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"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE ADELMAN ADVANTAGE

by Rebecca Adelman

Professional Liability Insurance Essentials in the Senior Living Marketplace

As we've explored over many years here in this monthly column, the senior housing industry includes a multitude of risks and emerging risks and of liabilities. These risks require not only comprehensive and pro-active risk mitigation, but also insurance coverage. Each year, Aon Global Risk Consulting's (Aon) Actuarial and Analytics practice has conducted an actuarial analysis of general liability and professional liability (GL/PL) claim costs for the long term care profession in the United States.

In the 2018 report, Aon's finding concluded the following:

Loss rates, or losses per occupied bed, are increasing by 6% annually.

The 2019 forecast occurrence year loss rate limited to $1 million per occurrence is $2,410 per bed.

Total claim frequency is increasing by 3% annually.

The 2019 forecast occurrence year claim frequency is 1.11 claims per 100 occupied beds.

Claim severity or average size of a claim, is increasing by 3% annually.

The 2019 occurrence year GL/PL severity limited to $1 million per occurrence is forecasted to be $216,000.

You can see that there is an increase in claim frequency in skilled nursing facilities. Recent studies also show that assisted living and memory care communities are averaging higher severity losses than those in skilled nursing facilities.

As an attorney representing senior housing industry members and the insurance companies that provide professional liability risk coverage, I've been involved in excellent risk management programming with owner and operators and also appreciate the need for a variety of insurance products to insure risks.

I want to highlight some of the essential insurance policies for senior housing operators as well as various products.

Following are essential policies to consider for skilled nursing facilities:

Medical Professional Liability (Claims Made & Occurrence)

Medical Malpractice for Physicians and Other Providers

Commercial General Liability and Property

Miscellaneous Medical E&O

Primary and Excess Limits

Hired and Non-owned Auto

Sexual Misconduct/Abuse

Employee Benefits

Employment Practices

Punitive Damages Coverage

Resident Evacuation Expenses

Crisis Communication/PR Expense

Cyber/Privacy Liability

Civil Fines and Penalties

Medical Billing E&O and Regulatory Coverage

Management Liability (D&O, EPL, Fiduciary)

Worker's Compensation

Additional Insured Coverage

Vicarious Medical Liability

Professional liability insurance is covers the community from damages that result from a medical incident by facility staff members treating residents. Claim include negligence, medical malpractice and abuse/neglect.

Commercial general liability insurance covers some of the most common non-employee lawsuits that result from everyday business activities. A slip and fall claim may be covered with this policy.

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Commercial property insurance is another common type of commercial insurance that all business, including senior facilities, should carry. It covers damages to the building as well as equipment, supplies, fixtures and furniture in the event that they are stolen, damaged or destroyed due to a fire or non-excluded natural disaster.

Workers' compensation is essential for skilled nursing facilities. Staff may face risks for injury or accidents. Additionally, some residents with behavioral issues or with dementia can become violent resulting in employee injuries.

Commercial auto liability protects the community from damages resulting from an accident or injury in a commercial vehicle. Some facilities may take residents off-site for activities or treatments, creating additional liabilities.

Sexual abuse and molestation coverage is another necessary coverage for senior housing. Most general liability policies contain specific sexual abuse exclusions. Having policies and procedures in place to prevent sexual abuse and compliance with state and federal regulations will mitigate risk yet it's important to secure this coverage as well. It is important to understand how this coverage is constructed with respect to defense costs and indemnity payments, as well as final adjudication implications.

Punitive damages coverage may cover claims for intentional and gross misconduct. Depending upon the states in which you operate, you may or may not be insurable by law. However, it is important that you understand how this would be implicated in the states in which you operate as most lawsuits allege punitive damages claims.

Vicarious Medical Liability covers this exposure for the community and any employed medical professionals.

Civil Fines and Penalties are insurable, although some policies do not cover this portion of any claim, which could be significant.

I do not describe all of the insurance policies to consider. Please contact me if you'd like to discuss further.

Nursing facilities seek insurance coverage through traditional insurance providers. There are additional coverage programs that includes alternative risk transfer programs such as surplus line carriers; captives; and risk retention groups (RRGs). A surplus line carrier is unregulated and handles risks that admitted carriers are unwilling to write and although recognized as an insurance carrier, is licensed in another state.

Captive insurance programs are "an external funding mechanism whereby a provider (or group of similarly related providers or a trade association) creates a separate legal entity, typically a subsidiary or sister corporation, to act as the provider's limited purpose insurance company." A captive can write insurance or reinsurance and is required to file financial statements, audit reports, and actuarial reports, but not rate justifications and form filings. Captives are also not covered under the state reserve fund.

Self-insurance funds can be formed by a group or an organization and are "arrangement(s) whereby a provider contributes monies to a self-insurance reserve that is held by an independent entity and specifically dedicated to the payment of anticipated professional liability claims."

Similar to captives, RRGs are member-owned business associations that are formed specifically for the purpose of pooling and sharing similar business risks. RRGs are effectively exempt from state law except that the states can still collect premium and surplus taxes, force compliance with unfair claim settlement practices, and follow a few other requirements common to insurance companies. States may not, however, dictate rates, coverages, forms, methods of operations or investment activities, loss control or claims. RRGs are often used in conjunction with captives to insure various levels of risk

This article provides a glimpse into the various insurance products that cover the risks in the senior housing industry and serves as an overview for those who would like to learn more about relationship between the insurance company, the community and insured risk

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Getting on the Same Page by Paige Hector, LMSW

Trauma-Informed Care: Just Another Requirement?

NOTE: Part II of the data topic from April will continue in June.)

Throughout their lives, people will be exposed to traumatic events and psychological trauma. Such experiences are not new, but how we address trauma in our facilities is, and, the crux of the new requirement that facilities become trauma informed starting November 2019.

As of the writing of this article, CMS has not yet issued guidance on trauma-informed care (TIC). From the little that we do know from a regulatory perspective, F699 states, "The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident."

Take note of the phrases in this new requirement – "trauma survivors," "culturally competent," "trauma-informed care," "professional standards of practice," "accounting for residents' experiences and preferences," "eliminate or mitigate triggers," "re-traumatization." Wow, that's a lot of expectation written into one regulation. And, the expectation for TIC is referenced in multiple other Ftags including F659 Qualified Persons, F741 Sufficient Competent Staff, F740 Behavioral Health Services, F742 Treatment/services for Mental-psychosocial Concerns, and F743 No Pattern of Behavioral Difficulties Unless Unavoidable.

Consider the multitude of processes inherent just in F699. Staff need to understand what TIC *is*, and what it looks and sounds like in the post-acute and long term care (PALTC) setting. Staff are expected to identify trauma survivors which means training and coaching to develop the skills to screen for trauma. They have to know what to do in the event of a positive trauma screen, the next steps which should be firmly grounded in facility policy and procedure. They have to provide culturally competent care (I prefer the concept of cultural humility but that's another article) which requires more knowledge, training and skill. In order to operationalize standards of practice for TIC, staff have to know what they are which means more study, training, coaching and mentorship. The same for eliminating and mitigating triggers – staff first need to understand what triggers are in general and then specific triggers for each resident or patient, and to communicate that information to the interdisciplinary team. The care plan should reflect resident-specific trauma-informed information and interventions. Then, staff must operationalize those interventions consistently across all shifts in order to avoid retraumatizing the resident or patient and ultimately improve the individual's well-being.

The purpose of this article is not meant to cause panic; the purpose is to help conceptualize and eventually operationalize a new level of care that will benefit the people we serve in our facilities and also the staff that serve them.

Let's start with a basic definition of trauma.

""Trauma" refers to experiences that cause intense physical and psychological stress reactions. Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, TIP#57, 2014). PALTC facilities should use this broader definition of trauma, not the narrower definition found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

When an individual moves into a PALTC setting, their trauma history comes with them. The long-term effects of adverse childhood experiences (ACEs) on health and well-being are well-documented. For individuals who grew up in a household with domestic violence or where someone was abusing drugs or alcohol, the lifelong impact of developmental trauma can manifest in the PALTC setting.

Sources of trauma are varied, all of which can have long-lasting post-traumatic stress repercussions. Typically, when people think about trauma, events like rape, murder, torture, abuse, and natural disasters come to mind. Additionally, many residents and patients have experienced *medically-related trauma*, such as sedation, intubation, invasive medical interventions and restraints, or perhaps they received a diagnosis that is life altering or life limiting. Aging and illness can be traumatic, especially when the result is the loss of independence, function, finances or requires transitioning into a different living environment.

Remember years ago, when the "culture change" movement started, and more recently, the movement for person-centered care? These concepts required (and still do) a shift in how we care for residents and patients, including the processes that we work with every day. The same holds true for TIC. Becoming trauma-informed is not an item on a checklist. It is not something to be assigned to one person or department. "Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date" (SAMHSA, 2014). Becoming trauma-informed requires a facility-wide commitment to fundamentally changing the way we treat the people we serve, *and the staff that serve them*. A trauma-informed organization recognizes that staff, too, have trauma histories, some of which are being lived out on a daily basis.

There is concern that the urge, and urgency, to "do something" will lead facilities down a broken path that could result in a helter-skelter approach to becoming trauma-informed that may actually do harm. Becoming a TIC organization requires as much thinking as doing. In our eagerness to meet the requirements, it might be tempting to rush in, pick a trauma screening tool, assign the task to someone, and think your facility is magically trauma-informed. This is wrong. Slow down and consider the implications of what we are being asked to do.

Fundamentally, we must embrace a paradigm shift that offers a new way of approaching residents and patients that asks, "What happened to you?" rather than "What's wrong

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with you?" Staff must also be aware of their own perceptions of what they consider traumatic and not judge residents' and patients' interpretation of their experience. Trauma is what the person says it is; individuals may experience the same, or similar, traumatic events very differently. Trauma reactions may manifest as depression, anxiety, fear, isolation, insomnia, decreased coping ability, challenging behavioral expressions and overall decline.

Without knowing, staff may retraumatize a person when triggers (associations that are paired with a traumatic event) occur in the PALTC setting – things like a darkened room, being in an institutional environment, being told what to do, the smell of body fluids or the sound of a resident in distress yelling (Janssen, 2019). Triggers (think of them as trauma reminders) can be interpreted as "I'm not safe," "I can't protect myself," or "I'm going to die" (Janssen, 2019). So, rather than label a person as "noncompliant," "refusing care" or "difficult," instead we must be diligent about asking ourselves, and each other, if the person's response (usually labeled as a "behavior") could be trauma-related, which requires an entirely different approach to care.

When staff asks a person trauma-related questions, they must be prepared for the answers. Typical trauma questions inquire about difficult times in a person's life or if they were ever in a situation in which they thought they were going to die. Imagine asking those questions and the resident says, "My husband wasn't feeling well when he went to bed. He never woke up. It's my fault." Or, "I was just diagnosed with lung cancer and I'm so angry at myself for not quitting smoking when I was young." Or, "I saw my neighbor shoot my dog." Or, "I was tied to the bed in the hospital because I kept pulling out my IV. It's hard to breathe if I feel like I can't escape." Of course, responses like these indicate an individual with capacity to engage in that level of discussion. Trauma screening and assessment pose different challenges when the resident or patient is unable to participate in the process, perhaps due to a cognitive impairment or dementia.

Not only is it unfair to place untrained staff in a position to conduct a trauma screen, it is unfair to ask for such personal information and not be prepared to respond appropriately, both in the moment and with additional resources if necessary. We must realize that we are being tasked with something very important and it is not to be taken lightly. The questions we ask around trauma can be traumatic in and of themselves and we have an ethical responsibility to be aware, informed and prepared to support our residents.

We do not need to wait on guidance from CMS to begin the journey to become trauma-informed organizations. But let's approach this deliberately and with understanding; change takes time and diligent effort. Here are some great resources to get you started:

- "Resources to Support Trauma Informed Care for Persons in Post-Acute and Long Term Care Settings" https://www.lsqin.org/wp-content/uploads/2018/09/Trauma-Informed-Care-Resources.pdf
- A Treatment Improvement Protocol Trauma-Informed Care in Behavioral Health Services, SAMHSA Tip #57 https://store.samhsa.gov/system/files/sma14-4816.pdf. This industry staple explains the 4 concepts of TIC as well as the stages to creating a TIC organization.
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, https://store.samhsa.gov/system/files/sma14-4884.pdf
- Talking About Trauma, Guide to Conversations and Screening for Health and Other Service Providers. https://www.blueknot.org.au/Portals/2/Newsletter/Talking%20About%20Trauma%20Services_WEB.pdf?ver=2018-04-06-160830-113 Published 2018.
- Janssen, S. Assessing for PTSD in Terminally Ill Patients. *The New Social Worker*. Spring/Summer 2019. https://www.socialworker.com/feature-articles/practice/assessing-for-ptsd-in-terminally-ill-patients/.

So, back to the question in the title. TIC is not "just another requirement." It is so much more than that and more importantly, as our facilities and staff become trauma-informed, we will provide better and more compassionate care to residents, patients, families and even staff.

Please join me for a 60 minute webinar on trauma-informed care on 6/4/19 at 10:00 AM or 2:00 PM EST, as I will be digging even deeper into this subject matter. The webinar has been approved by the National Association of Boards (NAB) for 1.25 of continuing education credit. For more information and to register go to www.WebinarLTC.com or call 800-807-4553. I look forward to having you with us!

Broad River Rehab, "*A **knowledgeable** and **compassionate** Partner*"

FY 2020 SNF PPS/PDPM Updates

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affairs

As you may be aware, on April 19th CMS released the FY 2020 SNF PPS Proposed Rule that sets forth the proposed updates to FY 2020 beginning Oct 1, 2019. A copy of the proposed rule may be found here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08108.pdf As you know, CMS finalized the Patient Driven Payment Model in last year's final rule, so the proposed rule contains mostly expected revisions related to the new payment model.

However, CMS also uses more than half (147 pages) of the 232-page document to detail significant proposed updates to the IMPACT act quality reporting program (QRP). It is important that providers understand the proposed updates to the PDPM as well as the future of QRP. In this article, we have provided a synopsis of the major provisions of the proposed rule.

FY 2020 SNF PPS/PDPM Updates

1. CMS has proposed a Market Basket Update of 2.5%. This equates to $887 million in aggregate payments to SNFs during FY 2020.
2. Base Rates for all PDPM Payment categories have all been updated:
3. Several of the PDPM payment category CMIs have been revised
4. The Relative Importance Factor has been updated.
    a. Labor Related: 0.708
    b. Non-Labor Related: 0.292
5. Wage Index Adjusted Rate Calculation same as FY 2019: The total case-mix adjusted per diem rate is the sum of all five case-mix adjusted components into which a patient classifies, and the non-case-mix component rate.
   In order to calculate the labor portion of the case-mix adjusted per diem rate, one would multiply the total case-mix adjusted per diem rate by the FY 2020 labor-related share percentage. The remaining portion of the rate would be the non-labor portion.
   The final case mix adjusted rate would be the sum of the Wage index adjusted labor related portion of the total case-mix adjusted per diem rate and the non-labor related portion of the total case-mix adjusted per diem rate.
6. Updated Wage Indexes: can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html

SNF-Level of Care – Administrative Presumption

CMS is retaining the Administrative Level of Care Presumption defined at section 30.1 of CMS Pub. 100-2 Chap.8 with modifications to accommodate the differences between RUG IV and the PDPM. CMS continues to believe that this designation reflects an administrative presumption that those beneficiaries who are correctly assigned one of the designated case-mix classifiers on the 5-day Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment. This presumption recognizes the strong likelihood that those beneficiaries who are assigned one of the designated case-mix classifiers during the immediate post-hospital period would require a covered level of care, which would be less likely for other beneficiaries.

Group Therapy Redefined

CMS is proposing to define group therapy in the SNF Part A setting as a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities. CMS believes this definition would offer therapists more clinical flexibility when determining the appropriate number for a group, without compromising the therapist's ability to manage the group and the patient's ability to interact effectively and benefit from group therapy. CMS also believes this revised definition would support CMS' cross-setting initiatives under the IMPACT Act and Meaningful Measures Initiative, and would align the definition of group therapy used under the SNF PPS more closely with the definitions used within the outpatient setting covered under Medicare Part B and under the IRF PPS, and that this type of standardization would reduce administrative burden on providers by utilizing the same or similar definitions across settings.

Sub Regulatory Process for Updating ICD-10 Initiated

CMS indicates that it is essential that they are able to update the code mappings and lists consistent with the latest coding guidance. Therefore, to ensure that the ICD-10 mappings and lists used under PDPM reflect the most up to date codes possible, CMS is proposing to update any ICD-10 code mappings and lists used under PDPM, as well as the SNF GROUPER software and other such products related to patient classification and billing, through a subregulatory process which would consist of posting updated code mappings and lists on the PDPM website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Beginning with the updates for FY 2020 , nonsubstantive changes (changes limited to those specific changes that are necessary to maintain consistency with the most current ICD–10 medical code data set) to the ICD-10 codes included on the code mappings and lists under the PDPM would be applied through this subregulatory process. Substantive revisions (changes that go beyond the intention of maintaining consistency with the most current ICD-10 medical code data set. For instance, changes to the assignment of a code to a comorbidity list or other changes that amount to changes in policy) to the ICD–10 codes on the code mappings and lists used under the PDPM would be proposed and finalized through notice and comment rulemaking.

Quality Reporting Program (QRP) Updates

1. CMS is proposing to expand data collection for the SNF QRP quality measures to all SNF residents, regardless of payer source.
2. 2 New Proposed QRP Measures to begin to be reported FY 2022 (Both of these proposed measures support CMS's Meaningful Measures priority of promoting effective communication and coordination of care, specifically the Meaningful Measure area of the transfer of health information and interoperability):

· (1) Transfer of Health Information to the Provider–Post-Acute Care (PAC); assesses for the timely transfer of health information, specifically a reconciled medication list. This measure evaluates for the transfer of information when a patient is transferred or discharged from their current setting to a subsequent provider defined as a short-term general hospital, a SNF, intermediate care, home under care of an

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organized home health service organization or hospice, hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

SNF Denominator

The denominator is the total number of SNF Medicare Part A covered resident stays ending in discharge to a short-term general hospital, another SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital. Discharge to one of these providers is determined based on response to the discharge location item, A2105, of the MDS assessment, shown below. A stay is defined as the time period from resident admission or reentry to the facility (identified by a 5-day PPS assessment) to discharge.

SNF Numerator

The numerator is the number of stays for which the MDS 3.0 indicated that the following is true: At the time of discharge, the facility provided a current reconciled medication list to the subsequent provider (A2121= [1]).

· (2) Transfer of Health Information to the Patient–Post-Acute Care (PAC). This proposed measure assesses for and reports on the timely transfer of health information, i.e., a current reconciled medication list, to the patient/resident when discharged from their current setting of post-acute care to a private home/apartment, board and care home, assisted living, group home, transitional living, or home under the care of an organized home health service organization or hospice.

SNF Denominator

The denominator for this measure is the total number of SNF Medicare Part A covered resident stays ending in discharge to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice. Discharge to one of these locations is determined based on response to the discharge location item, A2105, of the MDS assessment, shown below. A stay is defined as the time period from resident admission or reentry to the facility (identified by a 5-day PPS assessment) to discharge.

SNF Numerator

The numerator is the number of stays for which the MDS 3.0 indicated that the following is true: At the time of discharge, the facility provided a current reconciled medication list to the resident, family and/or caregiver (A2122= [1]).

3. CMS is proposing to update the specifications for the Discharge to Community–PAC SNF QRP measure to exclude baseline nursing facility (NF) residents from the measure. Baseline residents are residents who lived in a NF prior to their SNF stay and may not be expected to return to the community following their SNF stay.

4. Standardized Patient Assessment Data Elements (SPADEs): The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for post-acute care (PAC) settings. The four PAC settings specified in the IMPACT Act are home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), and skilled nursing facilities (SNFs). The goals of implementing cross-setting SPADEs are to facilitate care coordination, interoperability, and improve Medicare beneficiary outcomes.

Existing PAC assessment instruments (i.e., OASIS for HHAs, IRF-PAI for IRFs, LCDS for LTCHs, and the MDS for SNFs) often collect data elements pertaining to similar concepts, but the individual data elements -- questions and response options -- vary by assessment instrument. With a few exceptions, the data elements collected in these assessment instruments are not currently standardized or interoperable, therefore, patient responses across the assessment instruments cannot be compared easily.

The IMPACT Act further requires that the assessment instruments described above be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. Implementation of a core set of standardized assessment items across PAC settings has important implications for Medicare beneficiaries, families, providers, and policymakers. CMS is proposing standardized patient assessment data elements for five categories specified in the IMPACT Act. These categories are:

1.Cognitive function (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
2.Special services, treatments, and interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
3.Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
4.Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
5.Other categories as deemed necessary by the Secretary

CMS has finalized the adoption of SPADEs for two of the categories (1) Functional status: Data elements currently reported by NFs to calculate the measure Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); and (2) Medical conditions and comorbidities: the data elements used to calculate the pressure ulcer measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and the replacement measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/ Injury.

CMS is also proposing that SNFs would be required to report an extensive new group of SPADEs beginning with the FY 2022 SNF QRP. If finalized as proposed, SNFs would be required to report these data with respect to SNF admissions and discharges that occur between October 1, 2020 and December 31, 2020 for the FY 2022 SNF QRP. Beginning with the FY 2023 SNF QRP, CMS proposes that SNFs must report data with respect to admissions and discharges that occur during the subsequent calendar year (for example, CY 2021 for the FY 2023 SNF QRP, CY 2022 for the FY 2024 SNF QRP).

The following is a list of the proposed SPADEs. The document located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Proposed-Specifications-for-SNF-QRP-Quality-Measures-and-SPADE.pdf offers an much more thorough explanation of the proposed SPADEs listed below as well as examples of the proposed data elements as they would appear in assessment tools, **most of which have been modified from the way they appear in the current assessment tools, including the MDS**. I a recent Open-Door Forum, CMS indicated that these additional proposed SPADEs, while not part of any formal QRP measure, would be subject to the QRP APU requirements.

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A. **SPADEs for Cognitive function (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)**

1. The Brief Interview for Mental Status (BIMS)
2. The Confusion Assessment Method (CAM)
3. Mental Status (Depressed Mood) PHQ-2 to 9

B. **SPADEs to Assess for Special Services, Treatments, and Interventions**

1. Chemotherapy
2. Radiation
3. Oxygen Therapy
4. Suctioning
5. Tracheostomy Care
6. Non-invasive Mechanical Ventilation
7. Invasive Mechanical ventilation
8. IV Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)
9. Transfusions
10. Dialysis (Hemodialysis, Peritoneal dialysis)
11. V Access (Peripheral IV, Midline, Central line)
12. Parenteral/IV Feeding
13. Feeding Tube
14. Mechanically Altered Diet
15. Therapeutic Diet
16. High-Risk Drug Classes: Use and Indication (anticoagulants; antiplatelets; hypoglycemics (including insulin); opioids; antipsychotics; and antibiotics)

C. **SPADEs to Assess for Medical Conditions and Co-Morbidities**

1. Pain Interference

D. **SPADEs to assess for Impairments**

1. Hearing and Vision Impairments
2. Vision

E. **SPADEs to assess for a new category: Social Determinants of Health**

1. Race and Ethnicity
2. Preferred Language and Interpreter Services
3. Health Literacy
4. Transportation
5. Social Isolation

5. CMS also posted concepts of Proposed future QRP measures and SPADES that are under consideration:
   A. Assessment Based:
      1. Functional Maintenance Outcomes
      2. Opioid use and frequency
      3. Exchange of electronic health information and interoperability
   B. Claims Based:
      1. Healthcare-Associated infections in SNFs
   C. SPADEs:
      1. Cognitive complexity, such as executive function and memory
      2. Dementia
      3. Bladder and Bowel continence including appliance use and episodes of incontinence
      4. Care preferences, advance care directives and goals of care
      5. Caregiver status
      6. Veteran status
      7. Health disparities and risk factors, including education, sex and gender identity, and sexual orientation
6. SNFs are currently required to submit MDS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system. CMS will be migrating to a new internet Quality Improvement and Evaluation System (iQIES) that will enable real-time upgrades over the next few years, and CMS is proposing to designate that system as the data submission system for the SNF QRP once it becomes available, but no later than October 1, 2021. CMS is proposing to replace the Survey Provider Enhanced Reports (CASPER)" with "CMS designated data submission". CMS is also proposing to replace the reference to the "Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP)" with "CMS designated data submission" and replace the reference to "QIES ASAP" with "CMS designated data submission system" effective October 1, 2019. In addition, CMS is proposing to notify the public of any future changes to the CMS designated system using subregulatory mechanisms, such as website postings, listserv messaging, and webinars.
7. CMS is proposing to begin publicly displaying data for the Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) measure beginning CY 2020 or as soon as technically feasible.

Proposed SNF Value Based Purchasing Updates

1. The SNFPPR and the SNF QRP potentially preventable readmission measures assess different aspects of SNF care, CNS has received stakeholder feedback that having two SNF potentially preventable readmission measures has caused confusion. To minimize the confusion surrounding these two different measures, CMS is changing the name of the SNFPPR to Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge.
2. FY 2022 Performance Period and Baseline Period for Subsequent Years
   A. The performance period for the FY 2022 program year will be FY2020, and the baseline period will be FY 2018. Estimated performance standards: Achievement Threshold – 0.79476, Benchmark – 0.83212
   B. CMS is proposing that SNFs would have 30 days from the date that they issue VBP reports to review the claims and measure rate information and to submit to us a correction request if the SNF believes that any of that information is inaccurate. CMS indicates that this 30-day review and correction period would commence on the day that they issue the June report, and a SNF would not be able to request that CMS correct any underlying claims or its measure rate after the conclusion of that 30-day period. This proposal would change the deadline from March 31st of the following year.
   C. CMS published Table 18 that estimated the SNVBP Impact to SNFs for FY 2020

FY 2020 Proposed Rule Impact Analysis

1. Information Collection Requirements
   A. CMS estimates that the total number of PPS 5-day assessments, PPS discharge assessments, and IPAs that would be completed across all facilities will be 4,905,042 assessments (2,406,401 + 2,406,401 + 92,240, respectively). The total estimated time for all assessments across all facilities is 4,169,286 hours per year (4,905,042 assessments x 0.85 hours/assessment). For all assessments across all facilities, CMS estimates a burden of $280,421,251 (4,905,042 assessments x $57.17/assessment).
   B. CMS posted Table 17 which displayed estimates to the overall Impact to SNFs for FY 2020

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