Goals Set for Use of Antipsychotic Medication



Beginning in 2012, the National Partnership to Improve Dementia Care has been working to provide tools to reduce the use of antipsychotic medications in nursing homes. Teleconferences were held and training materials (e.g., Hand-in-Hand) were supplied. A goal was set of a 15% reduction; a decrease of 17.1% was reached by 2014. Pennsylvania decreased antipsychotic medication use from 21.3% in mid-2011 to 17.7% in the first quarter of 2014, a 16.9% reduction.

Now new goals have been set. By the end of 2015, the new national goal is to reduce the use of antipsychotic medications in long-stay nursing home residents by 25%. By the end of 2016, the goal is set at a further 30% reduction. In addition to reduction in the use of medication, the Partnership wants to enhance the use of non-pharmacologic approaches and person-centered dementia care practices. (<http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-19.html>)

Building Respect for LGBT Older Adults

According to a recently released Survey and Certification Letter (<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-42.pdf>), there are approximately 1.5 million adults over the age of 65 in the United States who identify as lesbian, gay or bisexual. By 2030, those estimates are expected to rise to nearly 3 million. Estimates indicate that there are hundreds of thousands of older adults who are transgender. Many of these older LGBT adults in long term care facilities do not feel safe being open about

their sexual identity.



CMS has released a learning tool on Building Respect for LGBT Older Adults. This tool, offered free of charge, will educate care providers about the needs and rights of older LGBT adults. It consists of six short training modules providing information on how to make LTC more inclusive for this population. Steps to access the Learning Tool are included in the letter.



IMPACT Act of 2014

On October 6, 2014, President Obama signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014). The primary impetus for this act was a recognition that Medicare payment to post-acute care (PAC) providers varied greatly even though the residents they cared for appeared to be quite similar. PAC providers include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies (HHAs).

Resident specific data must be submitted from each of these providers at the current time, but the instruments used vary widely: LTCHs submit a version of the Continuity Assessment Record and Evaluation (CARE) document; IRFs submit the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI); SNFs submit the Minimum Data Set (MDS); and HHAs submit the Outcome and Assessment Information Set (OASIS). The items and definitions on these documents vary widely. Without comparable information across PAC settings, policymakers and providers cannot determine whether patients treated and the care provided in different settings is, in fact, the same or whether one PAC setting is more appropriate than another. Without this information, it is difficult to move forward with PAC payment reforms.

The IMPACT Act is an extensive piece of legislation with many parts, most of which in some way will affect SNFs. In 2016, the use of quality data to inform hospital discharge planning will begin. In 2017, PAC providers must report standardized patient assessment data, data on quality measures and data on resource use so that standardized quality and resource use measure reporting can begin. In 2019, standardized assessment data will be required from all PAC providers. The PAC assessment instruments will be modified for the submission of standardized patient assessment data, which will enable assessment data comparison across all such providers.

By 2022, CMS and the Medical Payment Advisory Commission (MedPAC) must report to Congress on possible PAC payment systems that would be applicable to all PAC providers. This system is to establish payment rates according to the characteristics of individuals instead of according to the PAC setting where the Medicare beneficiary involved is treated. Achieving this goal will require tremendous changes in SNF activities over the years. (<https://www.govtrack.us/congress/bills/113/hr4994/text>)

Announcements

Therapy Caps

The Balance Budget Act of 1997 applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. For Calendar Year 2015, the allowed dollar amount is \$1,940 for physical therapy and speech-language pathology combined and \$1,940 for occupational therapy. (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3120CP.pdf)

5-Star Rating System Changes (cont'd)

(Continued from page 1)

of Quality Measures. The first additional measure, starting January 2015, will be the extent to which antipsychotic medications are in use. Future additional measures will include claims-based data on re-hospitalization and community discharge rates.

Timely and Complete Inspection Data: CMS will also strengthen requirements to ensure that states maintain a

DPW Becoming DHS

On September 24, 2014, Governor Tom Corbett signed House Bill 993 officially changing the name of the Department of Public Welfare (DPW) to the Department of Human Services (DHS). The new law will officially take effect in November, with a phased-in approach and measured transition to the new name beginning at that time.

Resident Data Reporting Manual (RDRM)

A revised version of the RDRM was released November 6, 2014 at www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_118067.pdf.



user-friendly website and complete inspections of nursing homes in a timely and accurate manner for inclusion in the rating system.

Improved Scoring Methodology: In 2015, CMS will revise the scoring methodology by which each facility's quality measure rating is calculated.