

Centers for Medicare & Medicaid Services  
Questions and Answers  
Open Door Forum: SNF/LTC Open Door Forum  
Thursday, August 31, 2023

1. Question: When can we anticipate receiving the revised methodology for five-star staffing calculations with the removal of section G and elimination of regs and relevant study data?
  - a. Answer: We expect to release a memo describing these methodology changes in September.
2. Question: First question has to do with value-based purchasing. In the proposed and final rule this year in relationship to the validation process that CMS is planning to implement related to value-based purchasing quality measures and data from the MDS, indicated potential penalties related to non-compliance there with audits and so forth. My question there is, is there any word further on what those penalties might be or how that might affect the SNF? And then the second question I have has to do with the updated RAI manual. There were three cause [indiscernible] assessments that were updated related to section GG. Rather than adding the additional items for column 1, which would have been for admission, there was an X added to the items for GG 130 and 170 in three different cause. And I'm curious to know what that X is supposed to indicate. I know there's been some confusion on that. I wonder if somebody could answer that question for me.
  - a. Answer: I'll answer the second one. So, with the manual, we do know that there are two cause that are in error. One that you're referencing is, I think, cause 5. That X represents all the ADL items or functional items. So instead of listing them all out we chose to shorten it, and just use the X as a placeholder. So sorry for that confusion. But the data specs, if you look at those, those are accurate and list everything out in the technical data specs. The two cause that we will be issuing just an update, not a whole manual, I don't know if we'll call it an errata. I think off the top of my head, it's cause 6 and 15, maybe, but I'm not exactly sure. And we'll be adjusting those so that they do match the data sets. And for your first question, we won't be providing any updates on the validation side of things at the moment for the SNF VBP.
3. Question: My question had to do with the last presentation about the changes to the QMs, because of the new MDS. There was mention of re-specifications, and then she also said something about freezing QMs. Which ones will be frozen, and for how long?
  - a. Answer: We're working on that. The division of nursing homes will be releasing a memo shortly with the exact length of the freezing, and for how long, and when. But this will be for only the new measures that I talked about in the beginning, the ones that are changing. So, the function measures, the short-stay and long-stay, and then the high-risk pressure ulcer long-stay, and the bowel and bladder long-

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stay measures. The rest of the measures will not be frozen because they just had label changes, which were minimal changes.

i. Question: What about the ADLs and the ability to move?

1. Answer: Those will be the function measures I was talking about, as well, those will be frozen.

4. Question: Do you know what facilities are going to be doing about the ones that don't have case mix or Medicaid that affects or uses section G? Are the aides being recommended to complete parts of section GG? I know it's an assessment tool. And I know that they probably gather information. But are they going to be participating in any part of that?

a. Answer: We allow the providers to determine how they are going to code the MDS, and who in their facility will partake and be a member of the interdisciplinary team. So that we leave up to the individual providers. We would recommend that you use the certified aides and their information, since you are looking at most usual. In terms of training and post-training event materials on the SNF QRP training page, there's a post-training event Q&A document and there is a written response to that question there, if you want to reference it.

5. Question: I just wanted to ask if you could review what you said about correcting once October 1 comes. I know that especially in our [indiscernible] rating report it comes out six months later, I usually have a quarter to do any corrections. So, does that mean that once September passes, we won't be able to fix that quarter? I just need clarification.

a. No, that doesn't mean you cannot modify a record that is prior to October 1. What you cannot do is change the target date so that it is either the original target date is prior to October 1. You cannot change it to post-October 1 and vice versa.

6. Question: I have two questions. One is, can you tell us when the updated PDPM grouper file will be available. And then the second question has to do with the RAI manual. And where it references that other payers, such as Medicare Advantage plans, may require health insurance prospective payment system codes on the MDS, or like HIPPS codes for billing purposes. And then the manual was updated to state, "however, facilities must not code assessments done for these purposes as PPS assessments in A-0310-B, and A-0310-H or submit these assessments to iQIES." And they've not been submitted to iQIES, or they're not supposed to have been. But I guess my question specifically is can you give guidance on how providers should code these assessments that Medicare Advantage payers are required—when they require a HIPPS code, and how would—how would providers code the MDS then in order to get that HIPPS?

a. Answer: We are trying to get the grouper software released. I am hoping that we're going to have that available today. For your second question, we looked to you guys, the vendors, to work with the providers on how to do that. You can add an item into your software, if you'd like, as long as it doesn't get submitted to CMS. That's the big push that it doesn't get submitted to us. When you're having an audit, you don't want something that's coded as a PPS, and maybe the Mac

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looking at it and saying why wasn't this submitted if it is a PPS assessment, if that makes sense.

7. Question: I just want to kind of revisit the question about the Medicare Advantage and coming the MDS, and this may not be the place to ask the question but if you know where we would get the answer that would be helpful. Some of us are wondering if we're coding the Medicare Advantage, I am assuming that since we can't code it as a Medicare five-day, we're going to be coding it as *not* a PPS assessment, so coding a A0-Plan 310-B as a 99 for not a PPS assessment. How would the software know, then, to pull up the correct data set for that Medicare Advantage?
  - a. Answer: I cannot speak for Medicare Advantage, but, as far as I'm aware, we do not—CMS does not instruct Medicare Advantage that they must use the MDS. And that they must use the PDPM grouper.
    - i. Comment from participant: I'm assuming then that we're going to be coding not a PPS assessment then, an A0310B. So, I guess we need to find out from Medicare Advantage how, how that data set—because in the past we've coded as a five-day, so when we pull up the five-day assessment for Medicare Advantage, that's how we got the data set.
8. Question: How do providers code with the new data set the ethnicity and race? On the discharge assessment, if the resident was sent for an unplanned discharge to the hospital, if we can't ask the resident.
  - a. Answer: If you read the guidance in the RAI manual, you'll see there's almost a hierarchy of how you collect that data. Obviously, patient self-report is the primary way we want that data collected. If the patient's unable to respond, you can use a proxy respondent. And then the third option is through medical record documentation. So, we would expect that you would have that information available. Even if the resident wasn't immediately available to you.
9. Question: Prior to the call I was looking at the facility five-star rating and I noticed that on our most recent health inspection section, there was an incorrect number of deficiencies listed as the number. So, the number of deficiencies listed was incorrect based on the survey that's posted on the site, and I was wondering if there is a contact email, or who I can reach out to, to correct that.
  - a. Answer: You can reach out to [bettercare@cms.hhs.gov](mailto:bettercare@cms.hhs.gov).
10. Question: When will PCC (*Point Click Care*) have updated questions in the POC that will be available to use to reflect the changes in GG?
  - a. Answer: You will have to reach out to them.
11. Question: The first one is back on ethnicity and race. I just want to clarify. I know that it's an interview question. Are we truly expected to ask our resident their race and ethnicity with every MDS, or the way the manual reads, I believe that is the case. So, if the patient's unable to respond, would we truly, if we have five MDSes for whatever reason, need it done in a quarter's time frame, we would need to call and interview the family each individual time? Or once we've established the race are we able to use that information? My second question is, under GG, and I apologize if this was clarified in the

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final, I have not gotten through the errata for the final version in GG, but most of GG references as if it's a new admission, including in the examples. And with the OBRA assessments the option for "not applicable," because it did not happen prior to admission, my question is for OBRA assessments would "not applicable" be from assessment to assessment if we were to use that option? What is the, I guess, what's the surroundings around using the "not applicable" on long-term care residents?

- a. Answer: I would say for the race and ethnicity items this is absolutely correct; it's designed to be an interview item. I would expect that you would be clarifying that there's no change to that information with the resident. In terms of the GG applicability, can you go ahead and send me that question in? Because I feel like we've already issued guidance about this and I believe it's in the training Q&A document.
- 12. Question: Before October 1, when should we be expecting updated coding guidance regarding the ADO section of the 672 form, when G is going away?
  - a. Answer: That will be out sometime this fall.
- 13. Question: Let's say we have an outside vendor, like a psychotherapist, come to the facility and do the interview for the PHQ-9. I know the person who does the interview [indiscernible] is supposed to sign MDS, but the psychotherapist is like a third-party vendor and she's not going into our MDS. What's the guidance of using like a supportive interview that's documented in the progress notes to sign that section? And my next question is, we've had insurance deny GG information, when the actual documentation date was documented after the three ARD dates. We're supposed to review, the understanding is we're supposed to review over the usual, the three days, and then come to a conclusion, which many are saying should be after the three days. So, is there any written guidance on when that conclusive usual should be documented?
  - a. Answer: I can comment on the second, on the GG question. Again, it's in the post-Q&A guidance training document. And, you can certainly be interdisciplinary team, and it's in writing on the Q&A document on page 29. So, completion of section GG does not need to occur within the three-day assessment window, but it's expected to be based on assessments completed within the three-day assessment window. So, the interdisciplinary team can assimilate the data to determine the usual performance after day three, as long as they only utilize information from the three-day assessment window. And again, that's in writing on the post-training Q&A document that's posted. For the first question, if it's documented in the medical record, and the person was interviewed, you can, based on your policy and procedures, code the MDS based off what's documented and whoever is coding the MDS based off that therapist information would be the one who signs it.
    - i. Question back to participant: They would use the collection date of the date that's in the progress notes?
      - 1. Answer: Correct. It does say the date of completion, not the date of signature. So, yeah, it says you put in the date that you completed

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the interview, not the date that you're actually inputting it into the MDS.

14. Question: I have a GG question for shower base shelf, for the OBRA ones. We scheduled, but the resident is on hospice, for example, and the shower base is done by a hospice aide. How can we code it in the MDS?
  - a. Answer: My recommendation is that you reach out to your state RAI coordinator. And that would be in Appendix B of the manual.
15. Question: The first one is regarding this new VBP affecting Fiscal Year 2027 programs, when stated that CMS is adopting the audit portion of the validation process for MDS-based measures. How exactly are you planning to do this? Is it going to be done on all facilities? Because I understand the auditing of the claims, this is—I guess I just need more clarification that you will be able to. And my second question is, I'm just piggybacking on an earlier question regarding the freezing of the QMs affected by the re-specifications, specifically for the five-star QM rating. If I understand it correctly, these QMs will be frozen until, during the transition, and that means that whatever scores, whatever points you have, through September 30, 2023, will be the same points that we will have until the transition is done. Just need to know if I'm understanding that correctly. My last comment, the number of health inspections, those are the ones that were being IDR'd, they were reflected in Care Compare, they were calculated prematurely. And I did reach out to CMS. I did reach out to Better Care. And they told me that you have to reach out to the state because it's dependent on what's being entered in Aspen. And so, I'm just letting Brad know that, if that helps him out.
  - a. Answer: I can answer your question about the QMs. Only the four QMs will be frozen out of the 15 used in the five-star, so your scores can still be changing during that time, as the rest of the quality measures will not be frozen. I can take a point here with the VBP question. So, like we've referenced previously, we will collect the 1,500 SNFs that submitted at least one MDS record in calendar year 2024 or we're anticipating in the FY2026 SNF VBP program for validation in the FY2025 performance period. This will include a validation contractor requesting up to ten randomly selected medical charts for each SNF and we'll have more detailed information concerning the policy in both future rule-making, and appropriate frequently asked questions.
16. Question: My question is on the October 1 new MDS set, we would only code PT, OT, or ST if the assessment is a Medicare Day 5 PDPM, is that correct?
  - a. Answer: I can say that you definitely code it if it is a PDPM assessment. I can't speak to what will be coded for non-PDPM assessments.
    - i. Comment from participant: it's like the quarterly assessment, an annual assessment, and the guidance within the form states only code if it's a Day 5 PDPM. So, with that being said then, we would not code that in the OBRAs; is that my understanding?
      1. Answer from CMS: That would be consistent with that guidance. Yes.

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17. Question: Two questions. Regarding OBRA assessments, and hopefully you're able to answer, regarding OBRA assessments, it's my understanding that on the item sets for GG that we will not be assessing the walking 10 feet or the step questions. Is that correct on OBRA assessments, including an admission OBRA?

- a. Answer: We suggest that you reach out to your state RAI coordinator.
  - i. Question: Is there any scenario that you guys are aware of where if someone were to come in, admit at the end of the month, and our ARD date were to overlap?
    - 1. Answer: Your lookback window is your lookback window, if that's what you're asking about. So, if your ARD is October 2, depending on the item, you would be looking back into September.
    - a. Comment: Right. So, in that case, like if we were going to do like an admission assessment on October 1, for instance, we would need to have collected GG data on that person even though it wouldn't actually be an active system until the ARD date, I think that makes sense to me.
    - i. Answer from CMS: Yes.

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