Questions and Answers from Open Door Forum: Skilled Nursing Facilities/Long Term Care, 08/06/2020

1. I'm just trying to understand that 5% cap. It's for the decrease. Is there a cap on an increase? So if the decrease was over 5% would it allow that or is it also capped at 5%?
    - **a.** The cap is only on the decreases. It is not on the increase side. So if you had an increase of 10% in your rate index, that's a 10% increase. But if you had a decrease of 10% then for fiscal year 2021 it would be capped at 5%.
        - **i.** We'll also see the wage unit values in the file. They're going to be different based upon those that are moving from rural-to-urban and urban-to-rural. So like in 99901, could have a different wage index in it based upon another location coming into it.
            - **1.** If you had a provider in that (CBSA) area, who generally remain the same, then the regulate indices that had been posted reflect the 5% decline. However, you might have providers move from urban to rural or that had moved from one PPS base to another. There may be differences for certain providers. Also, if you have a new provider that say, opens up in fiscal year 2021. They, you know, since the decrease policy only applies to those that have experienced a decrease, then obviously they wouldn't experience a decrease in so much as they are a new provider. there will be some differences for certain providers. And this is something that the (MACs) are very well aware of. And so we would encourage anyone that has questions about their specific wage index, for their specific situation to reach out to their (MAC) and they should be able to provide them with that.
                - **a.** But those are reflected in that wage index file. For those of us that are vendors, it's reflected in that file. It's not necessarily a provider-to-provider basis. Is that correct?
                    - **i.** Correct. It's on the (CBSA) level. It is not on our provider level. So individual buyers might be different but that final provides that 5% cap at the CBSA level.
2. I understand that the quality measures are now only reflecting through quarterly for 2019. When can we expect a change in our quality measures? For example, we see in our second quarter of 2020 we're going to be five stars. For how long? I mean usually, it's six months behind. For how long at this point are we going to be looking at the quality measures through 2019?
    - **a.** Has not yet been determined.
3. Just a follow up on the MDS or the (RII) updates. If we could get an estimation of when the (RII) manual will be posted. And then secondly as you know the question, some of the questions that the states may require related to capturing PDPM information for comparison and so forth from section I and from section J particularly relates particularly to the preceding hospital sta. The most recent Medicare stay or the qualifying stay throughout the guidelines. And my question is related to those items. Will CMS give us

guidelines in relationship to how those will apply to long term care patients or will the states be required to give us specific coding guidelines related to that?

- **a.** At this moment we are not going to issue a new MDS manual. The coding will remain the same other than the language that has changed on the item set. So for example, I believe it's item I 0020 that speaks to the SNF -- the hospital stay preceding the SNF day. That item is specific to the SNF stay. That's how it was tested. That's how it's used in the PDPM calculation. There certainly are going to be some differences in terms of items that were specifically designed for use for Part A patients that had had a qualifying stay that preceded this. And certainly when you have a first step in a long-term stay that's not likely to occur or at least not necessarily to occur. And so I think there have been some changes that were made to the MDS items like. So I would encourage you to take a look at those. And then we can always circle back regarding if you feel like the manual needs any additional information or clarification or if we should if there's something else we should be considering. But I think that the item sets were adapted to try and help to adjust for some of that.
    - **i.** Because the item set and the instructions haven't changed and they were designed specifically for part A situation -- Medicaid Part A situation -- for the long-term care patient which is going to be the majority of the time, you know, the states were looking to compare this information related to their legacy systems currently for drugs, you know, compared to PDPM and adjusting case mixes and so forth in anticipation of (GE) being gone and other kinds of things happening. Are the states going to give us instructions or will CMS give us more specific instruction on how those particular items will relate to those long-term stand-alone quarterlies and comprehensive assessments?
        1. If you think about what the purpose of this item is, it's to identify instances in which a SNF patient has received a recent surgery that could impact on their care trajectory. Because, you know, you may have patients that have the same diagnosis but one that received a surgical intervention during the preceding hospital stay may have a different care trajectory and from our analysis have a different cost trajectory than a patient that received a non-surgical intervention, which is why the system was designed to adapt to those differences. If you have a person on a long-term stay the chances that they had a recent surgery is pretty low. And the manual provides guidelines for what defines that recent surgery. And so even though the item sort of still exists in a similar fashion to what it did, the guidelines set around what defines that recent hospitalization should help the states to clarify when that item should be covered and providers as well to define when the item should be covered and when not. Because if a person had a surgery, nine months ago and hasn't been to the hospital, it's unlikely that that surgery is something that is affecting their current care trajectory nine months later. From a simple PDPM classification perspective, that wouldn't be the type of surgery that

you would want to code on the MDS position classification. So I think understanding the nature of intent of that item helps to filter when that item should be coded and when not.

   a. So basically we would just answer no in those cases where there wasn't a recent survey. Or for instance again on section I at I20B it's again related to the, preceding hospital stay in particular. And I guess that's just been a lot of people's questions as to how that might relate to a long-term care patient. So what you're saying is in J, we would just answer no but for I20B where we're required to put in an ICD-10 code, that's a bit of a different scenario.
      i. Right. For I20B you would still want to have the ICD-10 code that represents their primary diagnosis because that's obviously the primary diagnosis. It's still very relevant to the patient classification. But in terms of surgeries, a non-recent surgery is unlikely to be related to their cost and care trajectory. So that wouldn't be something that you would want to pass on and classify them under.

4. First question: Because of that increased cost of PPE and the requirements especially in California to increase and continue to increase the isolation for patients, will there be a change for that isolation guideline for coding for MDS? Second question: That funding that was released on July 22, it indicated that that is completion of training will be an additional requirement, can receive that additional funding. Is that in the educational module, the 23 educational module being mentioned in that funding information? Is that the one that's already being released for infection control (petitioner) or is that in addition to that? The third question: the testing machines that we're really facing a mess. Is there any communication with state regulators, the regulator particularly in California? Since in California, we have specific regulations requiring for tests, test machines, even for point of care to be at least 90 95 specificity and sensitivity.
   a. I can speak to the first question. And the answer is that we are not we're not planning at this time to make any changes to our equation coding guidance. That will remain as it is.
   b. We are currently working to in conjunction with CDC to get a frequently asked questions document regarding testing, which we anticipate to be posted very shortly.
5. Were the states given a certain timeline to opt into using the PDPM items in order to do the comparison? And if so, how will that be communicated to the states? Would that be the individual state's responsibility if they choose to use that? Second question is, where those items that are asked that relate specifically to the Medicare Part A quality measures, will they continue - will they also be asked and be a part of that or will it only be those item set items I should say in the item set sort of quarterly or for the comprehensive that will be required just to be able to generate that PDPM rate?
   a. We have requested that the states notify us so that we can update the key system to accommodate for the PDPM by October 1. However, states will have the ability to request the PDPM after October 1. Let's say New Jersey did not opt for

PDPM for this October 1. They could come October 9 say yes, we want to start collecting those items for December, yes, for December 1 of 2020. So they will have that capability. Our system is not created yet or it's been updated to allow them to go in and do that. The second is the only items that I can recall off the top of my head that are going to be active will be the GG01 30 column 1 and the GG01 70 column 1. The I0020, the J2100 and then the J2300 to J5000 series. But they are for PDPM. They're not for measures.

6. For the payroll-based journal updates, my first question was what was the waiver that is going away. Second question was when do the facilities need to start reporting again. And the third question was what was the timeframe they need to report.
    a. So the waiver basically applied to the data from January through March. It would have been submitted on May 15th. And we waived that May 15th deadline. And although submission of that data is not mandatory, we are encouraging facilities to submit that data when they can. We are not using that in the calculation of the five-star ratings that we will be posting it in the public use files on data.medicare.gov. The next submission deadline is August 14th and August 14th is data from April 1st through June 30th.
        i. And was that going to be updated on the PBJ website that's linked to in the agenda? Because I went to that under and what's new that information is not there.
            1. For change the deadlines were always the same. And those, the submission deadlines are posted on the PBJ website.
7. My question is regarding clarification of the 1135 waiver regarding the three-day qualifying hospital stay. Is this a complete waiver for the entire country no matter whether you are in a high infection rate or not? If your hospital has no infection rate does this waiver still apply?
    a. That is correct.
8. Will there not be a new (RAI) manual issued? And my question maybe comment is will the survey teams be aware of that. Oftentimes when they're onsite doing survey they'll ask to see the current RAI manual that's being used. So when they move in and do surveys after the first of the year, they're still going to see October 2019 because there's no manual? When is an updated appendix TP be posted?
    a. I will be sure to communicate with the survey team that there will not be a release of the RAI manual and they will continue to use the 2019 version. And as far as your second question, Appendix TP we are working to get appendix TP updated and released but we do not have a release date for it at this time.
9. The wage index posting at the wage index website when you all posted the wage indexes for the proposed rule was tremendously helpful. It had a lot of the tables that were similar to what was in the past and it also had sort of an appendix or another tab there that gave a really nice comparison table to the changes that occurs. It's a lot easier to read. The one that got posted with the final rule was a little bit more scaled-down. Wondering just as a suggestion if you guys might be able to post a similar table that you had for the proposed rule.
    a. We'll definitely look into that. Thank you.