

CMS and SMA National MDS 3.0 Teleconference Minutes

November 10, 2010

I. MDS 3.0 Technical Problems, Alerts and Website Releases

http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage

Jack Williams CMSO-DNS and Jean Eby, IFMC

1. MDS 3.0 Rollout Problems:

- a. Jack Williams gave a high level summary of the rollout problems and CMS corrections for the problems. He referenced the following reprocessed records information included in the 10/13/10 Minutes.
 - i. Submission files with Submission IDs from 1 through 33,291 were reprocessed on Thursday, October 21st. These submissions will receive new MDS 3.0 Final Validation Reports.
 - ii. The accepted assessments in these reprocessed submission files will be transferred to the QIES Reporting database, where they will be accessible in the CASPER Reports and MDS 3.0 Viewer, as well as QIES Workbench (QW) after the refresh on October 24, 2010.
 - iii. The reprocessed nursing home records that are accepted are in the State Assessment Extract file dated 10/22/2010. Please notify your State Assessment Extract File users that these assessments have been reprocessed. Please disregard any previous daily state assessment extract files.
 - iv. The nursing home records were included in a state assessment extract file. Since these records have been reprocessed and information on the record may have changed, users of the state assessment extract file will need to delete the nursing home assessments listed in the attachment from their system and use the reprocessed records instead.
 - v. The documents include the following elements:
 - 1.State CD
 - 2.Submission ID
 - 3.Assessment ID
 - vi. Nursing home records include:
 - 1.State Assessment Extract File Number Original Processing
 - 2.State Assessment Extract File Name Original Processing
2. CMS posted the corrected MDS 3.0 DLL to www.qtso.com MDS 3.0 web pages for vendors to incorporate it into their software.
3. Jack also described the contents of the following attachments sent to the SMA e-mail lists by CMS.
 - i. Attached: 'MDS 30 Provider and Association Alert 201010120 v6 .pdf' (MDS 3.0 submission system alert), which was e-mailed to SMAs on 10/21/2010)
 - ii. Attached: 'MDS 3.0 Helpful Hints.pdf' (Addresses how to submit a file, use the submission status link on the upload page, get into CASPER to view the system-generated validation report and the submitter validation report, log in with an individual user ID rather than shared provider user ID. It also clarifies that States cannot see validation reports for assessments they did not submit and confirm they will not be receiving initial validation reports with the new MDS 3.0 system.) - It is also available at https://www.qtso.com/download/mds/MDS_3.0_Helpful_Hints.pdf

4. Jean Eby and Jack Williams Technical Questions

- a. Minnesota reported that they experience a validation report problem in that they could not view the Facility ID number.
 - i. Please refer to the Helpful Hints document for the lists of errors file to help resolve this problem. The document also provides other important information.
- b. Montana asked if there were materials that provide step-by-step information on how to access MDS 3.0 validation reports to manage the validation process.
 - i. The Helpful hints document provides screen prints and validation processes and procedures.
- c. Some vendors are not sending validation reports or using XML format.
 - i. Submissions must be sent in the correct format using XML to be able to produce a validation report.
- d. New York asked whether they should maintain records submitted before October 22, 2010
 - i. Jean indicated that states do not need to maintain records because they were replaced in the latest report.
 1. States may want to keep the resident and facility files

II. Jeannette Kranacs and Ellen Berry, CMM Questions

1. Ohio indicates that some providers have not submitted any MDS 3.0 submissions and so there is no data in their Flat File.
 - A. Many Ohio facilities have not transitioned from MDS 2.0 to 3.0 and from RUGs III to RUGs IV on October 1, 2010. Ellen indicated that if there is no MDS 3.0 assessment, there is no way that they can be paid.
 - a. Patsy Strouse will contact Ellen Berry to discuss this problem further.
 - b. Other states indicated that providers and vendors had the same problem and were not following the transition document.
2. Would providers submit PPS assessments even if it was a managed care?
 - A. If a provider wants to complete assessments for other payers, they should work with their vendor to allow them to complete assessments and obtain the needed items for their purpose. Assessments the provider needs/wants to complete other than for OBRA or SNF PPS do not need to be submitted to QIES ASAP. However, if they do submit them, they will need to pass all our edits. There are some items that are not appropriate for other payers, such as A0310 & A2400.
 - B. Given that other payers have their own payment methodology, their vendor would need to incorporate that logic. For example, only a RUG-IV can be obtained via a start of therapy OMRA, as well as an end of therapy OMRA. Therefore, if a payer uses RUG-III, these assessments would not 'pass' our edits b/c they would contain items that are not part of RUG-IV. In addition, for Medicare Part A, RUG-IV divides concurrent therapy in half and applies that number to total therapy minutes – other payers may or may not follow that logic.
 - a. So, yes they can submit, but there are no reason codes for other payers (A0310) and for other reasons the assessments would probably not pass our edits.
3. For OBRA, how will a late submission effect payment if the delay is caused by CMS submission delays?
 - A. From a SNF PPS stand point, late assessment refers to the allowed ARD window. If the ARD is after the allowed window then the assessment is late and the default applies. It is not based on transmission to the CMS system. Please refer to chapter 6 of the RAI manual.

- B. Late transmissions policy falls under survey and certification process (in other words OBRA). A provider may be subject to a monetary penalty. Please refer to the Survey and Certification memo issued earlier this week regarding the survey process and late transmissions.
 - a. Please see S&C: 11-02-NH Memorandum.doc sent with the 11/10/10 Agenda.
- C. You should contact your State agency to determine if Medicaid payment is impacted when transmissions are late.

III. MDS 3.0 Survey & Certification Issues *Chrissy Stillwell-Deaner, S & C*

1. There were no questions regarding S&C: 11-02-NH Memorandum that was sent to SMAs.
2. Additional questions
 - a. Since accurate MDS 3.0 coding is critical to RUGs case mix state auditing and payment, can Medicaid staff attend the April 2011 RAI Conference under the same conditions that SMAs were allowed to attend the March 2010 RAI conference?
 - i. CMS is scheduling an April 2011 RAI meeting in San Antonio, TX.
 - ii. As with the March 2010 RAI Conference, states will be allotted up to 3 slots.
 1. As stated in the S & C call letter, States must send an RAI Coordinator and can decide on their second & third attendees (i.e., Medicaid Case Mix staff, automation coordinator, surveyor trainer, etc.)
 - b. Is the MDS 3.0 coding self learning computer training similar the MDS 2.0 on line computer training, available? If no, when does CMS anticipate that it will be ready?
 - i. CMS has no plans for MDS 3.0 web based online training because of all of the training materials currently available on the CMS website.
 1. There is an "Introduction to MDS 3.0" on-line training being piloted as part of the new surveyor course. CMS is evaluating the effectiveness of this course and is considering whether the on-line MDS 3.0 training course should be offered to a broader audience.
 - c. Are there other training MDS 3.0 RAI coordinator training materials or webinars beyond the OCSQ training information available for SMA audit nurses and staff?
 - i. No.
 1. CMS communicates with RAI coordinators on a monthly basis on the All State teleconference
 - a. CMS strives to provide consistent information on teleconferences, with its website and through training materials and conferences so providers, SMAs and others hear the same information.
 - d. What are the Survey and Certification roles for MDS 3.0 the Section Q review process?
 - i. As for the survey policy on Section Q regarding providers referring everyone is not something that SCG would get involved in.
 1. Surveyors are only instructed, for F279 & F284 F-TAGs to evaluate whether comprehensive care planning is conducted appropriately using the information from the MDS, which would include Section Q & its CAA, if triggered.
 - a. Please review Attachment 1 for a more detailed description of current S & C regulations, interpretative guidance and surveyor probes.

IV. SMAs questions or problems regarding MDS 3.0

Mary Beth Ribar & John Sorensen, CMSO-DEHPG

1. Sue Schroeder, from Wisconsin, shared that providers are overwhelming local contact agencies with all of its discharge referrals even when they have SNF discharge plan because of fears of survey citations if they don't refer all residents.
 - a. CMS has talked with AHCA and AAHSA and they have agreed to disseminate accurate information regarding the referral process to their members.

- b. As stated above, state survey agencies are not focusing on referrals to local contact agencies (LCAs) but on comprehensive care plans so SMAs should educate providers.
- c. Mary Beth indicated that this problem will be addressed in a new Q & A document that will be posted soon and will be discussed on the 12/14 MFP and Section Q Point of Contact technical assistance teleconference
 - i. CMS believes this is an education issue for states and AHCA and AAHSA have agreed to send out bulletins about referral guidance for LCAs to resolve this problem.
- 2. John indicated that the Ombudsman will be a resource for Section Q compliance and in some states Ombudsman are doing transition referrals and assuming LCA functions.
- 3. State Section Q comments and problems:
 - a. Can CMS facilitate the designation of the LCA in a state?
 - i. No. SMAs are responsible to designate their LCA and define their transition referral processes.
 - 1. CMS has Section Q subcontractors Dann Milne and Bob Connolly under the New Editions contract that can be utilized with states that request assistance.
 - b. What should be in the LCA referral?
 - i. This is an SMA decision of what information is required for the LCA to assist in resident transition to the community.
 - ii. Some states organize or provide automated MDS 3.0 coding information.
 - 1. If MDS 3.0 information is transmitted to the LCA, the State Medicaid Agency must have this/these agency (ies) listed on their current DUA or develop a DUA.
 - 2. The sharing of standard discharge information with the LCA does not require a DUA and is covered under the facility's standard medical release form which is signed upon admission.
- 4. CMS announced that there was a November 9 PASSR call and asked that the following PowerPoint materials be shared with all participants on the SMA call.
 - a. "Barkoff_PASRR_webinar_9Nov2010.pdf"
 - b. "Bearden_PASRR_webinar_9Nov2010.pdf"
- 5. AoA/CMS/HHS Joint Memorandum
 - a. Attached please find the "AoA CMS Section Q memo 508 11-8-10.pdf"
 - i. In an effort to support individuals living in SNFs/NFs who wish to learn about available home and community based services (HCBS) options and available long-term care (LTC) supports in the community, the Centers for Medicare & Medicaid Services (CMS) has revised the Minimum Data Set (MDS) version 3.0 Section Q. The MDS is administered to all individuals in SNF/NFs nationwide that receive Medicaid and/or Medicare funding. The purpose of the attached memorandum is to inform State Medicaid Agencies (SMA) and other stakeholders about opportunities for collaboration and coordination with State Long-Term Care Ombudsman Programs for the implementation of the SNF/NF MDS 3.0 assessment tool.

V. CMS MDS 3.0 Content or RAI Manual Website Releases

Tom Dudley, OCSQ

- 1. Jim Sims, a Minnesota Case Mix Analyst, discussed the importance of educating providers regarding the MDS 2.0 to MDS 3.0 Transition Document and the fact many in his state are not aware of or using this important document.
 - a. State questions and comments.
 - i. Large numbers of nursing homes are not aware of the transition document and not following it. There is lots of confusion.
 - 1. There is no way for SMAs to know if providers are not following the transition document

2. Some providers have not transitioned from MDS 2.0 to MDS 3.0 and from RUGs III to RUGs IV.
 3. There is confusion since some providers do not realize that MDS 3.0 are now submitted to CMS and not to their state server.
 4. Some software vendors are not resolving submission problems and making software and specification changes, which mean MDS 3.0 submissions are not being transmitted.
 - a. Lack of submission can result in a survey deficiency and no payment.
 - b. Late submission can result in a RUG default payment.
 - c. Texas suggested that if vendor software is not available for submission because of programming delays that providers could use JRAVEN software in the interim.
2. Will mds30comments@cms.hhs.gov clinical questions and responses be posted?
- a. CMS is considering how to share and post Q & As beyond changes to the MDS 3.0 RAI Manual. CMS is planning to publish any revisions to the MDS 3.0 RAI Manual and Item Set in the spring of 2011.
 - i. CMS is working with contractor to develop a mechanism to provide updates.
 1. Carol Job indicated that there was a valuable lesson learned with MDS 2.0 implementation regarding Q & As. Since Q & A documents became outdated quickly and there were multiple versions, she recommended that CMS put clarifications in the RAI Manual and not in Q & As.
 - a. This is CMS's plan.
 - ii. SMAs indicated transition document clarifications were important for a nursing facility coding regarding:
 1. A0310E. [*Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?*] That was completed for first time MDS 3.0 on an existing resident.
 2. A1600. [*Entry Date (date of this admission/reentry into the facility)*]
 3. J1700. [*Fall History on Admission*]

VI. Need for SMA Comments to mdsformedicaid@cms.hhs.gov by 2/2/11

Bob Connolly, CMS Consultant

CMS has decided that the last MDS 3.0 SMA call will be held on February 9, 2011 unless SMAs write mdsformedicaid@cms.hhs.gov with suggestions for MDS 3.0 content, education, technical or other agenda items to justify continuing this call. SMAs can also suggest how CMS might modify other CMS calls (i.e., All State RAI Call or the SNF PPS Open Door Forum) to meet the needs of SMAs. CMS has asked for comments before and not received substantive comments. CMS requests that SMAs send suggestions and comments to mdsformedicaid@cms.hhs.gov by 2/2/2011

VII. Announcements

1. Future SMA Calls
 - A. December 8, 2010 1:30-3PM EST
 - a. *Correction to the 11/10/10 SMA MDS3.0 Agenda: there is a December 8, 2010 but no January 2011 SMA Teleconference because of the holiday season."*
 - B. February 9, 2011 1:30-3PM EST
2. Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Resource Utilization Group-Version 4 (RUG-IV) National Provider Call PowerPoint Presentation-November 9th, 2010 is now available
 - A. To access the presentation, go to http://www.cms.gov/SNFPPS/03_RUGIVEDu.asp#TopOfPage , and scroll to the bottom of the page to the Downloads section. Then, select the "November 9, 2010 National Provider Call Materials" PowerPoint presentation.

3. Please send correction or questions regarding the '10_13_10_MDS Medicaid Minutes Final.doc' sent on 11/1/10 to Bob Connolly @ rpc2536@yahoo.com

Attachment 1

F279

(Rev. 66, Issued: 10-01-10, Effective: 10-01-10 Implementation: 10-01-10)

§483.20(d) (A facility must..) use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

§483.20(k) Comprehensive Care Plans

(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:

- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and**
- (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).**

Interpretive Guidelines §483.20(k):

An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the care area assessments (CAA) summary or clinical record of the following:

- The resident's status in triggered CAA areas;
- The facility's rationale for deciding whether to proceed with care planning; and
- Evidence that the facility considered the development of care planning interventions for all CAAs triggered by the MDS.

The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan or care.

The requirements reflect the facility's responsibilities to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. However, in some cases, a resident may wish to refuse certain services or treatments that professional staffs believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment).

Probes §483.20(k)(1):

- Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment?
- Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths?

- Does the care plan reflect standards of current professional practice?
- Do treatment objectives have measurable outcomes?
- Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment.
- Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.
- If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?

For implementation of care plan, see §483.20(k)(3).

F284

(Rev. 66, Issued: 10-01-10, Effective: 10-01-10 Implementation: 10-01-10)

§483.20(l)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Interpretive Guidelines §483.20(l)(3):

A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with mental retardation. Resident protection concerning transfer and discharge are found at §483.12. A —post-discharge plan of care means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community.

Probes §483.20(l):

- Does the discharge summary have information pertinent to continuing care for the resident?
- *Is there evidence of a discharge assessment that identifies the resident's needs and is used to develop the discharge plan?*
- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)?
- Do discharge plans address necessary post-discharge care?
- Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?
- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?
- *Does the discharge summary have information identifying if the resident triggered the CAA for return to community referral?*