2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice residents:** When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.
- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
  - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("**-**") (See Chapter 3 for more information).
  - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs and must initiate a plan of care to meet those needs upon admission.
  - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g., pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed facilities:** SNF-level services of non-critical access hospital (non-CAH) swing bed (SB) facilities were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed facilities must assess the clinical condition of Medicare beneficiaries by completing certain MDS assessments for each Medicare resident receiving Medicare Part A SNF level of care in order to be reimbursed under the SNF PPS Patient Driven Payment Model. CMS began collecting MDS data for quality monitoring purposes of non-CAH SB facilities effective October 1, 2010. Therefore, SB providers must complete these assessments: Swing Bed PPS (SP) and Swing Bed Discharge (SD) assessments, and Entry Tracking and Death in Facility records. Swing bed facilities may also choose to complete an Interim Payment Assessment (IPA) at any time during the resident's stay in the facility. Swing bed providers must adhere to the same assessment requirements including, but not limited to, completion date, encoding

requirements, submission time frame, and RN signature. Swing bed facilities must use the instructions in this manual when completing MDS assessments.

Skilled Nursing Facility Quality Reporting Program: The IMPACT Act of 2014 established the SNF QRP. Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that SNFs are to collect and report on standardized resident assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year. Data collected for the SNF QRP is submitted through the Internet Quality Improvement Evaluation System (iQIES) as it currently is for other MDS assessments.

- Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.

The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.*
  - Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into iQIES. Therefore, these assessments cannot be submitted to iQIES.
  - Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to iQIES.
    - For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, OBRA Discharge, etc., the facility may

receive a sequencing warning message, but should still submit the required assessment.

- **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments.

— *NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.

- **Adding Certified Beds:**
  - — If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - — Medicare and Medicaid residents should not be placed in one of these additional beds until the facility has been notified that the beds have been certified.
- **Change in Ownership:** There are two types of change in ownership transactions:
  - — 1) Assumption of Assets and Liabilities: This is the most common situation and requires the new owner to assume the assets and liabilities of the prior owner and retain the current CMS Certification Number (CCN). In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - Staff with iQIES user IDs continue to use the same iQIES user IDs.
    - **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 5-Day PPS assessment was combined with the OBRA Admission assessment, the next PPS assessment could be an Interim Payment Assessment (IPA), if the provider chooses to complete one, and would also be submitted under the existing provider number.
  - — 2) No Assumption of Assets or Liabilities: There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - The beds are no longer certified.
    - There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, CMS Certification Number (CCN), etc.
    - The previous owner would complete an OBRA Discharge assessment - return not anticipated, thus code A0310F = 10, A2000 = date of ownership change, and A2105 = 02 or 03 for those residents who will remain in the facility. Refer to Chapter 3, Section A for additional guidance regarding A1805.

- The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F = 01, A1600 = date of ownership change, A1700 = 1 (admission), and A1805 = 02 or 03. Refer to Chapter 3, Section A for additional guidance regarding A1805.
- Staff who worked for the previous owner **must** update their iQIES role to submit data for the CCN associated with the new owner.
- Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.

- **Resident Transfers:**

— When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.

— When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within 14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-Day assessment.

— The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.

— When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their CMS Location (formerly known as Regional Office), State Agency, and Medicare Administrative Contractor (MAC) for guidance.

— When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their CMS Location, State Agency, and MAC for guidance.

— More information on emergency preparedness can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.