Medicare Updates and SNF Final Rule 2017

Thursday, August 25, 2016
10:15 – 11:15 am
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Objectives

1. Review the SNF PPS final rule for FY2017
2. Discuss Medicare hot topics and new regulations for SNFs
3. Report regulatory changes which affect skilled nursing facilities
SNF Final Rule 2017

- The SNF PPS Final Rule for fiscal year 2017 (which begins on October 1, 2016) was published in the Federal Register on August 5, 2016
- Includes payment changes for 2017, as well as updated on various quality reporting programs
Payment Changes

- Overall, the SNF PPS payments for FY2017 will increase by 2.4 percent, or $920 million over FY2016
  - Up from the projected 2.1% increase ($800 million) in the proposed rule
- This includes a 2.7 percent market basket growth rate increase, reduced by a 0.3 percent multifactor productivity adjustment
  - There is no forecast error adjustment for FY2017, as the actual market basket index increase for FY2015 was within 0.2% of the estimated increase, which is within the allowable threshold to not require an adjustment per statute
# Wage Index Changes

<table>
<thead>
<tr>
<th>Location</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
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<td>(0.0372)</td>
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<tr>
<td>Flint</td>
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<td>(0.0069)</td>
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<tr>
<td>Grand Rapids/Wyoming</td>
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<tr>
<td>Jackson</td>
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<tr>
<td>Kalamazoo/Portage</td>
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<td>Lansing/East Lansing</td>
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<td>(0.0163)</td>
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# Wage Index Changes

<table>
<thead>
<tr>
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<th>FY 2017</th>
<th>Difference</th>
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<tbody>
<tr>
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<tr>
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<td>(0.0026)</td>
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<tr>
<td>Rural Michigan (all other counties)</td>
<td>0.8380</td>
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<td>0.0002</td>
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# Rate Changes – Flint

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>650.12</td>
<td>662.58</td>
<td>12.46</td>
<td>1.92%</td>
</tr>
<tr>
<td>RVC</td>
<td>557.71</td>
<td>568.41</td>
<td>10.70</td>
<td>1.92%</td>
</tr>
<tr>
<td>RMC</td>
<td>426.93</td>
<td>435.12</td>
<td>8.19</td>
<td>1.92%</td>
</tr>
<tr>
<td>RLB</td>
<td>415.08</td>
<td>423.05</td>
<td>7.97</td>
<td>1.92%</td>
</tr>
<tr>
<td>ES2</td>
<td>612.83</td>
<td>624.60</td>
<td>11.77</td>
<td>1.92%</td>
</tr>
<tr>
<td>HB1</td>
<td>386.73</td>
<td>394.16</td>
<td>7.43</td>
<td>1.92%</td>
</tr>
<tr>
<td>CC2</td>
<td>354.97</td>
<td>361.78</td>
<td>6.81</td>
<td>1.92%</td>
</tr>
<tr>
<td>PA1</td>
<td>214.81</td>
<td>218.94</td>
<td>4.13</td>
<td>1.92%</td>
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</table>
## Rate Changes – Monroe

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>544.73</td>
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<td>(13.76)</td>
<td>(2.53%)</td>
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<tr>
<td>RVC</td>
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<td>(11.81)</td>
<td>(2.53%)</td>
</tr>
<tr>
<td>RMC</td>
<td>357.72</td>
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<td>(9.03 )</td>
<td>(2.52%)</td>
</tr>
<tr>
<td>RLB</td>
<td>347.80</td>
<td>339.02</td>
<td>(8.78 )</td>
<td>(2.52%)</td>
</tr>
<tr>
<td>ES2</td>
<td>513.49</td>
<td>500.54</td>
<td>(12.95)</td>
<td>(2.52%)</td>
</tr>
<tr>
<td>HB1</td>
<td>324.04</td>
<td>315.86</td>
<td>(8.18 )</td>
<td>(2.52%)</td>
</tr>
<tr>
<td>CC2</td>
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<td>289.92</td>
<td>(7.50 )</td>
<td>(2.52%)</td>
</tr>
<tr>
<td>PA1</td>
<td>179.99</td>
<td>175.45</td>
<td>(4.54 )</td>
<td>(2.52%)</td>
</tr>
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</table>
# Rate Changes – Grand Rapids/Wyoming

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>548.11</td>
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<td>28.10</td>
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</tr>
<tr>
<td>RVC</td>
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</tr>
<tr>
<td>RMC</td>
<td>359.94</td>
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</tr>
<tr>
<td>RLB</td>
<td>349.95</td>
<td>367.92</td>
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<td>5.14%</td>
</tr>
<tr>
<td>ES2</td>
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<td>5.14%</td>
</tr>
<tr>
<td>HB1</td>
<td>326.05</td>
<td>342.79</td>
<td>16.74</td>
<td>5.13%</td>
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<tr>
<td>CC2</td>
<td>299.27</td>
<td>314.63</td>
<td>15.36</td>
<td>5.13%</td>
</tr>
<tr>
<td>PA1</td>
<td>181.11</td>
<td>190.41</td>
<td>9.30</td>
<td>5.14%</td>
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</tbody>
</table>
## Rate Changes – Rural Michigan (Other Counties)

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>552.45</td>
<td>566.11</td>
<td>13.66</td>
<td>2.47%</td>
</tr>
<tr>
<td>RVC</td>
<td>467.30</td>
<td>478.85</td>
<td>11.55</td>
<td>2.47%</td>
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<tr>
<td>RMC</td>
<td>349.13</td>
<td>357.76</td>
<td>8.63</td>
<td>2.47%</td>
</tr>
<tr>
<td>RLB</td>
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<td>342.07</td>
<td>8.25</td>
<td>2.47%</td>
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<tr>
<td>ES2</td>
<td>482.87</td>
<td>494.80</td>
<td>11.93</td>
<td>2.47%</td>
</tr>
<tr>
<td>HB1</td>
<td>307.14</td>
<td>314.74</td>
<td>7.60</td>
<td>2.47%</td>
</tr>
<tr>
<td>CC2</td>
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<td>6.98</td>
<td>2.47%</td>
</tr>
<tr>
<td>PA1</td>
<td>173.54</td>
<td>177.83</td>
<td>4.29</td>
<td>2.47%</td>
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</table>
SNF Value Based Purchasing

- CMS finalized a new rehospitalization measure: SNF Potentially Preventable Rehospitalization (PPR)
- Required by the Protecting Access to Medicare Act of 2014 (PAMA)
- Program cuts 2% from SNF Part A payments, then the SNFs can earn it back in the form of a payment adjustment based on rehospitalization scores
- The final rule also finalized the calculation method of the rehospitalization score
SNF Quality Reporting Program (QRP)

- CMS finalized the 4 proposed new measures
  - Drug Regime Review – for FY2020
  - Average Cost per Medicare beneficiary – for FY2018
  - Potentially Preventable Rehospitalizations post-SNF discharge – for FY2018
  - Discharge back to the community after SNF admission – for FY2018
Other Medicare Hot Topics
PEPPER

- The current year Program for Evaluating Payment Patterns Electronic Report (PEPPER) became available in April.
- As of July 20, 2016, there were 425 PEPPERs available for Michigan providers, and only 235 (or 55.29%) have been downloaded.
- Provides an analysis of Medicare Part A claims data for specific areas that are considered to be at high risk for fraud, waste, and abuse.
- More information or to download your PEPPER: https://pepperresources.org/
Peer Groups for PEPPER

- TMF has added new tools for providers, including the Peer Group file
- Searchable by provider name or CCN (Medicare) number
- Sorts by urban/rural, ownership type, and indicates number of total episodes
  - Smallest 1/3 number of episodes of care (33.4%) – 1 – Smallest 1/3 of SNFs
  - Middle 1/3 number of episodes of care (33.3%) – 2 – Middle 1/3 of SNFs
  - Largest 1/3 number of episodes of care (33.3%) – 3 – Largest 1/3 of SNFs
## Peer Group Example

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>CMS Cert Number</th>
<th>Location</th>
<th>Ownership</th>
<th>Total number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tall Ship Nursing Facility</td>
<td>000000</td>
<td>Urban</td>
<td>Nonprofit/church</td>
<td>Smallest 1/3</td>
</tr>
</tbody>
</table>
Target Area: Therapy RUGs with High ADL

Total Episodes

- 80th Percentile:
  - Smallest 1/3: 19.2%
  - Middle 1/3: 22.0%
  - Largest 1/3: 49.5%

- 50th Percentile:
  - Smallest 1/3: 34.7%
  - Middle 1/3: 33.6%
  - Largest 1/3: 45.5%

- 20th Percentile:
  - Smallest 1/3: 20.7%
  - Middle 1/3: 32.0%
  - Largest 1/3: 49.6%
Target Area: Therapy RUGs with High ADL

Location

80th Percentile

50th Percentile

20th Percentile

Urban  Rural

46.8%  51.3%
32.3%  36.0%
20.2%  22.2%
Target Area: Therapy RUGs with High ADL

Ownership Type

- 80th Percentile:
  - Nonprofit/Church: 18.2%
  - Government: 47.3%
  - Forprofit/Phys: 48.9%

- 50th Percentile:
  - Nonprofit/Church: 30.6%
  - Government: 32.9%
  - Forprofit/Phys: 45.4%

- 20th Percentile:
  - Nonprofit/Church: 21.7%
  - Government: 34.1%
  - Forprofit/Phys: 30.6%
Provider Revalidation

- Medicare providers must revalidate their enrollment every 5 years (DME suppliers must do so every 3 years)
- Cycle 2 of revalidation is beginning, with a new look up tool: [https://data.cms.gov/revalidation](https://data.cms.gov/revalidation)
- Providers can check by their enrollment revalidation status by name or NPI
- The tool will list the revalidation due date or “TBD” if it is not due within approximately 6 months
- MACs will still send notifications, but CMS urges providers to check the look up tool monthly to determine if they are up for revalidation
Provider Revalidation

- Failure to revalidate will result in the provider number being deactivated
  - Providers will be able to reactivate and get the same provider transaction access number (PTAN) number
  - However, they will not be able to retroactively submit Medicare claims during the period in which they were deactivated
- Revalidation can be done on the Provider Enrollment, Chain, and Ownership System (PECOS)
- Change of ownership and other change of information must be completed separate from revalidation
New Recovery Audit Contractors

- Coming soon...new Recovery Audit Contractors (RACs)
- CMS is currently in the procurement process for the next round of RACs
- Current RACs are to follow the timeline on the next slide
New Recovery Audit Contractors

- May 16, 2016 - the last day that a RAC could send Additional Documentation Request (ADR) letters or semi-automated notification letters
- July 29, 2016 - the last day that a RAC may send notification of an improper payment to providers. This includes sending a review results letter or no findings letter, and/or providing a portal notification to each provider.
- August 28, 2016 – RACs will complete all discussion periods that are in process by this date. RACs continue to be required to hold claims for 30 days, starting with the date of the improper payment notification (via letter or portal) to the provider, to allow for discussion period requests.
- October 1, 2016 - the last day a RAC may send claim adjustment files to the MACs.
Conditions of Participation

- The proposed rule regarding the Requirements of Participation in Medicare and Medicaid for LTC facilities was released in July 2015: they have not be updated since 1991
- The proposed rule touched upon many different areas revolving around patient care
- Patient centered care plans
  - Better discharge and transition planning
  - Quality of care and quality of life for our residents
- Providers need to keep watch out for the Final Rule, which will probably be released before the end of the year in 2016
PROPOSAL

Conditions of Participation

- Stresses the importance of an interim care plan while completing the MDS: a baseline interim care plan must be developed upon admission to all proper and professional, care and services immediately
- Adding Nursing Assistant to the required personnel attending of the interdisciplinary team
- If there are behavioral or mental issues, a mental healthcare professional must be included as part of the interdisciplinary team
PROPOSAL
Conditions of Participation

- Services provided must be culturally competent and trauma-informed
- Competencies for nursing staff
- Increase number of RNs
- Development of a QAPI plan that focuses on systems of care, outcomes and services
PBJ
Payroll Based Journal (PBJ)

- Not the happy sandwich, but a labor intensive requirement for staffing and census
  - Hours worked by each person whether employed or by contract
- Staff turnover: start and end dates of employee whether facility employed or by contract
- Census information on the last day of each month
# PBJ - Submission schedule

<table>
<thead>
<tr>
<th>Fiscal Quarter</th>
<th>Date Range</th>
<th>Deadline for Submission</th>
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<tbody>
<tr>
<td>1</td>
<td>October 1 – December 31</td>
<td>February 14</td>
</tr>
<tr>
<td>2</td>
<td>January 1 – March 31</td>
<td>May 15</td>
</tr>
<tr>
<td>3</td>
<td>April 1 – June 30</td>
<td>August 14</td>
</tr>
<tr>
<td>4*</td>
<td>July 1 – September 30</td>
<td>November 14, 2016</td>
</tr>
</tbody>
</table>

Must submit data by the end of the 45th calendar day of the quarter end. The end of the calendar day is 11:59 PM EST.
Facility is held responsible for accuracy even if an outside agency is utilized for the submission

Noncompliance will result in enforcement action by CMS
  - Though not yet identified, CMS indicated they will use a ”full array of remedies” to enforce non compliance

No guidance for self identified errors is available:
  - Take as much of the 45 days to check the accuracy before submitting
  - Establish a QA or QAPI activity to oversee the process
PBJ – Answers

- Only long term care nursing facilities report hours paid for direct care services performed onsite by those employed or by contract
  - Lunch, vacation time, sick leave are not reported
  - Therapists, Medical Director, nurses, CNA, etc. are examples of those whose time is included
  - Based on the calendar, not the shift

- Direct Care Staff are those individuals who provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being through interpersonal contact with residents or resident care management
PBJ – Answers

- Reporting of time is based on the primary role or duty of the person
  - If multiple roles, the time should be divided between different labor codes and descriptions
  - If non-primary duties occur throughout the day, base it on the primary code
- Data must be auditable and verifiable
  - Develop a mechanism for identifying the specific reportable time for each person
  - For Medical Director, do not report time spent with patient
- Do not report any time that is billed to a third party payer
PBJ – Answers

Updates to the RAI Manual
New Item Set

- PPS Discharge Assessment
  - Required each time a resident ends their Medicare Part A stay whether they remain in the facility or not
  - Only on planned discharges
  - Refers only to traditional Medicare, but check with MA plan to ensure they don’t require one as well
  - Does not eliminate the need for an OBRA discharge assessment when the resident actually leaves the facility or moves to a non-certified section
Different ARDs depending on whether combined or not

**Standalone**

The ARD is the same as the Part A end date: the resident is discharged from Medicare Part A but remains in the facility and the same as the discharge date at A2000.

**Combined with an OBRA Discharge**

- The ARD is equal to the discharge date.
- Only if the discharge is planned and the discharge date from the facility occurs on the day of, or one day after the end of the most recent Medicare stay.
- Must be completed within 14 days of the end of the most recent Medicare Part A stay
- Must be submitted within 14 days of the completion dated
- If the end date of the Part A Medicare Stay is day 7 of the COT observation period, the PPS discharge assessment must be combined with the COT if required
Related to Delirium

- Minor but significant change
  - Deletes psychomotor retardation
  - Combines C1300 with C1600
Related to Delirium

- Section C1310A
  - Must have a baseline to code whether there is an acute change in mental status
- Examples
  - A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive
  - A resident who is normally quiet and content suddenly becomes restless or noisy
  - A resident who is usually able to find his or her way around the unit begins to get lost
Acute onset mental status change

Item 1310A=1

OR

Item 1310B, 1310C, or 1310D = 2

AND

Item 1310B= 1 or 2

AND

Either Item 1310C= 1 or 2
OR
1310D= 1 or 2

Inattention
Disorganized thinking
Altered level of consciousness
More Accurate Determination of Injury

- Often an injury is not noted at the time of a fall
- For better care planning and more accurate MDS information, there must be follow-up after a fall
- Should there be an injury that is identified after the MDS is completed and accepted in the QIES ASAP, a modification must be completed
There are 3 actual assessment fields to be done
- 1) The admission performance & 2) discharge goal completed at the time of admission
- 3) The discharge performance completed at the time of discharge

Section GG is only completed on a 5-day PPS assessment for residents on a Part A Medicare stay whether or not the activity was attempted at the time of admission
Admission performance & Discharge Goal

- Are completed at the start of admission if the assessment is a 5-day PPS Assessment for a resident on a Medicare Part A stay as indicated by the Start of Medicare Stay date in A2400B
- Days 1-3 of admission date in A2400B
Discharge Performance

- The last 3 days of the SNF PPS Stay (A2400C) and only if
  - The discharge is planned
  - The assessment is coded a SNF Part A PPS discharge assessment
  - The end date for the Medicare stay is more than 2 days from the start of the Medicare stay date
  - The person was not discharged to an acute care setting
## PPS Assessments

### A0310. Type of Assessment

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<tr>
<th>Enter Code</th>
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<tr>
<td>0 1</td>
<td><strong>PPS Scheduled Assessments for a Medicare Part A Stay</strong></td>
</tr>
<tr>
<td></td>
<td>01. <strong>5-day</strong> scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>02. <strong>14-day</strong> scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>03. <strong>30-day</strong> scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>04. <strong>60-day</strong> scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>05. <strong>90-day</strong> scheduled assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>G. Type of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Complete only if A0310F = 10 or 11</td>
</tr>
<tr>
<td></td>
<td>1. Planned</td>
</tr>
<tr>
<td></td>
<td>2. Unplanned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>H. Is this a SNF Part A PPS Discharge Assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
## PPS Assessments

### A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Community (private home/apt., board/care, assisted living, group home)</td>
</tr>
<tr>
<td>02</td>
<td>Another nursing home or swing bed</td>
</tr>
<tr>
<td>03</td>
<td>Acute hospital</td>
</tr>
<tr>
<td>04</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>05</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>06</td>
<td>ID/DD facility</td>
</tr>
<tr>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>08</td>
<td>Deceased</td>
</tr>
<tr>
<td>09</td>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
</tbody>
</table>

### A2400. Medicare Stay

**A.** Has the resident had a Medicare-covered stay since the most recent entry?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No → Skip to B0100, Comatose</td>
</tr>
<tr>
<td>1</td>
<td>Yes → Continue to A2400B, Start date of most recent Medicare stay</td>
</tr>
</tbody>
</table>

**B.** Start date of most recent Medicare stay:

- **01 15 2016**

**C.** End date of most recent Medicare stay - Enter dashes if stay is ongoing:

- **10-31-2016**
Definitions

- Each activity is defined differently than those in Section G
- The terms are similar to therapy terms, but different
- There is no resemblance to what direct care staff is used to coding
- The assessor is looking at the same activities at two different times during the stay: using the same coding and description of the activity
Definitions

SELF-CARE

- Eating

- Oral hygiene

- Toilet hygiene
Definitions

MOBILITY

- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet transfer
- Does resident walk

- Use scooter or wheelchair
- Wheel 50 feet with 2 turns
- Manual or motorized chair

- Wheel 150 feet
- Manual or motorized chair

50 feet with 2 turns

150 feet
## Coding Definitions

<table>
<thead>
<tr>
<th>Independent</th>
<th>Setup or clean-up assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Resident completes the activity by him/herself</td>
<td>☐ Helper sets up or cleans up – only assists prior to or after</td>
</tr>
<tr>
<td>☐ No assistance from a helper</td>
<td>☐ Resident completes the activity</td>
</tr>
<tr>
<td>☐ 06</td>
<td>☐ 05</td>
</tr>
</tbody>
</table>
Coding Definitions

**Supervision or touching assistance**

- Helper provides verbal cues or touching as resident completes the activity
- Assistance may be throughout or intermittent
- 04

**Partial/moderate assistance**

- Helper does less than half the effort
- Helper lifts, holds, or supports trunk or limbs
- 03
Coding Definitions

**Substantial/maximal assistance**

- Helper does more than half the effort
- Helper lifts, holds, or supports trunk or limbs
- 02

**Dependent**

- Helper does all the effort
- Resident does none of the effort OR
- The assistance of 2 or more helpers is needed to complete the task
- 01
If the activity was not attempted code reason:

- Resident refuse-07
- Not applicable-09 if the resident did not perform this activity before
- Not attempted due to medical condition or safety concerns-88
Definitions

- Helper is defined as
  - Facility staff, direct employees
  - Facility-contracted employees
  - Not those who are hired and compensated by other than facility management

- Usual performance
  - Baseline performance
  - Resident’s usual activity or performance
Instructions

- Based on direct observation, resident’s self-report, family and direct care staff reports
- May be completed with or without assistive devices
- Base coding on usual performance during the 3 days, not the most independent or dependent
- Coding is based on whether or not assistance is required because resident’s performance is unsafe or of poor performance
Whether pressure ulcers stage 2-4 and unstageable were present on admission or entry/reentry has been added to the discharge assessment item set and the new Part A End of Stay assessment.
The addition of the requirement to code medications received during the last 7 days by *pharmacological classification* should be helpful in identifying the type of medication coded
The new discharge from Medicare assessment has been added to the choices for doing a correction.

<table>
<thead>
<tr>
<th>Section X</th>
<th>Correction Request</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X0600. Type of Assessment - Continued</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td><strong>D. Is this a Swing Bed clinical change assessment?</strong> Complete only if X0150 = 2</td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td><strong>F. Entry/discharge reporting</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>01. Entry tracking record</td>
<td></td>
</tr>
<tr>
<td>10. Discharge assessment-return not anticipated</td>
<td></td>
</tr>
<tr>
<td>11. Discharge assessment-return anticipated</td>
<td></td>
</tr>
<tr>
<td>12. Death in facility tracking record</td>
<td></td>
</tr>
<tr>
<td>99. None of the above</td>
<td></td>
</tr>
<tr>
<td><strong>H. Is this a SNF PPS Part A Discharge (End of Stay) Assessment?</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>
SNF Quality Reporting Program (QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- The IMPACT Act of 2014 mandated the establishment of the SNF QRP
- The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16
  - 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 from the FY 2018 reporting year
  - 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
Reporting of standardized quality measures must begin by October 1, 2016 for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)

Home Health Agencies (HHAs) must begin reporting by January 1, 2017
Process Measures

- Indicate what a provider does to maintain or improve the residents health:
  - The numerator is the number of people in the denominator who received the care process
  - The denominator is the number of residents cared for during a defined period of time we were at risk of or eligible for the numerator event or outcome: Only Part A stay residents
  - Higher quality is indicated by
    - A larger numerator relative to the denominator for desirable care process
    - A smaller numerator relative to the denominator for undesirable care process
Outcome Measures

- Reflects the impact of interventions on the person’s health status:
  - The numerator is the number of residents in the denominator who experienced the specified outcome
  - The denominator is the number of residents cared for during a defined period of time we were at risk of or eligible for the numerator event or outcome: Only Part A stay residents
- Higher quality is indicated by
  - A larger numerator relative to the denominator for positive outcomes
  - A smaller numerator relative to the denominator for adverse outcomes
Definitions

- Incomplete stays are those residents who
  - Who are discharged unexpectedly due to a medical emergency,
  - Who leave the SNF against medical advice, or
  - Who die while in the SNF

- Residents not meeting the criteria for incomplete stays will be considered complete stays

- Risk adjustments
  - **Exclusions**: Residents whose outcomes are not under SNF control or for whom the outcome maybe unavoidable are removed from the calculation.
  - **Stratification**: Residents with similar risks for the outcome based on their clinical characteristic sare grouped together, and the measure is calculated separately for each risk group.
  - **Covariates**: Resident characteristics that may affect risk for a certain outcome.
Assessments

- OBRA-required
- Scheduled PPS
- Discharge
  - Discharge assessment – return not anticipated
  - Discharge assessment – return anticipated
  - Part A PPS Discharge assessment
Quality Reporting Program

Table 1: Previously finalized SNF QRP measures affecting FY 2018 payment determination

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Resulting changes to MDS 3.0</th>
<th>Data collection period for FY 2018 payment determination</th>
<th>Data submission deadline for FY 2018 payment determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of Percent of Patients or Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</td>
<td>MDS 3.0</td>
<td>None. The items used to calculate the measure have been included on the existing MDS 3.0 item sets as part of the CMS’s Nursing Home Quality Initiative (NHQI) since 2010. Items for this measure are included in the SNF Part A PPS Discharge Assessment.</td>
<td>10/01/16- 12/31/16</td>
<td>05/15/17</td>
</tr>
<tr>
<td>Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF #0678)</td>
<td>MDS 3.0</td>
<td>None. This measure is the same measure that nursing homes have been reporting for short stay residents through CMS’s NHQI since 2010. The items used to calculate this measure are also the same. Items for this measure are included in the SNF Part A PPS Discharge Assessment.</td>
<td>10/01/16- 12/31/16</td>
<td>05/15/17</td>
</tr>
</tbody>
</table>
## Quality Reporting Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Resulting changes to MDS 3.0</th>
<th>Data collection period for FY 2018 payment determination</th>
<th>Data submission deadline for FY 2018 payment determination</th>
</tr>
</thead>
</table>
| Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) | MDS 3.0     | **Addition of Section GG.**
New functional status items assessing self-care and mobility activities are used to calculate this measure. Section GG will appear in the October 1, 2016 MDS 3.0. Section GG is included in the SNF Part A PPS Discharge Assessment. | 10/01/16- 12/31/16 | 05/15/17 |
Questions and Discussion
About Marcum

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