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Highlights/Summary of the CMS Skilled Nursing Facility Open Door Forum
January 16, 2014

Chair – Jeanette Kranacs (Center for Medicare)
Moderator – Jill Darling (Office of Communications)

I. **Announcements & Updates** (From the Cms.gov/medicare/medicaidcoordination/ office)

- **CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents -** Innovation in Nursing Facilities [– from the 'duals' office]
- This initiative is based on a long-standing problem, i.e., it is estimated that 45% of hospitalizations are avoidable.
- There is evidence that interventions that have had positive impact, e.g., Evercare; InterAct.
- The goal is to scale these best practices to bring positive result for beneficiaries
- CMS-funded organizations must partner with at least 15 nursing homes; these entities would be onsite at the facilities, but would not supplant staff; interventions must be evidence-based; and must coordinate through transitions.
- CMS has awarded funds to 7 organizations.These entities are working with a total 147 nursing facilities;
- The models vary: some are nursing practitioner-based; some RN-based models are in the form of train-the-trainer / teaching best practices; some models are hybrid, i.e., RN/Nurse Practitioner/Direct Care combinations
- All are implementing InterAct [by coincidence rather than design]
- All are doing medication management; care planning
- Some have added special/unique interventions, e.g., Oral Care in NE; social work services to improve care planning; Telehealth in PA
- It is a 4 year initiative, ending in 9/16.
- An independent evaluator will assess & report on quantitative / qualitative data
- This initiative is consistent with others currently being undertaken by CMS, i.e. the partnership on dementia-; QAPI
- **Go to:** www.medicare/medicaid **coordination office.gov for more information.**

II. **Questions / Issues from previous SNF/LTC ODF**

- Coverage for services by Medicare Advantage (MA) plans
  - MA plans have to furnish at least the same coverage as original Medicare – Parts A and B
  - Appeals: www.medicare.gov; see – 11525 for the appeals process booklet

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- Providers wanting to appeal; are to contact the regional office

- Change of therapy
  - The OMRA is completed; the resident continues to receive therapy, but not enough to qualify for RUG IV;
  - Apologies, i.e., I did not get the complete response to this question, but CMS is continuing to work on this issue--- [I will follow-up for the complete response]

- Coding of K0710:, e.g.,the resident is able to take some liquids orally, but ms not allowing sufficient intake; some tube feeding is implemented to hydrate the resident over a period of 4 days in hospital and 3 days in the nursing home. The coding is based on the the total fluid intake while in the the hospital and in the nursing home. [Again, apologies, I did not get all of the details, but will follow-up for the complete response].

III. **Open Q&A**

- Medicare Advantage (MA) plans say that residents have to have 1 hour of therapy per day; traditional Medicare says that residents only need 15 minutes.
  - Some differences in how the therapy will be covered; this would be addressed in the Medicare Advantage plan; Medicare Advantage plan expert and/or the specific MA could provide an in-depth explanation, but the general rule is that MA plans have to cover the equivalent of traditional Medicare – but can be covered in different ways.
- Encoding period: Providers are encouraged to use that period to assure the MDS is correct before transmitting. Will an MDS that providers have to go back and unlock to re-sign come back on validation report? It says the MDS is late / completed in greater than 14 days; that the facility is not keeping the original completion date.
  - Not sure; when CMS is talking about 'late', it is talking about the ARD date; not submitted by submission date. Contact your software vendor – the software may be making some changes when going back in during the 7-day encoding period.
- Mental Health issues: The primary diagnosis is dementia with other health issues
  - SNFs by definition are institutions not designated for primary care of MI / not IMDs; check with your Medicare Contractor [MAC].
- Please clarify the definition on maintenance programs, i.e., must designed and provided by a clinician/Physical Therapist – not by an assistant. If having a restorative program developed, do the guidelines for maintenance programs apply?
  - Nothing in the recent decisions re: Jimmo changes existing policy; it simply a clarification. There was an error 30.4.1.1 of the Medicare Benefits Policy Manual that implied there could be no coverage by assistant. The regulations do not restrict to a therapist. CMS took this statement/parenthetical out to make the correction [Transmittal 179].
- Medicare Advantage coverage being in line with Medicare: Clearly, all plans use proprietary software systems for making coverage decisions. Can CMS confirms these systems align with Medicare Guidelines/coverage?
  - Should be addressed within the individual MA plan guidelines.
- Encoding period: MDS is complete;– 3 days later, something needs to be addressed/changed or there is an error. Where is this appropriately documented?
  - Signing attests to completion of section - Please send this question to the ODF mailbox for response.

- Please repeat the clarification on assistants' performance in therapy maintenance programs re: Transmittal 179
    - The Jimmo clarification made no change in policy re: who can perform the program. The SNF manual had an error for a short period of time. CMS removed the parenthetical from the SNF manual. The HH and outpatient therapy specifically do include this limitation.
- MA requiring the MDS to be completed for all plans/levels: Wondering if there has been any conversation around this because the plan won't be using the HPPS modifier for anything but data gathering, i.e., not used for billing.
    - CMS has been consulted on requirements re: PPS; trying to develop data comparisons re: Parts A and B and MA billing. There are additional conversations regarding the burden; speak to the MA policy folks or plans.
- The plans are not helpful on this issue, i.e., have no decision-making authority; how do we get to the MA policy folks?
    - [We] will forward the comments on to the MA policy staff; believe they do have stakeholder calls of their own. Maybe [we] can ask them to come for next ODF
- Scheduled assessment before/after leave of absence as long as before the benefit day? E.G., the 5-day is done on 5/10; 7 days later the resident goes to the ER; skip a day; change of therapy--
    - Please send the question to the ODF for response, i.e., will look at the numbers specifically.

****Next Open Door Forum: March 6, 2014****

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