Agenda

- Overview
- Fundamentals of Accurate Assessments
- RUG/PDPM Nursing Categories
- Determining Medicaid Only Case Mix Scores
- Monitoring Medicaid Resident Acuity
- What Next?

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Why Change?

- This version of the MDS 3.0 contains substantial revisions related to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which requires that standardized assessment items be collected across post-acute care (PAC) settings.
- Standardized data will enable cross-setting data collection, outcome comparison, exchangeability of data, and comparison of quality within and across PAC settings.

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Why Change?

- WHY?
  - SPADES: Standardized Patient Assessment Data Elements
  - Retire Section G
- When?
  - The new item set will be used with any assessment with an ARD on or after October 1, 2023

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Section G: To Be Retired 10/1/23

- Implications?
  - Ohio Medicaid Case Mix
  - Ohio Medicaid Quality incentive Program
  - Quality Measures
  - Care Area Assessment triggers and worksheets
  - Care planning language

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Options for Case Mix States that Use RUGs

- Ultimately, CMS will require states who use RUGs for their case mix methodology to transition to PDPM or to develop a state supported infrastructure
- CMS is allowing states a two year transition where they can continue to use RUGs through the use of the Optional State Assessment
- Ohio Medicaid decision timeline

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Utilizing the Optional State Assessment

- CMS to provide OSA item set and manual instructions between now and of May

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Differences Between RUG IV and PDPM

- Ohio would use only the nursing component of PDPM to establish case mix scores
- The PDPM Nursing Component would not recognize therapy scores
- PDPM uses a function score calculated from Section GG instead of a late-loss ADL score calculated from Section G

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What Should I do to Prepare?

- Improve assessment accuracy to capture higher non-therapy RUG scores
- Improve Section GG coding, especially for items that "map" to the late loss ADLs
- Decide how you want to assign duties if we need to complete both Section GG and the late loss ADL items (bed mobility, toilet use, transfer and eating)
- Watch for CMS release of the OSA package and Ohio Medicaid decision on OSA vs. PDPM
- Improve interviewing skills
- Establish/improve process for monitoring acuity between assessments

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Function Score vs. ADL Score

- Eating = Eating (GG0130A)
- Toilet Use = Toileting Hygiene (GG0130C)
- Bed Mobility = Average of:
  - Sit to lying (GG0170B)
  - Lying to sitting on side of bed (GG0170C)
  - Sit to stand (GG0170D)
- Transfer = Average of:
  - Chair/bed-to-chair transfer (GG0170E)
  - Toilet transfer (GG0170F

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Fundamentals of Accurate Assessments

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What is an Accurate Assessment?

- The RAI process has multiple regulatory requirements.
- Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that
  - **(1) the assessment accurately reflects the resident's status**
  - (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
  - **(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.**

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What is an Accurate Assessment?

- In addition, an accurate assessment **requires collecting information from multiple sources**
- Those sources must include the **resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable.**
- It is important to note here **that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy** (what the resident's actual status was during that observation period) by the IDT completing the assessment.

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What is an Accurate Assessment?

- Nursing homes are left to determine
  - (1) who should participate in the assessment process
  - (2) how the assessment process is completed
  - (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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Steps for Assessment

- Talk to the resident
- Talk to the family/significant others
- Talk to the staff
- Review the record
- Observe yourself

- Pay attention to the specific look back period and item specific coding instructions

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MDS Accuracy

- MDS manual contains definitions, instructions, clarifications and examples critical to accurate completion of the MDS
- Assessment Reference Date (ARD) is critical to accurate assessments
- MDS is a functional assessment

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MDS Accuracy

- Updated MDS Manual
  - Most recent update: September, 2019
  - Substantial changes in draft posted April 1, 2023
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- Errata Document (?)

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Assessment Reference Date

- MDS accuracy: assessment must match the resident as of the assessment reference date
- Assessment reference date is the common date from which each participant in the assessment will count back the designated number of days for their section to establish the observation period
- MDS is a snapshot based on the ARD

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Impact – Return Anticipated vs. Not Anticipated

- Return Anticipated
  - Resident remain is case mix score
  - Resident remains in current episode for QMs
  - Only reentry tracking and possibly significant change assessment on reentry
- Return Not Anticipated
  - Resident excluded from case mix, ends current episode for QMs
  - Treated as new admission upon return

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RUG IV/PDPM Nursing Categories

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Nursing Category Hierarchy

- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavior and Cognition
- Reduced Physical Function

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Extensive Services

- Residents satisfying the following two conditions:
  - Having a minimum ADL score of 2 or higher.
  - **While a resident**, receiving :
    - tracheostomy care,
    - ventilator/respirator, and/or
    - infection isolation.

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Isolation Requirements and MDS Coding

- RAI User's Manual, page O-5 states: Code for "single room isolation" only when **all of the following conditions** are met:
  - 1. The resident **has active infection** with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
  - 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect
  - 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in a room alone **and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation**
  - 4. The resident must remain in his/her room. This requires that all services be brought to the resident

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Extensive Services Issues

- Clearly document each of the four criteria for isolation have been met

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Extensive Services

- ES3 Ventilator AND trach care 6.4889
- ES2 Ventilator OR trach care 4.9111
- ES1 Isolation/Quarantine 4.0667

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Special Care High

- Residents satisfying the following two conditions:
  - Having a minimum ADL score of 2 or more.
  - Receiving any of the following:
    - comatose,
    - septicemia,
    - diabetes with insulin injections and insulin order changes,
    - quadriplegia with ADL score of 5 or more
    - Asthma, chronic obstructive pulmonary disease (COPD) or lung disease with shortness of breath when lying flat,
    - fever with pneumonia, vomiting, weight loss, or tube feeding*
    - parenteral/IV feeding, or
    - respiratory therapy 15 minutes per day, 7 out of the last 7 days.

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Special Care High Issues

- Septicemia during hospitalization
- Monitor people with DMII for insulin order changes
- Fever: baseline temp plus 2.4 degrees
- Asthma, COPD or lung disease with SOB when lying flat
  - What do you code as other lung disease?
  - How do you assess shortness of breath?

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J1100: Shortness of Breath

- Steps for Assessment: Interview the resident about shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.
  - 1. If the resident is not experiencing shortness of breath or trouble breathing during the interview, **ask the resident** if shortness of breath occurs when he or she engages in certain activities.
  - 2. **Review the medical record** for staff documentation of the presence of shortness of breath or trouble breathing. **Interview staff** on all shifts, **and family/significant other** regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
  - 3. **Observe the resident** for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
  - 4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

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J1100: Shortness of Breath

- Coding Instructions:
  - Check J1100C: if shortness of breath or trouble breathing is present when the resident attempts to lie flat. **Also code this as present if the resident avoids lying flat because of shortness of breath.**

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Special Care High Issues, Continued

- Respiratory Therapy 15 minutes per day 7 out of the last 7 days
- Count only time clinician spent with the resident
- Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.

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Special Care High Issues, Continued

- Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse.
- A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws

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Special Care High

HE2 (15-16, depressed)	4.2444
HE1 (15-16, not depressed)	3.3111
HD2 (11-14, depressed)	3.7333
HD1 (11-14, not depressed)	2.9778
HC2 (6-10, depressed)	3.4444
HC1 (6-10, not depressed)	2.7333
HB2 (2-5, depressed)	3.3111
HB1 (2-5, not depressed)	2.6889

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Special Care Low

- Residents satisfying the following two conditions:
  - Having a minimum ADL score of 2 or more.
  - Receiving any of the following:
    - cerebral palsy with ADL score of 5 or more,
    - multiple sclerosis with ADL score of 5 or more,
    - Parkinson's disease with ADL score of 5 or more,
    - respiratory failure and oxygen therapy while a resident,
    - tube feeding,*
    - ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or stage II or higher pressure ulcers,
    - ulcer treatment with any stage III or IV pressure ulcer,
    - foot infections or wounds with application of dressing,
    - radiation therapy while a resident, or
    - dialysis while a resident.

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Special Care Low Issues

- While a resident vs. while not a resident in Section O
  - If a resident has not met the definition of "discharge", they are still a resident
  - Can capture services and treatments provided as an outpatient
  - Can capture services and treatments provided in the ER if never admitted to the hospital and returns within 24 hours

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Special Care Low

- LE2 (15-16, depressed) 3.6000
- LE1 (15-16, not depressed) 2.8222
- LD2 (11-14, depressed) 3.4444
- LD1 (11-14, not depressed) 2.7333
- LC2 (6-10, depressed) 2.8444
- LC1 (6-10, not depressed) 2.2667
- LB2 (2-5, depressed) 2.6667
- LB1 (2-5, not depressed) 2.1111

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Clinically Complex

- Residents receiving any of the following:
  - pneumonia,
  - hemiplegia with ADL score of 5 or more,
  - surgical wounds or open lesions with treatment,
  - burns,
  - chemotherapy while a resident,
  - oxygen therapy while a resident,
  - IV medications while a resident, or
  - transfusions while a resident.

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Clinically Complex

CE2 (15-16, depressed)	3.0667
CE1 (15-16, not depressed)	2.7556
CD2 (11-14, depressed)	2.8889
CD1 (11-14, not depressed)	2.5778
CC2 (6-10, depressed)	2.4000
CC1 (6-10, not depressed)	2.2333
CB2 (2-5, depressed)	2.0889
CB1 (2-5, not depressed)	1.8889
CA2 (0-1, depressed)	1.6222
CA1 (0-1, not depressed)	1.4222

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Behavioral Symptoms and Cognitive Performance

- Residents satisfying the following two conditions:
  - Having a maximum ADL score of 5 or **less.**
  - Having behavioral or cognitive performance symptoms, involving any of the following:
    - difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status <=9),
    - difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale >=3),
    - hallucinations,
    - delusions,
    - physical behavioral symptoms toward others,
    - verbal behavioral symptoms toward others,
    - other behavioral symptoms,
    - rejection of care, or
    - wandering.

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Behavioral Symptoms and Cognitive Performance

- BB2 (2-5, 2+ RNP) 1.8222
- BB1 (2-5, 0-1 RNP) 1.6667
- BA2 (0-1, 2+ RNP) 1.2889
- BA1 (0-1, 0-1 RNP) 1.2000

- Restorative nursing programs must be at least 15 minutes over the course of the day, provided at east 6 out of the last 7 days

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Reduced Physical Function

- Residents whose needs are primarily for support with activities of daily living and general supervision.
- (Residents who didn't group anywhere else)

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Reduced Physical Function

- PE2 (15-16, 2+ RNP) 2.8000
- PE1 (15-16, 0-1 RNP) 2.6000
- PD2 (11-14, 2+ RNP) 2.5778
- PD1 (11-14, 0-1 RNP) 2.3778
- PC2 (6-10, 2+ RNP) 2.0667
- PC1 (6-10, 0-1 RNP) 1.8889
- PB2 (2-5, 2+ RNP) 1.5556
- PB1 (2-5, 0-1 RNP) 1.4444
- PA2 (0-1, 2+ RNP) 1.1111
- PA1 (0-1, 0-1 RNP) 1.0000

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RUG IV: Depression Split

- Special Care High, Special Care Low and Clinically Complex categories have an end split for depression, consisting of a PHQ – 9© (mood) score = 10 or higher
- See MDS 3.0 Section D for PHQ – 9© calculation
- Depression has significant impact on case mix

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RUG IV: Restorative Nursing

- Programs must be delivered for at least 15 minutes per day, 6 out of the last seven days
- Must have two or more programs to increase reimbursement
- Specific documentation requirements
- Only effects Behavior/cognition and Reduced Physical Function categories

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Determining "Medicaid Only" CMI

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Semi-Annual Case Mix Score

- July 1 rate:
  - December 31 Medicaid only case mix score excluding PA1/PA2
  - March 31 Medicaid only case mix score excluding PA1/PA2
- January 1 rate
  - June 30 Medicaid only case mix score excluding PA1/PA2
  - September 30 Medicaid only case mix score excluding PA1/PA2

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Medicaid Only Case Mix Scores

- Identify last MDS for each resident as of the end of the quarter
- Is it a Medicare assessment? (Yes = MCARE)
- Is there a valid Medicaid SSN? (No = NSSN)
- Is resident Medicaid eligible as of ARD? (No = NELIG)
- If still remains = MCAID

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"MCARE"

- Assessment coded as Medicare assessments in A0310B do not count in the Medicaid Only case mix score ***even if combined with an initial, quarterly, significant change or annual assessment***
  - Note that a Part A PPS Discharge assessment does not count
- It doesn't matter how the resident's payor types are coded in section A

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Medicaid Only Considerations

- MDS timing during a skilled stay
- MDS Completion after skilled services end
- MDS Completion when resident becomes Medicaid eligible
- MDS Completion when Medicaid Pending at end of quarter
- MUST have good communication between MDS nurse and business office

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Monitoring Medicaid Resident Acuity

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Manage Medicaid Case Mix

- Weekly Medicaid Case Mix Meeting
- Monitor Case Mix Score
- Benchmark your score
- Talk about Medicaid residents in low RUG categories
  - Has anyone had a fall?
    - ADL score increase for transfer
    - Potential need for Part B

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Manage Medicaid Case Mix

- Talk about Medicaid residents in low RUG categories
  - Is anyone sick
    - Fever with vomiting, weight loss, tube feeding, pneumonia
    - Additional ADL assistance
    - PRN oxygen, IV Meds, respiratory treatments, COPD w/SOB (flat),
  - Any scheduled appointments or treatments
    - Chemo, dialysis, transfusions, radiation,

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What Next?

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Develop an Action Plan

- Review new item set and determine potential "gaps"
  - New process needs
    - Additional information needed on admission – race, ethnicity, SPADES items
    - How will CAA process change with removal of Section G
    - Care plan changes – section GG compatible language, culturally competent care, pain,
    - Discharge planning to include social determinants of health, health literacy,
    - Review each item set individually – for example a lot of new information is required on NPE (PPS Discharge), including interviews
  - New documentation needs
    - Indication of use for Section N drugs, details in Section O treatments, Section GG for direct care staff

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Action Plan, Continued

- Review new item set and determine potential "gaps"
  - Training Needs
    - MDS staff training on new items once draft RAI manual is released
    - Documentation training for nurses
    - Section GG training
      - Consider "train the trainer" training
      - Direct care staff training should probable occur much closer to October 1, as section G accuracy will continue to be important through September 30
    - Interview training
      - New interview process PHQ-2 to 9
      - Refresher on good interview techniques
  - Case mix training for the IDT as details become available

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CMS "Announced" Timeline

- RAI Manual draft release 2nd Quarter 2023
- OSA Package April – May 2023
- Online training Mid-may 2023
- Live workshops June 2023
- Final RAI Manual August 2023