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INSIDE THIS ISSUE

CMS announces a new finalized arbitration rule, proposes another that would postpone Phase 3

Editor's note: Look for more coverage in PPS Alert's September issue.

On July 17, CMS announced two new rules that, according to a CMS press release, will prioritize SNF residents over paperwork by reducing unnecessary regulations and protecting residents' legal interests. The proposed rule would delay Phase 3 requirements, including QAPI and ethics and compliance standards. The final rule upends the ban on SNFs offering arbitration agreements to residents. These changes, fueled by the Trump administration, will modify previous rules set forth between October 2016 and June 2017.

CMS-3347-P

The first proposed rule, titled "Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency" (CMS-3347-P), eliminates regulations deemed unnecessary, obsolete, or excessively burdensome on SNFs. CMS-3347-P would reduce the hours and resources devoted to regulatory paperwork, thereby saving time and money, according to the CMS press release. If finalized, CMS projects an estimated $616 million of savings annually.

Most notably, the revisions in the proposed rule would delay some Phase 3 requirements, making the deadline for implementation one year after the rule is finalized. Specifically, the designation and training of a facility's QAPI program (483.75), infection preventionist (483.80), and compliance and ethics program (483.85) would be delayed.

Some key takeaways of CMS-3347-P:

- Should the proposal be finalized, SNFs will be required to inform residents oftheir primary physician's name and contact information only upon admission to the facility, or if there is a change of physician.

- Records of grievances are currently required to be kept for a minimum of three years. CMS-3347-P would cut this in half by reducing the recordkeeping period to 18 months.
- If passed, the proposal would shorten the time frame that nursing staffing data will need to be kept from 18 months to 15 months, or per state laws, whichever is longer.
- In the event of resident transfer or discharge, CMS-3347-P would require that residents receive a written report explaining why they are being moved, in terms that they can easily understand. Under the new rule, facilities would only need to notify the state ombudsman of "facility-initiated involuntary transfers and discharges" unless an emergency arises, and the resident is expected to return to the facility after the event.
- Currently, PRN orders of psychotropic medications cannot be extended past 14 days without a physician or qualified practitioner evaluating the resident first. CMS-3347-P would allow an extension of prescriptions beyond the two-week mark without an examination of the resident, provided the physician has clear documentation as to why he or she is extending the prescriptions.
- Directors of food and nutrition services at facilities would no longer be required to take additional food and safety courses, provided that they have either been in the director role for a minimum of two years and regularly consult with a dietitian, or have completed a minimum course in food and safety.
- If passed, SNFs would no longer be required to have an infection preventionist (IP) at the facility part time. Instead, the IP would only need to attend the facility frequently enough to meet the objectives of the facility's infection prevention and control program.
- CMS-3347-P would remove the requirement for facilities to have an ethics compliance officer. Currently, ethics and compliance programs must be reviewed annually, but the new proposal will only require a biennial review.
- The new proposal would allow older existing facilities to use the 2001 Fire Safety Equivalency System (FSES) requirements, rather than the more recent 2012 FSES requirements.
- New facilities would still be subject to the rule of two residents per room, with an attached bathroom; however, the proposal would lift this requirement for older facilities, which would be allowed to house up to four residents in a room with an attached bathroom.
- The proposal would increase the time frame for facilities to report abuse of residents.
- Facilities would be required to attempt to use alternatives before using bed rails. The risks and benefits of bed rails will need to be explained to the resident, and the resident must consent to their use.

If finalized, the changes could go into effect as early as November 28. CMS will be accepting comments on the proposed rule until September 16.

CMS-3342-F

The final rule, called "Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements" (CMS-3342-F), redacts a former rule that banned pre-dispute, binding arbitration agreements between SNFs and residents. According to the CMS press release, the reversal of "Reform of Requirements for Long-Term Care Facilities" (81 *FR* 68688) (2016 final rule) will protect the rights of residents, as they now have the option to sign arbitration agreements as a condition of admission to a SNF. Arbitration agreements are written contracts designed to keep disputes out of court, with both parties required to accept the ruling of a neutral arbitrator. The original ban was designed to offer residents or their representatives the freedom to choose what kind of legal recourse to pursue.

CMS-3327-F finalizes several provisions of the final rule:

- SNFs must not require residents to sign an agreement for binding arbitration as a condition of admission to or continuance of care at a facility

- SNFs must ensure that the agreement is adequately explained to residents in language that they understand, and receive acknowledgment from residents (or their representatives) that they fully understand what they are agreeing to
- SNFs are required to remove any language that prohibits or discourages residents from speaking about the arbitration to federal, local, or state officials
- SNFs must retain signed copies of the agreement for binding arbitration for five years following the resolution of any dispute, and make copies available to CMS upon request

To learn more about the new rules, please visit the *Federal Register* website. Look for future posts at **Post-Acute Advisor** covering these rules in more detail. ■

Expert Q&A

How to prepare for the September 30–October 1 transition to PDPM

On October 1, 2019, the reimbursement landscape as SNFs have known it for 20 years will switch overnight from the RUG-IV model to the new Patient Driven Payment Model (PDPM).

Providers will experience a sharp transition from September 30 to October 1: CMS says there will be a "hard stop" between the two payment models.

"Everything prior to September 30 will have to be billed under RUG-IV, and any services provided after October 1 will be billed under PDPM," says **Joyce Sadewicz, PT, RAC-CT,** vice president of HarmonyHelp, a part of Harmony Healthcare International.

CMS says that a transition period in which PDPM and RUG-IV ran concurrently would create an administrative burden for providers. Thus, they opted for a hard switch between the two systems.

To move patients from RUG-IV into PDPM and establish the PDPM payment rate, CMS will require providers to use the Interim Payment Assessment (IPA) item set for Medicare Part A residents who are admitted prior to October 1 and remain in the facility on that date, says **Robin L. Hillier, CPA, STNA, LNHA, RAC-MT**.

"All residents in this situation will have their PDPM rates calculated as if October 1 were day one of the stay as it relates to the variable per diem rate components for physical therapy, occupational therapy, and the non-therapy ancillaries," Hillier explains.

Providers must complete the IPA with an assessment reference date (ARD) that is no later than October 7, 2019.

If providers miss the IPAs for all patients on a covered Part A stay, you will be forced to bill the new default rate code, ZZZZZ, says **Jennifer Matoushek, MBA/HCM, CPC**, senior consultant with LW Consulting, Inc.

"Those patients will be placed in the lowest payment categories, so you want to avoid that. Additionally, CMS will assess penalties for missing the assessments," Matoushek adds.

Properly managing the billing process throughout the PDPM transition is critical to keeping your cashflow healthy during October and November, Sadewicz says.

To ensure a smooth transition into PDPM, **BALTC** asked Hillier (RH), Matoushek (JM), and Sadewicz (JS) some of our most burning questions about the RUG-IV to PDPM transition.

How should facilities manage billing for patients admitted to the SNF on a covered Part A stay in September?

RH: To bill for days in September, the facility will need a RUG-IV HIPPS code, which will only be generated from an MDS with an ARD in September. So, if there is a late September admission, the five-day assessment will have to have a September ARD, even though that might give a very short observation period.

For residents admitted after September 26, it will not be possible to capture a rehabilitation RUG score because you will not have five days in the observation period. The focus for those late September admissions should be to capture the highest appropriate nursing RUG score.

"Properly managing the billing process throughout the PDPM transition is critical to keeping your cashflow healthy during October and November."

Sadewicz

JS: If a patient is admitted on September 28, SNF will need to do an assessment with an ARD of September 30. It's unusual to do an assessment so quickly, but it is how CMS has decided to transition residents into the new payment system.

It's also important to know that you cannot do a short-stay assessment because the patients will be in the facility on Medicare Part A services after that assessment, so it's not appropriate.

The best you can do is conduct the assessment and capture that nursing RUG score so that you can receive some payment for the care provided for those few days at the end of September. Then, perform the IPA in October.

What do billers need to know when submitting the October claims?

RH: In order to bill for October, you will need a PPS assessment with an ARD in October to generate a PDPM HIPPS code. The ARD for the "transition" IPAs must be between October 1 and October 7, and providers have 14 days from the ARD selected to complete the assessments.

JS: CMS has said that you cannot mix bills. You must have one bill submitted in the RUG-IV for all services September 30 and prior, and a separate bill for PDPM for all services provided on and after October 1.

What should facilities do now to prepare to get all of the IPAs completed by the October 7 deadline?

JM: The first step is to familiarize yourself with the MDS items required to complete the IPA. I encourage everyone to refer to the MDS IPA sample that CMS published. Review it and become familiar with it now so that you will know exactly what information you must include on the IPA.

The number of IPAs you have to perform will depend on the number of patients in your facility who are on a Medicare Part A stay.

No matter how many patients you have, I recommend that you make an assessment schedule so that you know when the ARDs need to be completed. If you do not complete them on time, CMS will assess penalties.

It's very important for facilities to make sure all hands are on deck that last week of September and the first week of October. You will want anyone who completes MDS assessments and who will assist with IPA preparations to be present during that time frame to ensure you do not miss the October 7 deadline.

JS: When creating your IPA schedule, you will want to stagger the ARDs that first week of October. You do not want to perform everyone's assessment on October 7 because depending on how many Medicare Part A patients are on your census, that can be a huge amount of work.

However, you also cannot complete the assessments too early. Section GG of the MDS is a major component of the IPA, and it requires a three-day lookback period. So, I recommend they use an ARD starting on day 4, or October 4. That way, you will have enough documentation to support the function score.

You can use the first few days of October as an ARD for the PA if the facility begins collecting the data for Section GG—a major component of the IPA—at the end of September.

Will billers report HIPPS codes in the same way in PDPM?

JM: Yes, you're still going to report HIPPS codes for residents on the UB-04. That will still be a requirement in PDPM.

JS: Although the process for obtaining and reporting HIPPS codes will not change, billers need to be aware that the makeup of the HIPPS codes is different in PDPM because the assessment schedule in PDPM is different from RUG-IV. They will need to educate themselves on what the characters now correspond to.

(Tip: For more information on the new HIPPS codes, please read the RAI Manual updates article in this issue of BALTC.)

How can billers be sure that the software they use for projecting revenue is ready for PDPM?

JM: You definitely want to run test claims to ensure all the assessments are being pulled from your software and populating into the UB-04 correctly.

Also, review the reports that you run monthly for billing to ensure they are being generated accurately.

What problems do you anticipate billers facing regarding the diagnoses listed on the claim and those listed on the MDS?

RH: I anticipate the biggest problem from a theoretical aspect to be a disconnect between diagnoses being used on the MDS to generate the payment rates and diagnoses coded in the claim. It seems that in many facilities there is a disconnect between the diagnoses listed in the claim and those captured in the MDS. Facilities should start discussing diagnoses as a group to ensure everyone on the team is on the same page.

JM: Another area where billers really want to focus their attention is on the principal diagnosis. CMS does not require that the principal diagnosis on the SNF claim match the primary diagnosis in I0020B of the MDS, but it is a best practice.

If they do not match, the SNF should be asking why and determine if it's a data entry issue, or a software error.

Billers should really start looking at this now so that if it is a software issue, they can work with their vendors to address it.

Begin checking for this now by entering the primary diagnosis into the MDS and the reason for the SNF stay. That would be entered into I0020A now, but after October 1, you will enter that into I0020B.Then compare what pulls over to the claim.

How can billers project the PDPM revenue for the patients who will be in the facility during the transition to the new payment model?

JS: We recommend that they practice on their patients currently. Take one or two patients a week and run them through PDPM so they become very familiar with it.

This way, when October comes, the clinical staff knows what is needed in the medical record, the MDS coordinator knows how to code it currently on the MDS, and the biller knows that information is pulling from the MDS into the billing software appropriately. The biller will also have had plenty of practice projecting PDPM revenue for a variety of patients with different clinical conditions.

JM: Perform rate projections prior to entering into PDPM. Take a look at your current rate and compare them to your rates under PDPM. Pick a month and look at maybe 30 MDSs and compare what you received in RUG-IV to what you will receive in PDPM.

Share this information with management and with your clinician and interdisciplinary team to help them better understand the impact of what the new reimbursement system is going to have on the facility's revenue.

RH: Most long-term care software vendors have already introduced PDPM functionality that will tell you what the resident's RUG-IV score is as you complete PPS assessments, as well as what the PDPM HIPPS codes and rates will be based on the five-day assessment.

In order for this calculator to work, the MDS nurse must capture certain data elements that aren't technically required on the PPS assessments until October 1. If providers have questions about the PDPM functionality available in their software, they should reach out to their software vendor. Based on this information, you can get a fairly good projection of what revenue would look like under PDPM. ■

Emergency preparedness

Be prepared for all hazards: Training for the top issues

As hurricanes brew in the southeast U.S. and winter looms in the northern states, it's a great time to evaluate your emergency preparedness (EP) to ensure the safety of both staff and residents during an emergency.

In 2017, Hurricane Irma barreled through Florida, which resulted in the deaths of 12 SNF residents. According to the Sun Sentinel, after Irma knocked out the air conditioning in one SNF, temperatures soared to 99 degrees, and many residents succumbed to heat stroke. The deaths were ruled as homicides, and the SNF involved was found liable. Back in 2005, an astounding 35 people drowned in a flooded SNF after Hurricane Katrina. Sadly, these incidents weren't the first time SNF residents died as a result of negligent unpreparedness.

Though hurricane season is an obvious threat, emergencies of any kind can happen at any time. It's critical to have an EP plan tested and in place to avoid potentially life-threatening outcomes during a disaster.

During a natural disaster, nursing homes need to work with their region or state on addressing the issues that may come up, says Erin Prendergast, senior manager of quality improvement for the American Health Care Association.

Prendergast stresses that providers need to be familiar with who their local and state officials are and who to get a hold of should they need support, resources, or supplies. "During the event, support really takes place at a local level first," she says.

She also advises to routinely verify:

- Arrangements with other long-term care providers in case an emergency happens
- Arrangements for transportation, ensuring contracts and arrangements are in place
- Who your local and county emergency management officials are, depending on your region's infrastructure
- Methods for keeping up with NOAA and other hurricane trackers and prediction models, as these are the best sources of updated information if a storm changes direction quickly

Evacuate, or shelter in place

Depending on the type of emergency, SNFs need to have plans for either evacuation or staying in place. If emergency officials or SNF leadership order an evacuation, administrators need to have a plan to safely and quickly relocate residents.

CMS states in Appendix Z of the State Operations Manual that mobility plays a key role in successful evacuations. Because residents' mobility and medical needs vary, some are easier to transport than others. CMS suggests identifying residents who require special assistance before an emergency happens, and having appropriate transportation arranged in advance.

Prendergast says that although the regulations don't specify when to evacuate or shelter in place, they do ask providers to perform an all-hazards risk assessment and identify any risks or vulnerabilities they may have. She advises administrators to consider their facility's location and layout when developing an emergency plan. Leadership should have a good idea of what kinds of events would lead to an evacuation.

Both evacuating and sheltering in place come with challenges for providers, says Prendergast, so an emergency plan should consider the consequences of both actions.

The EP rule states that providers should consider the care and treatment of residents who are evacuated and know the staff responsibilities to support residents' care, treatment, and transportation. Administrators should identify where residents will go and know secondary ways of communicating with their evacuation location, says Prendergast.

EP pitfalls

EP plans should be as comprehensive as possible, yet many SNFs neglect to cover all their bases, says Paul

McManus, director of the Rochester, New York office at RPA, which provides fire and emergency management consultation. He identified ongoing gaps in SNF EP plans, such as:

- Effective facility evacuation planning
- Effective surge/influx planning
- Lack of ongoing collaboration with local emergency responders
- Lack of effective staff training and exercising of the plan on an annual basis
- Ability for the facility to operationalize its written plans

McManus says that the person in charge of EP at a SNF is often in charge of many other things, and sometimes lacks EP experience or knowledge. SNFs are also challenged to fund EP.

Providers often overlook keeping their emergency plan's chain of leadership up to date, notes Prendergast. She also urges SNFs to consider the "before, during, and after" stages of an emergency—for example, knowing how to inform families of their loved ones' whereabouts after an evacuation.

Direct families to a central phone number where they can get more information, even if it's a recording that explains how your organization is handling the situation and where residents are evacuating to, says Prendergast.

EP training

McManus asserts that staff training should take place upon hiring, and annually thereafter.

"Some of the things we stress is just the importance of drilling and exercising with staff in their buildings and really including all levels of staff and different shifts, as we know these events can occur at any time," says Prendergast. "So the best prep for it is really making sure all staff are comfortable with their emergency plans and that they're comfortable enough to activate them."

There are two training exercises that are expected of SNFs in addition to routine fire drill training, according to McManus:

- Staff (and facility volunteers) must be trained on their expected roles and responsibilities during an emergency or disaster and must be able to demonstrate knowledge of the facility's emergency procedures
- SNFs must conduct an additional exercise that may be a tabletop exercise, community drill, or facility-based exercise

In addition to staff training, SNFs should have a written communication plan in place with staff and residents as part of their EP. McManus suggests including the following in any such document:

- What residents and/or their families should do when the fire alarm activates (e.g., follow staff instruction, defend in place)
- How staff will be communicated with or have access to the facility if normal means (telephones) are impacted by the emergency or disaster
- Information on how staff are trained in fire and emergency incident response
- How drills and exercises are conducted to evaluate staff knowledge and plan effectiveness
- How the facility will shelter in place or issue notification if the facility is forced to fully evacuate

Prendergast reminds LTC leadership that new employees must receive EP training as part of their onboarding process. When conducting full-scale community-based exercises, include external stakeholders such as EMS, fire department, and other nearby providers. "It's important to get that comfort level with different entities," says Prendergast. Facilities must provide documentation of what they learned from their tabletop exercise and any revisions that they made to the plan. Generally speaking, if the plan undergoes significant changes, the facility should provide training to all staff to make them aware of those changes, she adds.

Large-scale drills are usually an all-day event involving a number of staff. As with tabletop exercises, any updates or revisions to the EP plan that come from the drill must be communicated to all staff, with additional training as appropriate.

Emerging infectious disease added as hazard

Appendix Z was updated in February 2019 with interpretive guidance for 2016 final EP rulerule to include emerging infectious disease (EID) threats in providers' EP planning efforts. EIDs include diseases such as Zika, Ebola, and other public health threats. The guidance states that EIDs may require modifications to facility protocols in order to protect the health and safety of patients, such as through the use of isolation and use of personal protective equipment.

Addressing active shooter emergencies

In recent years there have been several shootings in public spaces, including at least one SNF. In May 2007, a man entered a SNF in Ohio and began shooting. According to the Newark Advocate, a local news outlet, the shooter took two people hostage and ultimately shot and killed a police chief and two SNF staff members.

North Carolina's most deadly shooting to date took place in a Carthage nursing home that left eight dead. The shooter was a disgruntled ex-husband of a facility staff member, according to local news outlet WRLA.

While unexpected, these types of emergencies do happen, and SNFs should be prepared for them.

The FBI has released a document titled "Active shooter planning and response in a healthcare setting" that outlines procedures to follow in the event of an active shooter. A summary of the FBI outline is as follows:

- Run, Hide, Fight response
  - Run—Evacuate immediately
  - Hide—Find a secure place that the shooter cannot access
  - Fight—If confronted with the shooter, make a personal decision whether to attack and incapacitate the shooter
- Avoid-Deny-Defend response
  - Avoid—Avoid danger and confrontation if given ample notice of a shooter
  - Deny—If you cannot avoid the shooter, seek refuge and deny the shooter access
  - Defend—Act and defend yourself if you are in imminent danger
- The 4As response
  - Accept that an emergency is taking place
  - Assess what to do to save lives
  - Act (lock down, evacuate, or fight back)
  - Alert law enforcement
- ALICE response
  - Alert—Can be anything
  - Lockdown—If you decide not to evacuate, secure the room and deny access to the shooter
  - Inform—Pass on real-time information by any means necessary
  - Counter—Use simple, proactive techniques if confronted
  - Evacuate—Remove yourself from danger
- Window of Life Active Shooter Response
  - A person who is in a crisis has four responsibilities:
    - A person's first responsibility is for his or her safety. You are an important asset in a crisis, not one to throw away lightly. If you are lost, that loss is felt in successive areas around you, much like the ripples in a pond.
    - A second responsibility is to those in the immediate vicinity, those who are within line-of-sight or ear shot of where you are. Recognizing your importance as an asset involves using that asset to help others.
    - A third responsibility is to those in your place. Having protected yourself and alerted those near you, it is important to alert those who will also be affected by the crisis but may have a bit more time to react.
    - A fourth responsibility is to notify public safety.

While EP guidelines vary from state to state, many government websites offer state-specific templates for SNF EP plans. CMS also offers several printouts to assist in keeping your EP plan up to date and in compliance with federal and state laws. ■

EP final rule

CMS' emergency preparedness (EP) final rule, was enacted November 16, 2016. Appendix Z of the State Operations Manual provides interpretive guidance to the final rule that provides insight on how facilities will be surveyed.

The rule states that whether evacuating or sheltering in place, facilities must be able to supply food, water, medical materials, and pharmaceuticals to staff and residents. Additionally, facilities need alternative sources of energy to maintain temperatures, lighting, fire prevention systems (to detect, alarm, and extinguish), and waste disposal. The EP final rule also stresses the importance of having a tracking system in place for both staff and residents during an emergency. It's essential to be aware not only of the location of each resident, but staff as well in case an employee is suddenly needed elsewhere.

According to Paul McManus, director of the Rochester, New York office at RPA, which provides fire and emergency management consultation, "All facilities that are at risk of being impacted by a hurricane should have a plan in *place that accounts for actions to be taken before the storm, including annual preparation, action to be taken during a hurricane watch and warning, and actions to be taken to recover after landfall." He adds that the plan must be "fairly comprehensive." SNFs also need to make sure that:*

- *Critical information and written agreements for emergencies are current*
- *Inventory of stored emergency supplies is accurate*
- *Backup generators are maintained routinely and are operational*
- *Insurance plans are reviewed*
- *Alternate means of communication, both internal and external, are functional*

What does EP include?

CMS states in the *core EP rule elements* that there are four components SNFs should evaluate when creating an EP plan:

- Risk assessment and emergency planning
- Geographic hazards (hurricanes, earthquakes, tornados, etc.)
- Care-related emergencies
- Power and equipment failures
- Communication interruptions, including cyberattacks
- Loss of all or portion of facility
- Loss of all or portion of supplies
- Annual review and update of plan
- Communication plan
- Compliance with federal and state laws
- Communication systems to contact necessary staff
- Coordination across facility, with healthcare providers, and with state and local public health departments and emergency management agencies
- Policy procedures
- Compliance with federal and state laws
- Training and testing
- Compliance with federal and state laws
- Annual maintenance and update

CMS emergency plan checklist

CMS has released an informative *checklist* to prepare for an emergency. Following are some key points to consider when drafting an EP plan:

- Location of emergency exits
- Alarm system instructions, and modifications for hearing and visually impaired residents
- How to keep track of residents during an evacuation
- How medical charts will be transferred
- How families will be notified
- Where residents will evacuate to
- How medicines and supplied will be protected and transferred
- How residents and family members can be of assistance
- How able-bodied residents can be incorporated into the EP plan

Updates to regulations

On June 7, President Trump signed *S 1397, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act*. Title II, Section 202 of the law elevates SNFs to the level of acute care hospitals by including them in pre-disaster emergency planning and adding them as a priority for power restoration during and after an emergency. The act also addresses disease outbreaks as an emergency, and outlines guidelines to follow in the event of an outbreak. In short, the law aims "to help ensure that critical infrastructure will remain functioning during, or return to function as soon as practicable after, a public health emergency." ■

CMS issues new SNF PPS Final Rule for 2020

On July 30 CMS issued a final rule updating the payment rates under the prospective payment system (PPS) for SNFs. The rule, designed to increase aggregate payments to SNFs by $851 million in 2020 compared to 2019, will go into effect on October 1.

This rule includes three main revisions:

The rule includes minor changes to the regulation text to reflect the revised assessment schedule under PDPM. Rates have been lowered 0.4% for the multi-productivity factor, reducing costs for SNFs.

- The rule revises the definition of group therapy under SNF PPS. Currently, group therapy is defined as four patients, but under the new rule will be defined as between two and six residents.
- The rule adds two new measures to the SNF QRP which are designed to assess whether certain health information is provided by the SNF at the time of transfer or discharge:
  - Transfer of Health Information to the Provider-Post-Acute Care
  - Transfer of Health Information to the Patient-Post-Acute Care

In addition, CMS will update the specifications for the Discharge to Community PAC SNF QRP measure to exclude long-term residents, and only consider short-term resident discharges. It will also update the public reporting requirements from SNFs and give a 30-day deadline for Phase One Review and Corrections requests.

While the final rule will go into effect on the same day as PDPM, it does not include any changes to the new payment model. ■

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