Public Hearing Comments

August 2, 2018, at 10:00am

Woolfolk State Office Building, Room 145

Long-Term Care Updates #2

Kelly Stringer

Mississippi Healthcare Association (MHCA)

Good morning. Kelly Stringer, legal counsel for the Mississippi Healthcare Association. I thank the Division of Medicaid for the opportunity to provide comment this morning on the proposed amendments to the State Plan. The Mississippi Healthcare Association did submit written comments to the Division of Medicaid, which I hope that there has been opportunity to review. I brought a copy of those comments with me this morning, if needed. I want to address an issue which goes beyond the practical concerns surrounding the MDS penalty, and that's the lack of authority of the Division of Medicaid to create or impose the MDS penalty. As a state agency, Medicaid's power is limited by the legislative authority that has been granted it. An agency of the state, including Division of Medicaid, only has the powers which

have expressly or implicitly been granted it, and an administrative agency is restricted from exceeding the authority which it has been granted. It's well settled law in Mississippi. It's well understood the fact that an agency is limited by and cannot exceed the powers granted it by legislative enactment. Respectfully, Medicaid has not been empowered by legislative authority to implement a penalty on perceived errors on MDS submissions. The statutory provision establishing Medicaid's authority is codified in Section 43-13-121 of the Mississippi Code. And that states that the Division shall administer the Medicaid program under the provisions of this article and may do the following. It then goes on to list the authority of Medicaid to act. Nowhere in that provision or in any other statute has Medicaid been authorized to impose a penalty on MDS submissions. There's no express authority, and there's no implied authority. While Medicaid does have authority to submit a State Plan, it must do so subject to the limitations of Section 22 43-13-121. Now, there are certain penalties Medicaid has been authorized to enact. One of those is to impose penalties on Medicaid-only facilities for noncompliance of certification standards. That penalty is very specific, and it's inherently different from the MDS penalty. There's also statutory authority for a bed assessment. As part of that, there is authority for a late payment penalty. Likewise, that particular penalty is inherently different from the proposed MDS penalty. In addition to the fact that Mississippi law is well established that an agency must act within the powers it's been granted, the inclusion of those particular penalty provisions within the statutes governing Medicaid further indicates that Medicaid would need specific and express authority to create the MDS penalty at issue. Notwithstanding the negative and the potentially catastrophic effect on the long-term care industry and the concerns with the processes by which the penalty will be imposed, Medicaid, to put it simply, does not have the necessary legislatively-granted authority to create or to impose the MDS penalty. An amendment of the State Plan to include the penalty exceeds Medicaid's authority, and for that reason alone Division of Medicaid should withdraw this provision of the State Plan amendment. I will state one matter of substance. Generally as to the MDS penalty, I acknowledge Medicaid's apparent concerns with the error rates in the MDS submissions. But what this penalty does not do is address the root cause of those concerns, nor does it provide a methodology to correct those concerns. It's merely penal in nature. I would offer that if Medicaid's concern is in fact the MDS assessment error rate that the imposition of a penalty system is simply not the best solution. Regardless, at the present time, Medicaid has no authority legally to modify the State Plan to include the MDS penalty. And the Mississippi Healthcare Association would ask Medicaid to respect and abide by the limitations on its powers. Thank you.

Nisa McNeil

Registered Nurse (RN)

Good morning. I'm Nisa McNeil. I'm a registered nurse. I do MDSs, and so I'm going to talk a little bit about the MDS penalty. So let me give you a little background on what the MDS is. The Resident Assessment Instrument, which is the RAI, consists of three components. You have the MDS, which is the minimum dataset. You have the care plan through our resident assessments, and you have the guidelines which the federal government instructs us how to code that MDS. So we use those three components of the RAI to get information about our residents' functional status, their strengths, their weaknesses, their preferences, as well as offering guidance on further assessment once problems have been identified. Case mix audits are performed to determine if the facility's documentation is sufficient based on the supportive documentation requirements developed and implemented by the Division of Medicaid. These documentation requirements are in addition and often in direct opposition of the federally-mandated

Resident Assessment Instrument guidelines. So, simply, this places our residents or nurses between coding and compliance with CMS rules of participation and compliance with state regulations. So let's look at a few of those conflicts that are in the Mississippi's top reported errors from last year's Myers and Stauffer's training. So the number one error that they said was diagnosis coding. So diagnoses drive the care that the resident is given. So everyone understands how important a diagnosis is, whether or not you have a diagnosis that is new, such as pneumonia, or whether or not you have a chronic diagnosis, such as COPD or diabetes. So urosepsis is a type of septicemia. So septicemia is one of those items we code on the MDS. Anybody that knows what urosepsis is a type of septicemia caused by a urinary tract infection, where it's very common in our elderly population in long-term care. So, basically, the RAI says if we follow the guidelines, which includes a physician-documented diagnosis within 60 days and that we have active evidence of that diagnosis within the past seven days, then we can code that item on the MDS. It doesn't have any further recommendations for coding septicemia. However, if we look at the guidelines that are in place by the Division of Medicaid, it says that we have to have positive blood cultures to be able to code that on the MDS. So if you look at the MDS and we're using that instrument to plan our plan of care for that resident and we eliminate that, we've eliminated it from our federal guidelines, which we need for survey, and then we've eliminated that in our care planning process as well. So septicemia is very important because it centers that resident's care and determines how we need to care for that resident throughout their stay. Another common error is restorative. So if you're unfamiliar with the restorative plan that is where our nurse assistants help the residents with therapy to help adapt and adjust to living as independently as possible. So an example of that could be transferring or walking assistance. So a restorative program under the supported documentation guidelines state that we must have evidence of a periodic evaluation by a licensed nurse. So that's no different than what the RAI says, so the federal government says we also need to have an evaluation. What is different is we recently had a case mix audit in one of our facilities that stated the evaluation lacked documentation showing the resident issue with transferring and steps the staff took to correct. So the facility did indeed have an evaluation. However, according to the audit reporting, the evaluation was not good enough to substantiate coding that item on the MDS. So the facility provided the care. They complied with all federal and state guidelines and was still issued an error regarding the finding. So not only do we have to manage the supportive guidelines that differ from our RAI manual, but we also have to deal with subjective auditing. So number three is one I feel really compassionate about because we have a lot of residents, especially in Mississippi, that have COPD. COPD is chronic obstruction pulmonary disorder, and it's a progressive disease that makes it very difficult to breathe. So progressive means it gets worse over time. Imagine a resident that has COPD, and they have trouble while lying flat. That resident requires extra assistance by the staff. So we have to look at that resident. We have to determine what is going to help that resident not incur that trouble breathing while lying flat. So sometimes we put the resident in a recliner. Sometimes we use extra pillows on their head. We put that in the care plan. We let our staff know about that so that we know if something is to happen with that resident and they can't communicate that to us that we have that in their plan of care. So the Mississippi Division of Medicaid, their supportive documentation would not allow us to code shortness of breath while lying flat if the resident simply stated to us that they have trouble breathing while lying flat. Although, an example in the RAI manual says that a resident had trouble while lying flat, communicated with the nurse that they had trouble, and, therefore, you are to code that item on the MDS as trouble breathing while lying flat. So we also posed that question at the last Myers and Stauffer training, and the answer we were given was that we must observe the resident lying flat. So our question to pose to Medicaid is do you want me to put that resident in a position where they're short of breath to be

able to code that item on the MDS. So let's look at an even simpler example, which is the Bims interview. So CMS stated that the MDS should be the resident's voice. So in 2010 they introduced four interviews that we were to give to our resident. They also told us exactly what to say during those interviews. They gave us a script. One of the first questions in the Bims is, "I'm going to say three words for you to remember. The first -- the words are sock, blue, and bed." And they'll tell me those three words. So if I were interviewing my resident and they told me those three words, I would code it on the MDS. But for Mississippi case mix, if the resident told me those three words I coded on the MDS but I failed to document exactly what that resident said, then that is included in an error. So that's included in my error rate and changes my category. So with each example that I presented, the facility is left in a conundrum to decide whether to follow the RAI guidelines to be in compliance with CMS recertification process or follow the case mix guidelines to be in compliance with the Division of Medicaid and thus avoid further penalties to the facility rate. So, as a provider, our resident is the foremost center of our care and of our MDS. So, therefore, the MDS should paint an accurate picture of our MDS and our resident. And if the facility follows those Mississippi supportive documentation requirements, then that painting of the picture becomes blurry. Thank you.

Angela Cooper

Registered Nurse (RN)

Good morning. My name is Angela Cooper, and I have been a registered nurse in the State of Mississippi for over 23 years. Almost my entire career has been spent in long-term care. I have been a floor nurse, staff developer, a director of nursing, a nurse consultant, and now I'm able to serve my company as director of clinical services. We have eight skilled nursing facilities in Mississippi. I've also coded many MDSs in my tenure as a healthcare provider and been in management positions that assisted with the process of overseeing and guiding our MDS nurses with teaching and training to ensure they're accurately assessing, care planning, and coding for us to be able to provide the highest quality of care for our residents. I tell you all of that so that you understand I've been around case mix the bulk of my career. The new plan, which came with only two days of prior notice, quite frankly, scares me. The centers already are so very busy documenting the care and coding to such stringent case mix guidelines that they're not able to spend that quality of time with the patients themselves who need us. That seems to be the fate of healthcare this day, and it's quite sad to me. More legislation, more documentation means more time away from our patients. First of all, I would like to make it clear that coding the MDS is part of the resident assessment process to ensure quality of care for our residents. Coding the MDS leads to items triggering on the care area assessments, also known as the CAAs in our world. From the care area assessments, the care givers make the decisions to care plan various items that were coded, to have the resident-specific care plan, which is our plan that we use to take care of our residents. The primary reason for MDS assessments is for us to guide the resident care process and ensure quality resident care and the best outcomes for that population. The financial piece of the MDS is secondary to that. So let me tell you a little bit more about our process so that you better understand it. All assess -- all residents are assessed, and that information is coded on a minimum dataset, also known as an MDS form, and transmitted to CMS. This must happen on admission and at least quarterly thereafter. We get a score based on the acuity level of the resident, meaning how sick they are, how much assistance they need. By coding these MDS assessments, we paint a picture of the resident's functional status, showing what they can do for themselves, what they can't, their diagnoses, their mental status, and their preferences, just to name a few.

That is over 400 questions for each resident for each assessment. The higher the acuity level, meaning the more assistance that they need or how sick they are, the more that is coded on the MDS. The more coded on the MDS means a higher score for that particular resident. And all of the residents in the center, their scores are averaged together to get an overall case mix score for that center, and that's how the Division of Medicaid sets the Medicaid rates for the center on a quarterly basis. Now, that's a very high level kind of a -- just to tell you how that is -- that process is. But it is a lot more convoluted than that, and I don't truly understand all of the ramifications of it. But I wanted to kind of give you a high level overview. I know that Nisa already spoke of this, but I find it so important to speak of it again. There is one particular coding requirement made by the State of Mississippi that I feel puts the resident in a dire situation and a risk for a negative clinical event. And that would be coding for MDS Section J -- question J1100C, shortness of breath when lying flat. We are unable to code for this unless we have a situation where we lay the resident flat and they become short of breath. In my opinion, it is horrible to put a resident in an uncomfortable compromised position just to code a box on the MDS. We must document the specific instance when it happens during the look back period for that particular assessment. These types of residents are chronic and never lie flat due to being compromised. They're anxious. They can't breathe. And they are not going to lie flat. That impedes our care. We have to do this, and, yet, our company won't. We don't want to code this because we don't want to put the resident flat to be able to code it. However, the CMS RAI manual, which is the federal manual that says how we should be coding our MDSs, is a little bit different. It says that we can code it without having the specific observation of one specific instance. It also says that we can code it if residents sometimes limit their activities from shortness of breath due to lying flat. And it also says that we can code it if the resident avoids lying flat just to prevent shortness of breath. Why would we subject patients to a potential harm in order to check a box on a form? In healthcare we're supposed to do no harm. We should be able to code the question without putting the resident in a contraindicated position. Also, if we're unable to code shortness of breath while lying flat due to the resident never lying flat because they can't, because they can't breathe, then we will not be able to code the MDS properly, which leads us to not being able to have triggers from the care area assessments, which leads to a thorough care plan. And these supportive documentation requirements could potentially cause us to not have a thorough assessment and thorough care plan, and I find that problematic. Also, I was quite surprised to see that the State Plan amendment has of the case mix audit reviews at least 10 percent of total facility beds being selected. But in my entire career it has always been 20 percent of licensed beds. So I am curious about that. So please let's reconsider this plan. Let's come up with a collaborative approach to where we work with the Division of Medicaid on these case mix supportive documentation requirements that are so incredibly detailed and work more towards the resident assessment manual. We all want a process that allows the Division of Medicaid to assess for reimbursement. We definitely do. But we want a process that will allow us to take better care of our residents and cut through the red tape that takes us away from patient care. Thank you.

Cassandra Chancellor

Registered Nurse (RN)

Good morning. I'm Cassandra Chancellor. I've been a nurse for 43 years in the State of Mississippi. Thirty-two of those 43 years have been spent working in long-term care, specifically long-term care clinical reimbursement of the MDS. I started out my career as a case mix review nurse, auditor. During that timeframe, part of my task included the development and implementation of the original case mix

review process, as well as the very first set of documentation guidelines for that MDS. From that job, I was promoted to the project manager for the case mix demonstration project and was then later promoted to the Division of Medicaid as a Division director of long-term institutional care for the Division of Medicaid. I currently am a regional clinical reimbursement specialist with a company that oversees 13 facilities here in Mississippi. And specifically I oversee the MDS process in clinical reimbursement of these facilities. Needless to say, there's been a lot of changes since that a long time ago in that process, and it seems now that this is necessary again to make more changes. Unfortunately, every MDS nurse in this state are being put in a position to decide whether or not to follow RAI federal mandated regulations or state Division of Medicaid regulations when coding the MDS for their residents. The purpose of the RAI manual, as the lady stated earlier, is to offer clear guidance about how to use the RAI correctly and effectively to help provide the appropriate care for the resident. This was well brought out by the previous speakers that whatever you code on the MDS is eventually going to end up on your plan of care of how you take care of your residents. Based on how you code the MDS care areas, they're triggered or flagged. These are the areas that you proceed to care plan with. These are the areas that your care plan must have in them. In addition to this, the coding affects the amount of payment that you receive from the facility from Medicaid. The SDR, or the document requirements from the Division of Medicaid, addresses only the payment system and the payment items for the MDS system that's required for the documentation. And it is very specific documentation that's for the MDS. As a long-term care clinical reimbursement specialist, the dilemma that we face today is not the fact that we are required to provide supporting documentation for issues. As nurses, that's what we are trained to do. This is part of our school. This is part of our career. You document what you do for your residents. The dilemma is that we are faced with deciding which system do we follow. Do we go with the federal guidelines in the RAI manual? If we don't, then you're going to be subject to penalties from the survey and licensure certification process, which also is going to affect the care of your resident because everything that your care plan is going to come from that MDS assessment. Or do you code your MDS based on reimbursement items that are mandated in the supported documentation requirements. Going back again to the beginning of the case mix program and the work that we did in it, the documentation guideline, which is now referred to as a supporting documentation requirement, was a guide that I created specifically to assist the nurses in documentation. All that I did in that document was take word for word from the RAI manual and put it in a condensed smaller version so that our nurses could use it so that they could -- so that they could document what was required of them. I don't know if anybody has seen the RAI manual. But if you're talking about direction on coding over 400 items, then you've got directions on doing the CAA process and care planning, this manual could be this thick. We needed a way to train our MDS nurses in the state, our case mix review nurses, as well as the nurses in the facility, on how to document this very important document that we're required to use. So what do you do? You know, what do you do? This is what my MDS nurses are now going through. Do you code according to the federal requirements so that you satisfy the compliance with the recertification survey process, or do you code your MDS based on the requirements from the Division of Medicaid regulations, and you risk having an inaccurate care plan. That's the bottom line, y'all. All I can see is a “lose/lose” situation here. And you know who's losing? It's our residents. It is our residents' quality of life and quality of care that we're missing out on. I think we need uniformity between our federal and state regulations and guidelines and not two separate different document requirements for our nurses in the State of Mississippi to follow. Thank you.

Shane Hariel

Horne, LLP

Thank you. My name is Shane Hariel. I'm partner with Horne, LLP. We did submit comments on this particular SPA. And I do refer to those. Some, though, I will just hit kind of some of the high points. First of all, thanks to the Division of Medicaid for allowing public comments, written comments. My comments will be brief today since I think I've covered them pretty extensively in the previous written submission. They will be limited to just my concerns on the MDS penalty and its impact on providers. The one thing that I have observed through the case mix audits in the past -- and let me just say I'm not a case mix audit expert, MDS expert. But, you know, common sense tells me in -- and I have been practicing close to 29 years -- is that any time you have two sets of standards, it will create inefficiencies, it will create errors, and it will create confusion. And so, you know, I don't think you have to be an expert. Just have a little common sense to say that if you've got some uniformity in your regulations and your policies, you're going to have better compliance. But, going back, what I have seen in the results from the average case mix audits, the reimbursement impact on direct care has been fractional in comparison to the penalties that are being proposed to being put on providers. And specifically what I would offer is that, based on the database information that we look at -- we represent a number of providers in this state and other states. Based on the data for Mississippi nursing homes, the average margin per patient day is only about $4 a day per patient day. So meaning if it costs you $190 a day to treat a patient, your average reimbursement is $194 a day. So you've got $4 to spare, the average facility. And the minimum penalty that is proposed in this SPA, the minimum penalty, is $8 per patient day. The maximum is going to be above $40 per patient day if you have extremely high error rate. Now, you don't have to be an accountant to realize that's ridiculous. And you don't have to be an accountant to realize that will put providers out of business. And I think that's the thing we just want to point out, is the total disproportionality of the penalty in relation to the reimbursement that's being reviewed and in relation to the financial condition of providers. So the ultimate result, if these penalties are moved forward and they're applied to providers, you're going to have patient access issues because providers are not going to be able to afford this kind of penalty. So I think one of the things we can agree on, the industry, as well as Medicaid, is we want error rates to go down I mean, I think that's a good start that we're starting from a place of common agreement. Providers have no interest in having high error rates they have to spend more time working on. Division of Medicaid has no desire for high error rates. They have to put more resources into it. So at least we start off at a point of agreement that both parties want lower error rates. So the question is how do you get to them. You know, I think, as been previously mentioned, assessing a penalty doesn't get rid of the error rates. It just financially cripples the provider. How do we -- how do we get the provider to make less errors or Medicaid to opine that they have made less errors. And I think uniformity is a big step, uniformity in the regulations, as I already said. That's the biggest one step you can make. But I think there are some other things you can do. You can do some targeted customized education to facilities. You could put in place at the facilities' expense even some monitoring, competency testing. There's lots of other things to accomplish what the Division says they want to accomplish, rather than using this penalty. The -- I want to see if I covered everything. But -- I think that's pretty much it, is that we just -- we just felt like and appreciate the frustration on both the providers' standpoint and Medicaid's standpoint with these errors. But the goal should be provider compliance and not just absolute financial devastation on a

provider that has these rates which I contend are significantly driven by Medicaid's choice of using different regulations. And I'd just point out this final thing, that the way this policy is written, even if facilities, because they were wanting to be conservative and not get in trouble with Medicaid and under code, they under coded everything because they didn't want to have a penalty or didn't want to overstate their direct care, they would have a high error rate. Medicaid auditors could come in and say, "Nope, you should have coded it higher. You should have coded it higher. You should have coded it higher." And all of a sudden you have increased their direct care payment and killed them with a penalty on their administrative cost. I mean, it's just absolutely absurd. Thank you for hearing my comments.

Bobby Beebe

Mississippi Healthcare Association (MHCA)

Good morning. Thank you for seeing us today. I am here on behalf of the MHCA, and also our company operates throughout the state. I had a preprepared speech, but I'm going to go off that a moment. For years our association, our industry, our people have worked in a collaborative effort with the Division of Medicaid. A little quick item would be in the year 2013, 2014, we worked together with the Division because the legislators asked that we look at our reimbursement methodology. We went through that a year and a half. Part of what we agreed to do as a group was to make some changes to the RUG's classification system and to come to what we felt was a neutral rate reimbursement adjustment. Part of that adjustment in 2014 was to go to RUG's 4. That proposal was given to us near the last of the meetings, but we sat and visited, and it made sense because that's where the nation was going, was RUG's 4. So we did it. We did that to be collaborative. We did that for the strength of our industry. We meet regularly. We have good intentions. Good intentions do not always get good results. I say that more often than I ever want to repeat, but it happens. But, in that regard, to take a facility -- which I grabbed one unit that we have, I looked at one rate sheet, and I took one penalty. And you have a rate that travels based upon your case mix, and that is adjusted up or down based upon the needs of the patients. And so if the audit proved that there was a change -- and, generally, those changes are down, rather than up -- we're still talking about $2 a day, et cetera. The penalty comes along and in this one case would take away over $8.80 a day for a quarter from a facility that averaged 55 patients. I'm looking at over $40,000 in a penalty. The word punitive comes to mind immediately. The word collaborative doesn't come to mind. The word patient care doesn't come to mind. And what happens is that operator has to continue operating to take care of those residents for the opportunity to get the correction down the road, and it is like putting someone in a vise. Not a -- not a very good way to operate. I want to echo what Shane said. Of course, we don't desire error rates. I don't believe the Division desires error rates. But we would rather work towards a solution rather than a continual ratcheting. That's a dangerous way to go on a consistent basis. The battle that we face is serving two masters. Any time you have to serve two masters you're choosing your day. I am not a nurse by trade. I'm a facility administrator. I've done that since 1985. But I do know this, nurses are driven to meet compliance and to meet certification and to meet survey. It's the word we all dread. It comes every year. It is what we work towards. So that is always in the back of your mind. And, yet, you have these additional items that come on top for coding and the worries of the shortness of breath, the cognition. Normally would score a 3, rather than having to write, "The respondent said bed, sock, blue. Even if it's out of order, you have to write it that way. So, therefore, what I'm trying to come together and say, that by

working as a partner, we believe we're working for the health of the industry long term, which is what we should do. I only have 2016 data because we're always behind. But at that time the snapshot when we closed out at the end of December was 16,476 residents, give or take. That's a lot of people to take care of in 80 of the 81 counties. There is only one county that does not have a nursing home. So let's work toward that goal, rather than against each other. Some suggestions that I believe truly in my heart are to, instead of assessing a penalty of that excess, we would agree and want to work toward having more training in our facilities, or would the Division consider using the RAI manual as the basis for the reviews. Either case brings us to a better result, rather than trying to take such a strong and quick action otherwise. I could go on for hours. I won't. It is not proper. It is not what this was designed to do. Unfortunately, I put the three ring binder back in Nisa's office this morning. The manual is this big. Well, then you've got on top of that. So, in closing, in general, it sounds like you have, in your desire, for us to be a better industry. I know it is our desire. I'd rather find a collaborative way to do it, rather than a punitive way to do that. Thank you.

Bea Tolsdorf

Independent Nursing Home Association (INHA)

Good morning, everybody. I'm Bea Tolsdorf. I'm with the Balch & Bingham law firm, and I represent the Independent Nursing Home Association. We have several representatives here today. And, like everybody else, we submitted comment letters, and we'll defer to our comment letters and just make a few points here. There have been so many great comments. We'll be brief, but we would just like to say that we concur, obviously, with all of the comments that have been made with regard to the legal problems and the actual clinical problems that could come forward with this proposed plan amendment. I would like to just reiterate what Ms. Stringer (*Kelly Stringer, MHCA*) said regarding the legal authority of Medicaid to even adopt a proposed MDS penalty. I mean, the Medicaid statutes very clearly outline the powers that Medicaid has and the fees that it can assess. This MDS penalty is just simply not there. And also to build on what Shane (*Shane Hariel, Horne LLP*) and Angela (*Angela Cooper, RN*) said, I think that there's been a lack of study with regard to the real financial impact that this proposed plan amendment will have. Not just with regard to the penalties themselves, but staffing and monies that the facilities are going to have to spend just to try and avoid getting a penalty. So, like I said, I'm going to be brief. I'm trying to be brief, anyway. I suppose that just in conclusion I would say that the INHA would just ask Medicaid to withdraw this plan amendment. Let's work together to try to find a more feasible and reasonable way to address what I guess is a perceived problem with the error rate and MDS completion, as opposed to punishing providers and just moving on without addressing the root issue.
