January 13, 2015 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

CMS Region 5 Provider Association Meeting
The annual Region 5 LTC Provider Association Meeting was held December 9-10, 2014 in Chicago. State survey agency representatives, state LTC provider association representatives and state ombudsmen were all present. The agenda included updates on data trends, enforcement issues, survey issues, electronic POC updates, managed care, hearing case results, life safety code issues and other general LTC questions. A summary of the information discussed at the meeting can be found below:

1) CMS discussed (click here for handout) the latest trends regarding the Top Ten Citations on Standard and Complaint Surveys (by Region 5 States and the Nation), Average Number of Deficiencies Cited per Survey, Total Deficiencies Cited by Severity Level on Standard and Complaint Surveys, Percentages of IU Citations and Harm Citations in both Standard and Complaint Surveys, and Remedies in Effect. F441 - Infection Control was the top cited deficiency on standard surveys in both Illinois (48.9 percent) and in the nation (37.5 percent). F323 - Accidents was the top cited deficiency on complaint surveys in both Illinois (7.1 percent) and in the nation (5.4 percent). Illinois had an average of 5.4 deficiencies per standard survey versus a U.S. average of 5.7 deficiencies per standard survey. For Illinois, 10.9 percent of the deficiencies cited on standard surveys were at Level 1, 85.6 percent at Level 2, 2.5 percent at Level 3 and 1.1 percent at Level 4. For Illinois complaint surveys, 4.4 percent of the deficiencies cited were at Level 1, 82.9 percent at Level 2, 9.1 percent at Level 3 and 3.6 percent at Level 4.

2) Federal House Resolution 4994: IMPACT Act of 2014 was signed into law by the President on October 6, 2014. It amends Title 18 of the Social Security Act and provides for standardized post-acute care assessment data for quality, payment and discharge planning and other purposes. One of the subsets of this legislation was the MDS and Staffing focused surveys. If you recall, Illinois was chosen as one of several pilot states to test the MDS focused survey process. CMS reported that all states will be included in these focused surveys in 2015. These surveys are done separate from the annual survey and will focus on the MDS and resident assessment area. CMS has not yet determined how many of these special focus surveys will be done per state. CMS also noted that reporting payroll staffing information will be voluntary in 2015 but will become mandatory in the future. This and other data will be incorporated at some point into the 5-Star Rating Process and into the Nursing Home Compare website. Nursing Home Compare will be updated and made more user-friendly. CMS will also add additional quality measures into 5-Star and Nursing Home Compare in the future. We will provide updates on this as we receive them.
3) CMS made it clear in their presentation on F329 - Unnecessary Medications (click here) that they believe it is not being cited enough or at the appropriate severity levels. As we have made you aware, CMS has a goal of a 25 percent reduction in the use of antipsychotics for 2015 and a goal of a 30 percent reduction in 2016. Illinois has a very high rate of antipsychotic use and we can expect increased state and federal scrutiny in this area. LTC facilities should also remember that CMS will be adding a quality measure on the use of antipsychotic medications for both long and short stay residents to the 5-Star Rating process.

4) CMS did a presentation (click here) on QAPI. Quality Assurance and Performance Improvement (QAPI) means a quality management system that is: 1) ongoing, systematic, comprehensive and data-driven; 2) engages everyone in the facility to continuously identify problems and opportunities for improvement; 3) develops interventions that address the underlying system, not only the symptom; and 4) continuously monitors performance. IHCA will continue to update our members on QAPI because it will become a mandatory regulatory requirement and it provides a good systematic approach for preventing compliance problems.

5) CMS provided a Life Safety Code update including the Top Ten K-Tags per Region 5 states and nationally and the most common reasons for the citations (click here). CMS also acknowledged that they are still reviewing the comments received with regard to the proposed adoption of the 2012 Life Safety Code (LSC). There was no date announced for when the 2012 LSC will go into effect (hopefully before the end of 2015) and therefore the 2000 LSC is still currently in effect. CMS also announced that there is no date yet for the adoption of the emergency preparedness proposed rulemaking. CMS wants to remind the LTC providers that for categorical waivers, the facility must announce that they are using them at the entrance conference, prior to the survey beginning. CMS also raised the issue that attics must be sprinkled (very limited exceptions), apparently there are providers that have overlooked this requirement.

6) Other issues raised during the general Q and A session include:

- CMS can and has changed state recommendations on penalties. They have a national standardized tool that they use and is explained in S&C 15-16. CMS is moving away from “per instance” fines and increasingly using “per day” fines. Each remedy case is reviewed by CMS individually.
- A hospital cannot change inpatient/observation decisions after discharge.
- LTC facilities cannot serve undercooked, unpasteurized eggs (S&C 14-34). Pasteurized eggs can be served to order.
- LTC facilities are prohibited from recording surveyor interviews either formally or informally.
- When giving medications through a nasal/gastro tube, the nurse must flush between each medication given by that procedure; however a deficiency can only be counted as one medication error.
- The 2567 can be released to the LTC Ombudsman prior to the POC being completed.
- CMS does not have any specific guidance with respect to Automated Drug Dispensing Systems/Stations. The use of these devices must comply with current state and federal medication regulations, the facility needs to have a policy with regard to refusal of medications and how it is accounted for in such a system and the nurse needs to be able to identify each medication for the resident. Consult with your pharmacist.
- As noted in S&C 14-01 (click here), a LTC facility cannot have a blanket no-CPR policy. The LTC facility must have a staff member that is certified for CPR 24/7 in the facility. The LTC Facility must also develop a policy on how CPR will be handled on resident outings. CMS stated that the facility is responsible for the residents (including CPR) on facility/resident outings. Keep staff CPR certifications current and maintain that documentation.
- CMS is piloting electronic POCs in several states. IDPH has not yet elected to be part of the pilot testing.
Revisions to State Operations Manual (SOM) - F309 Quality of Care and F329 Unnecessary Drugs

With an effective date and implementation date of December 12, 2014, CMS published revisions (Transmittal R130) to the State Operations Manual (SOM) regarding F309 – Quality of Care and F329 – Unnecessary Drugs as they relate to nursing home residents with dementia. CMS published an Advanced Copy back in May under S&C 13-35.

On March 29, 2012, CMS launched the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (this is now referred to as the Partnership to Improve Dementia Care in Nursing Homes, of which IHCA is a member and full participant). The goal of this Partnership is to optimize the quality of life and function of residents in America’s nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia.

Dementia Care Principles

Fundamental principles of care for a resident with dementia include an interdisciplinary approach that focuses on the needs of the resident as well as the needs of the other residents in the nursing home. Sections 1819 and 1919 of the Social Security Act (the Act) and current regulations already require a number of essential elements to be in place in order for facilities to be in compliance with federal requirements on quality of care and quality of life. This revised CMS guidance and surveyor training highlight and re-emphasize a number of those key principles, including:

1. Person–Centered Care. CMS requires nursing homes to provide a supportive environment that promotes comfort and recognizes individual needs and preferences.

2. Quality and Quantity of Staff. The nursing home must provide staff, both in terms of quantity (direct care as well as supervisory staff) and quality to meet the needs of the residents as determined by resident assessments and individual plans of care.

3. Thorough Evaluation of New or Worsening Behaviors. Residents who exhibit new or worsening BPSD should have an evaluation by the interdisciplinary team, including the physician, in order to identify and address treatable medical, physical, emotional, psychiatric, psychological, functional, social and environmental factors that may be contributing to behaviors.

4. Individualized Approaches to Care. Current guidelines from the United States, United Kingdom, Canada and other countries recommend use of individualized approaches as a first line intervention (except in documented emergency situations or if clinically contraindicated) for BPSD. Utilizing a consistent process that focuses on a resident’s individual needs and tries to understand behavior as a form of communication may help to reduce behavioral expressions of distress in some residents.

5. Critical Thinking Related to Antipsychotic Drug Use. In certain cases, residents may benefit from the use of medications. The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record. Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort discontinue these drugs.

NOTE: If during a survey, the team identifies a concern that an antipsychotic medication may potentially be administered for discipline, convenience and not being used to treat a medical symptom, the survey team should review F222 - 483.13(a) Right to be Free From Chemical Restraints.
6. Interviews with Prescribers. None of the guidance to surveyors should be construed as evaluating the practice of medicine. Surveyors are instructed to evaluate the process of care. Surveyors interview the attending physician or other primary care provider (NP, PA), behavioral health specialist, pharmacist and other team members to better understand the reasons for using a psychopharmacological agent or any other interventions for a specific resident.

7. Engagement of Resident and/or Representative in Decision Making. In order to ensure judicious use of psychopharmacological medications, residents (to the extent possible) and/or family or resident representatives must be involved in the discussion of potential approaches to address behavioral symptoms. These discussions with the resident and/or family or representative should be documented in the medical record.

Specifically, CMS under F309 added (see pages 9-22 of R130): Definitions Related to Recognition and Management of Dementia; Overview of Dementia and Behavioral Health; Therapeutic Interventions or Approaches; Medication Use in Dementia; Resident and/or Family/Representative Involvement; Care Process for a Resident with Dementia; Recognition and Assessment; Cause Identification and Diagnosis; Development of a Care Plan; Individualized Approaches and Treatment; Staff and Staff Training; Involvement of the Medical Team; Monitoring and Follow-up; Quality Assessment and Assurance (QAA); and Criteria for Compliance with F309. This guidance will be used by the surveyors to determine if the facility is in compliance with F309 with regard to persons with dementia.

On pages 47-61 of R130, CMS explains the decision making process with regards to deficiency categorization for all of F309 deficiencies, but adds some new criteria with respect to deficiencies regarding dementia care. Also included in this section (starting on page 56 of R130) is a Screening, Identifying and Addressing Behavioral Symptoms in Persons with Dementia flowchart and a checklist of factors nursing homes can use with regard to behavioral symptoms.

Under F329 – Unnecessary Drugs, CMS has added guidance (see pages 100-109 of R130) with respect to the use of antipsychotic medications on persons with dementia. CMS has added language regarding use of antipsychotics for: Conditions Other than Dementia; Behavioral or Psychological Symptoms of Dementia (BPSD); Additional Criteria for both Acute Situations/Emergency and Enduring Conditions; New Admissions; Dosage; Duration; Monitoring; Effectiveness; and Potential Adverse Consequences.

On pages 148-151 of R130, CMS explains the decision making process with regards to deficiency categorization for F329 deficiencies.

As stated earlier, this document/guidance is in effect as of December 12, 2014. Please review with your staff and make sure they are prepared to respond to questions from IDPH or federal surveyors with regard to your residents with dementia.

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**Preventable Hospitalizations Vary Widely by Region, AHRQ Analysis Finds**

Rates of potentially preventable hospitalizations in the United States declined 14 percent from 2005 to 2011, but rates varied widely by geographic region, according to a [new statistical brief](#) from AHRQ. Potentially preventable hospitalizations are admissions for certain acute illnesses or worsening chronic conditions that may have been
avoided with higher-quality outpatient treatment and disease management. Data from AHRQ’s Healthcare Cost and Utilization Project showed that rates of potentially preventable hospitalizations in 2011 were lowest in the West (at 1,220 discharges per 100,000 population) and highest in the South (at 1,845 discharges per 100,000). Hospitals in the South had a 17.2 percent higher rate of potentially preventable hospitalizations than the overall national rate in 2005, but by 2011 it was reduced to 10.5 percent higher than the national rate.


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**Important Rules, Regulations & Notices**

1) The following federal Survey and Certification Letters were released since the last issue of *Regulatory Beat*:

   - **S&C 15-13 – All** – CMS is clarifying that the terms “spouse”, “marriage,” “relative,” and “family,” as well as other terms that implicitly or explicitly implicate the spousal relationship, such as (but not limited to) “representative,” “support person,” “surrogate,” and “next-of-kin,” include all marriages lawful where entered into, including lawful same-sex marriages, regardless of the certified provider’s or supplier’s location or the jurisdiction in which the spouse lives.

   - **S&C 15-14 – PRTF** – Guidance Related to New State Operating Manual and Appendix N for Psychiatric Residential Treatment Facilities (PRTF). CMS has a new State Operating Manual and interpretive guidelines in the following State Operations Manual (SOM) Appendices to reflect recent amendments to the applicable Conditions of Participation (CoPs): Appendix N – PRTF.

   - **S&C 15-15 – CLIA** – This memorandum announces the release of CLIA Brochure #12, “Considerations When Deciding to Develop an IQCP” and Brochure #13, “What is an IQCP?” These brochures will be available on the CLIA website.

   - **S&C 15-16-NH** – CMS issued this guidance to notify states that CMS Regional Offices (ROs) are required to continue to use the CMP Analytic Tool and guidance in establishing CMPs, but are no longer required to submit Civil Money Penalty (CMP) Analytic Tool cases to the CMS Central Office.

2) The U.S. Congress passed and the President signed a $1.1 trillion spending bill that will fund government through September 2015 without any major changes to Medicare and Medicaid. Tucked deep inside the 1,603 page spending measure is a provision that effectively ends the federal government’s prohibition on medical marijuana and signals a major shift in federal drug policy. Under the provision, states where medical marijuana is legal would no longer need to worry about federal drug agents raiding retail operations including health care facilities and programs.

3) The CMS issued several news releases and informational notices since the last issue of *Regulatory Beat*. They include:

   - CMS adopted a final rulemaking (effective February 3, 2015) regarding requirements (click here) for Medicare Incentive Reward Program and Provider Enrollment. This final rule implements various provider enrollment requirements. These include: Expanding the instances in which a felony conviction can serve as a basis for denial or revocation of a provider or supplier’s enrollment; if certain criteria are met,
enabling us to deny enrollment if the enrolling provider, supplier, or owner thereof had an ownership relationship with a previously enrolled provider or supplier that had a Medicare debt; enabling us to revoke Medicare billing privileges if we determine that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements; and limiting the ability of ambulance suppliers to “back-bill” for services performed prior to enrollment.


- Recently, CMS issued guidance to states regarding Medicaid payment for services covered under a state’s Medicaid plan to an eligible Medicaid beneficiary that are available without chart to the beneficiary (including services that are available without charge to the community at large, or “free care”). The letter is available here.

- CMS recently sent a memo (click here) to all Medicare Advantage Organizations, PACE Organizations, Cost Plans and certain Demonstrations regarding Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System. The purpose of this memo is to provide further guidance about this requirement for SNF encounters when no Admission assessment was completed during the Medicare Advantage (MA)-covered stay. The guidance in the May 23, 2014 memo and this memo are extended through 2015 dates of services.

- CMS has added new quality data (click here) to the Physician Compare website. Additionally, CMS has updated quality measures on the Hospital Compare website and released data on new measures. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

4) The Illinois Department of Public Health (IDPH) has proceeded with two rulemakings that we believe would be of interest to you. They include:

- PA 98-990, effective August 18, 2014, mandates that IDPH create and administer a Licensed Medication Aide Pilot Program; this proposed rulemaking (click here 38/49 - starts on page 22373) implements this pilot program. The Act states that during the 3-year pilot program, the Department shall license and regulate licensed medication aides; this program is created in Subpart E of the Part. As part of the pilot program, no more than 10 skilled nursing homes, which shall be geographically located throughout the state, shall be authorized to employ licensed medication aides, as approved by the Department, and provides that the Department may consult with the Department of Public Health as necessary to properly administer and enforce this program. The proposed rulemaking also makes revisions to the foreign trained nurse provisions in this Part to allow additional paths to licensure and it updates Section 1300.430 (Prescriptive Authority) to reflect statutory changes made to the Controlled Substances Act [720 ILCS 570].

- IDPH adopted rules (starts on page 22897) creating a new Part 380 that implements the Specialized Mental Health Rehabilitation Act of 2013. Its six subparts address provisional licensure, licensure, training of staff, the assessment of consumers, physical plant requirements and the care to be provided to consumers in the four levels of service to be provided in specialized mental health rehabilitation facilities.

5) The Illinois Department of Healthcare and Family Services (HFS) has posted several new Notices to their LTC Provider Notice pages (http://www.hfs.illinois.gov/ltc/). They include:

- Required Use of Application for Benefits Eligibility (ABE) for LTC Providers
- Timeframes for the Submission of Admission Information by LTC Facilities
• Food Handler Training
• Active LTC case transition to the Centralized Hubs
• Prevention of Spousal Impoverishment Standards for 2015
• Licensing and Certification Status

6) Influenza Updates/Guidelines – CDC and IDPH have issued several releases/updates/guidelines with respect to the flu season. I also found a State of Wisconsin – Department of Health Services memorandum to their LTC facilities that I thought may be of interest. They include:

   • Early Data Suggests Potentially Severe Flu Season ([click here])
   • CDC’s Toolkit for Long Term Care Employers ([click here])
   • CDC’s Influenza News and Highlights ([click here])
   • IDPH Guidelines for the Prevention and Control of Influenza Outbreaks in Illinois LTC Facilities ([click here])
   • IDPH Influenza Prevention and Control in LTC PowerPoint Presentation ([click here])
   • [Click here] for the State of Wisconsin – Department of Health Services memo to their LTC facilities regarding influenza

7) CMS ICD-10 News and Updates. CMS has released several updates regarding the pending implementation of the October 1, 2015 compliance date for ICD-10. They include:

   • Get Ready Now for ICD-10 ([click here])
   • Coding for ICD-10-CM: More of the Basics MLN Connects Video ([click here])
   • ICD-10- News: Clinical Documentation Improvement Webinar Recording Available ([click here])
   • Results from November ICD-10 Acknowledgement Testing week ([click here])

8) AHCA released several items of interest. They include:

   • [Incorporating Active Shooter Planning into Health Care Facility Emergency Operations Plans](#) has been released and posted to the Public Health Emergency website. The document was developed with assistance from ASPR’s Divisions of Health System Policy and Tactical Programs, the Federal Emergency Management Agency, the Federal Bureau of Investigation and the Healthcare and Public Health Sector Coordinating Council. This document shows how government and private sector partners can work together to benefit our healthcare and public health communities. This overview, along with the more comprehensive "2014 Active Shooter Planning and Response in a Healthcare Setting" guide provides valuable tools for all healthcare locations, including academic institutions, hospitals, outpatient centers, and physician practices. We encourage you to review these guides and implement at your facility. In the near future, AHCA will be releasing an updated version of the "Active Shooter Planning and Response in a Healthcare Setting" guide which will include sections on law enforcement tactics and considerations, as well as an integrated medical and psychological response. Look for a future announcement when the document is complete.

   • AHCA sent out a memo ([click here]) regarding two new documents issued by CMS related to the Medicaid HCBS rule implementation. The first document is an optional tool that states can use to assess whether “the characteristics of Medicaid Home and Community-based Services, as required by regulation” are present. The second document is the long-awaited Q&A document from CMS about the final rule and includes common questions and answers about the following topics: Public Notice and Comments; HCB Settings – General; HCB Settings – Residential; HCB Setting – Non-Residential; and HCB Settings – Restrictions.
9) The federal Agency for Healthcare Research and Quality (AHRQ) in a recent study indicated that more than half of nursing home residents with advanced dementia – a terminal illness marked by severe cognitive impairment and functional dependence – continue to receive medications that may not help them, but incur substantial financial cost. The study and abstract, “Use of Medications of Questionable Benefit in Advanced Dementia,” were published in the November 2014 issue of *JAMA Internal Medicine*. An analysis of more than 5,400 residents at 460 facilities (using 2009-2010 data) found that nearly 54 percent of residents received at least one medication of questionable benefit. The average 90-day expenditure for medications with questionable benefits was $816. This accounts for 35.2 percent of the total average 90-day medication costs for residents with advanced dementia who were prescribed common medications with questionable benefits.

10) The federal HHS Office of the Inspector General recently conducted a study entitled, Access to Care: Provider Availability in Medicaid Managed Care ([http://go.usa.gov/6he4](http://go.usa.gov/6he4)). They did the study pursuant to a congressional request to evaluate the adequacy of access to care for enrollees in managed care. What they found was that slightly more than half of providers could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was two weeks. However, over a quarter had wait times of more than one month, and 10 percent had wait times longer than two months. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times. They recommended to CMS that together, these findings- along with those from our companion report-call for CMS to work with States to improve the oversight of managed care plans. We recommend that CMS work with States to (1) assess the number of providers offering appointments and improve the accuracy of plan information, (2) ensure that plans’ networks are adequate and meet the needs of their Medicaid managed care enrollees, and (3) ensure that plans are complying with existing State standards and assess whether additional standards are needed. CMS concurred with all three of the OIG recommendations.

11) CMS has launched the reorganization of the Quality Improvement Organization (QIO) Program to further enhance the quality of services for Medicare beneficiaries. The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human Services National Quality Strategy for providing better care and better health at lower cost. [Click here](http://go.usa.gov/6he4) for a one page description of the changes.

12) Medicare Learning Network’s MLN Connects Provider eNews had one educational product that might be of interest to you. The “Medical Privacy of Protected Health Information” Fact Sheet (ICN 006942) ([click here](http://go.usa.gov/6he4)) was revised and is now available in a downloadable format with a print ready feature. This fact sheet is designed to provide education on resources and information regarding the HIPAA Privacy Rule and how this rule applies to customary health care practices. It includes information on accessing the HHS HIPAA web page resources.

13) *McKnight’s* had several articles of interest. They include:

- HIPAA Breach leads to first-ever “neglect” settlement for a healthcare provider ([click here](http://go.usa.gov/6he4))
- More than 65% of Medicaid now is managed care, long-term care programs to expand, PricewaterhouseCoopers reports ([click here](http://go.usa.gov/6he4))
- Court tosses lawsuit over Medicare appeals backlog ([click here](http://go.usa.gov/6he4))
14) Interesting Fact: It's not just coughs and sneezes that spread diseases. One single bacteria cell can multiply to become more than 8 million cells in less than 24 hours. Just imagine what's on the toilet door handle you just touched, the taps and even on other people's hands...

If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don't hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!