CMS MDS Software Developer/Vendor Call Minutes

February 26, 2019
2:00 – 3:00 p.m. ET
Conference Line: 1-877-267-1577
Conference code: 993 017 289

Welcome.....Brandy Barnette, CMS

Welcome to the CMS MDS Software Developer / Vendor call. The purpose of this call is to provide information to MDS Software Developers and Vendors who are creating or have created software for MDS providers. The purpose of this call is to provide information on MDS updates that will be effective October 1, 2019.

If you do not have the agenda for this call, it may be found at https://qtso.cms.gov and click on the Minimum Data Set (MDS) Vendors link under the "I'm a Vendor" tab in the middle of the page.

Data Submission Specification Updates ..... John Jackson, GDIT

A new DRAFT version (V3.00.0) of the MDS 3.0 Data Specifications was posted. This version is scheduled to become effective October 1, 2019. These specs accommodate the utilization of the PDPM grouper, which also begins on October 1, 2019. Note that there are many significant changes:

- The removal of eight item sets (NS, NSD, NO, NOD, SS, SSD, SO, SOD). **NOTE:** In order to keep the item change report in the data specs from becoming enormous, the un-mapping of items to the deleted item sets is not shown in the item version notes.
- The addition of two new item sets (IPA and OSA). The IPA item set was added to support the implementation of the new PDPM grouper, which will be described later on this call. The OSA item set has been added to allow states to continue to do OMRA-type assessments for their own purposes, and allow the calculation of RUG-IV or RUG-III results. **NOTE:** Again, in order to keep the Item Change Report in the data specs from becoming unwieldy, the inclusion of items in the IPA and/or OSA is not in the item version notes. However, there are new IPA and OSA reports within the data specs database, so users can view what items are present in those ISCs.

- Item set additions were made in Sections A, GG, I, J, O and Z. Most of the new items are utilized in the PDPM grouper. However, the changes to Section A items used in determining the ISC are extremely important.
- First, take note of new items A0300A and A0300B. **If A0300A is equal to [1], the assessment is an OSA, period.** A0300B is then used to specify the assessment purpose for the state (e.g., Start of Therapy**). If A0300A is equal to [0], however, the assessment ISC is determined in a more familiar way…by the values of A0200, A0310A, A0310B, A0310F, and A0310H** (except on IPA assessments – if A0310B = [08], then A0310H does not apply, as that item is not on the IPA item set).
- Items A0310C and A0310D have been deleted, and are not used to determine the ISC. Also, notice that there are only three possible values for A0310B: 01 (5-day), 08 (IPA) and 99 (None of the Above). As a result, the number of combinations of these items that result in a valid ISC is much lower than before. Check the isc_val table in the data specs database to see the combinations.
- Regarding the new items for PDPM purposes, please take special note of new item I0020B (Primary Medical Condition ICD). This item MUST contain an ICD-10 code from a subset of the complete set of valid ICD-10 codes in effect on October 1, 2019; otherwise, the assessment will be rejected. Check the table pdpm_icd_codes within the data spec database for the applicable list used in the PDPM grouper (the SAS version) on the CMS website. This table will be updated when the final data specs are published, in order to reflect any FY2020 ICD-10 code changes.
- As a result of the many item changes, there are quite a few edits that were replaced or deleted, as well as the addition of format, skip pattern and consistency edits for new items. Please review the version notes for the individual edits in the Edit Change Report.
- A few issues have been identified since the posting of the data specs, and an errata will be forthcoming. Item X0600F will be active on IPA assessments. Items I0100, I0400, and I1500 will be active on NQ, NP and SP ISCs – they are currently listed as active only on the NC. Please continue to check the MDS Technical Information page for updates.

In addition, a new version (V1.04.0) of the MDS 3.0 CAT Specifications was posted. This version is also scheduled to become effective October 1, 2019. The specification for CAT 12

(Nutritional Status) has been updated in accordance with the changes in V3.00.0 of the MDS 3.0 Data Specifications.

Other than that, not much is happening in data specs. ☺

Validation Utility Tool (VUT) updates..... John Jackson, GDIT

As always, the VUT will be updated to reflect the changes described above, as well as process assessments from past spec versions. No interface changes are planned, so it will work as it does today.

Please note that the VUT will indeed check the value of item I0020B from the list of ICD codes valid for PDPM, and will report a FATAL error if the code cannot be found in the list.

I will now turn it over to Marni to discuss the ASAP system enhancements.

ASAP System Enhancements .....Marni Bussell, Telligen

- The ASAP system will edit records with a target date on or after October 1, 2019 using version 3.0 of the MDS 3.0 data specifications. It will continue to edit records with a target date prior to October 1, 2019 using the appropriate set of data specifications in effect for the target date of the submitted record.
- Please note there are many significant changes included in this MDS release that the ASAP system will adopt, including;
    - The removal of eight item sets (NS, NSD, NO, NOD, SS, SSD, SO, SOD);
    - The addition of two new item sets (IPA and OSA);
    - item additions in Section A, GG, I, J, O and Z.
    - The utilization of the Patient Driven Payment Model (PDPM) grouper,
    - A new version (V1.01.0) of the MDS 3.0 Care Area Triggers (CAT) Specifications which are also effective October 1, 2019.
- The ASAP system updates will also include updates to the following MDS 3.0 Provider Reports to accommodate the addition of new item subset codes and specifically ensure that item A0310 and A0300B are appropriately included:
    - MDS 3.0 NH Validation Report
    - MDS 3.0 SB Validation Report
    - MDS 3.0 Final Validation Report
    - MDS 3.0 Submitter Final Validation Report
    - MDS 3.0 NH Assessment Print Report
    - MDS 3.0 SB Assessment Print Report

- MDS 3.0 Assessments with Error Number XXXX Report
- MDS 3.0 SB Assessments with Error Number XXXX Report
- MDS 3.0 Error Number Summary by Facility by Vendor Report
- MDS 3.0 Error by Field by Facility Report
- MDS3.0 Error Detail by Facility Report

- State Required Section S Items
  - CA, FL, OH and VA will be making changes to what Section S items they are collecting.
  - Item response values have been updated for:
    - S9040A – Does Patient have a California POLST form
    - S9040F CA-POLST Section D – Signature of Patient or Legally Recognized Decision Maker
    - S8055 Primary Payor
  - Please note that Section S items will no longer be collected on OMRA Item Subset codes effective 10/1/2019.

I'll now turn it back over to Brandy.

PDPM Overview .....John Kane, CM

We would like to provide an overview of major changes occurring in the SNF Prospective Payment System, specifically the implementation of a new case-mix model used for classifying Medicare Part A patients into payment groups under the SNF PPS. It is called the Patient Driven Payment Model, or PDPM.

To begin, we should talk about why we are making these changes, as it may help you to understand why PDPM was designed in the way it was. The issues with the current case-mix model, RUG-IV, are well known and understood. Fundamentally, the main issue with RUG-IV, and more generally with the SNF Prospective Payment System since its inception, is that therapy payments under the SNF PPS are based almost entirely on merely the amount of therapy that the patient receives. This has led to a perverse incentive whereby the decisions around how much therapy a SNF patient should receive can be divorced from that patient's unique characteristics, goals, or needs.

A good example of this is something we have described as "thresholding", which refers to patients receiving almost exactly the amount of therapy necessary to achieve a particular therapy payment group. For example, a significant percentage of patients classified into the Ultra-High rehabilitation category, too significant to be an accurate reflection of that population's individualized needs, receives almost exactly 720 minutes of therapy per week, which is the minimum amount necessary to classify patients in this high paying therapy category. We have even heard tell of software programs that track therapy minutes relative to

these therapy category thresholds to aid providers in meeting these minimum standards independent of patient needs and goals.

PDPM, on the other hand, which will be implemented this October, improves the methodology used to classify SNF patients under the SNF PPS by having the patient's payment classification driven by that patient's unique characteristics and care needs, rather than the volume of services provided. Furthermore, PDPM improves over the existing payment structure by significantly reducing the administrative burden for providers resulting from SNF PPS policies and shifts payment to currently underserved beneficiaries without increasing total Medicare outlays. Finally, for those of you who are more medical review minded, PDPM provides a significantly better review and compliance environment, by shifting focus away from determining the reasonableness of therapy service volume to easily verifiable patient diagnoses as the basis for payment determinations.

Now that we have a better sense of why we are implementing PDPM, let's turn to a review of the basic structure of PDPM.

The current case mix system, RUG-IV, consists of two case-mix adjusted rate components, a therapy component which is adjusted to reflect relative resource use for therapy services and a nursing component that is adjusted to reflect relative resource use for nursing and non-therapy ancillary, or NTA, services. Just a quick note that whenever we use the term non-therapy ancillaries or NTAs, think drugs, as drug costs are the primary cost driver behind NTA costs.

PDPM, on the other hand, breaks these two case-mix adjusted components under RUG-IV into their constituent components. Specifically, the therapy component is broken into three case-mix adjusted components, one for each therapy discipline: Physical therapy, occupational therapy, and speech-language pathology. The nursing component under RUG-IV is similarly broken into its constituent components, specifically nursing and NTAs. Each of these components is adjusted for separately from the other components using data-driven patient characteristics that were vetted significantly by the public through a variety of different methods.

For each case-mix adjusted component, same as under RUG-IV, there is a base rate which is multiplied against a case-mix index, or CMI. However, under PDPM, there is an additional adjustment that is made to three of the components called the variable per diem adjustment. This adjustment factor adjusts the payment rate for three components, the PT, OT, and NTA components, for each day of the patient's stay.

After adding all of these five case-mix adjusted components together with the non-case-mix component, one would get the total PDPM case-mix adjusted per diem rate. This per diem rate, similar to how the RUG-IV per diem rates operate currently, is then labor adjusted using the SNF wage index and then further adjusted for such things as the SNF Value-Based Purchasing program.

In terms of what this means for patients, while RUG-IV boils everything about a SNF patient down to a single RUG-IV group, which can obscure significant differences between different patient types, PDPM is able to provide for a much more accurate and nuanced payment that is able to flexibly account for differences in patient needs and characteristics.

Now I believe other speakers will touch on some of these points, but let me conclude by just highlighting a few important aspects for vendors to consider and of which to be mindful as we move toward implementing PDPM.

First, as referenced earlier, PDPM utilizes patient characteristics as the basis for patient classification. One of those patient characteristics is the patient's primary diagnosis for the SNF stay, which will be captured on the MDS assessment using an ICD-10-CM code. On our website, we have crosswalks that outline how each ICD-10-CM code is used under PDPM, which can be a factor in four of the five case-mix adjusted components.

Second, speaking of the MDS, PDPM utilizes a significantly different assessment schedule than is used under RUG-IV. Specifically, PDPM uses only three different assessments. The 5-day assessment and PPS Discharge Assessment, as currently exist under the SNF PPS, and a new optional assessment called the Interim Payment Assessment or IPA. The data specifications related to these item sets are now available to the public and I will defer to my colleagues on this call to discuss any notable aspects of the data specifications.

Finally, given the significant changes in the payment classification methodology used under PDPM, as compared to RUG-IV, the GROUPER logic used under PDPM is quite different than what has been used previously. We are in the process of developing the typical GROUPER package that we release each year and I will defer to my colleagues to discuss this further. I did, however, want to call attention to two resources that are currently available to you which may provide aid to you in advance of the standard GROUPER package being released.

The first is a patient classification walkthrough, which is an over 30 page document that outlines how patients are classified under PDPM, step-by-step. This document is extremely helpful in understanding exactly how patients receive a group for each component of PDPM.

Second, we have released a GROUPER file in SAS, which we hope provides a stepping stone for vendors and programmers to begin to develop their own tools similar to the standard GROUPER package released by CMS.

We hope you found this basic overview of PDPM helpful. Should you have any questions, please feel free to contact us through our PDPM mailbox, which is PDPM@cms.hhs.gov.

Thank you!

Discussion of Submitted Q & A's.....Brandy Barnette, CMS

The following questions were submitted prior to this software developer/vendor call.

Open Q and A Session.....Brandy Barnette, CMS

Closing Comments.....Brandy Barnette, CMS

Thank you for attending the call and keeping updated on future changes to MDS.

If vendors have additional questions, please send them to the CMS technical issues mailbox at MDStechissues@cms.hhs.gov.

Important Resources

QTSO Website
https://qtso.cms.gov/
https://qtso.cms.gov/vendors/
https://qtso.cms.gov/vendors/minimum-data-set-mds-vendors/

CMS.gov - MDS Technical Information
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

CMS.gov – MDS RAI Manual
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

CMS.gov – MDS Payment Driven Payment Model
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Email - MDS Technical Issues
MDSTechIssues@cms.hhs.gov