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!

Are You Prepared for a Medicaid Audit?

The Illinois Department of Healthcare and Family Services (HFS) will conduct reviews to determine the accuracy of the resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. The MDS data used by the Department to set the reimbursement rate will be used to conduct the validation reviews. Such reviews may, at the discretion of the Department, be conducted electronically or onsite in the facility.

Facilities chosen for on-site reviews will be based upon facility characteristics, atypical patterns of scoring MDS items, no-submission or late submission of assessments, high percentage of significant corrections, previous history of review changes or “the Department’s experience.” The Department may also use findings of licensure and certification surveys conducted by the Illinois Department of Public Health (IDPH).

Other factors that could warrant an audit include: Frequent changes in administration or management; unusually high percentage of residents in a specific case mix classification or high percentage of change in the number of residents in a specific case mix classification; frequent adjustments of case mix classification as the result of reconsiderations, reviews or significant correction submitted; criminal indictment alleging fraud; and/or other similar factors that relate to a facility’s ability to conduct accurate assessments.

The following are some things to consider to assure that you are prepared if HFS should choose your facility for an on-site audit.

All medical records and pertinent documentation should be kept in an organized manner. Not only does this keep the audit process from experiencing unnecessary delays, it gives a positive impression that the facility is well-run and on top of resident issues. Current charts and completed MDS records for the previous 15 months need to be provided to the review team within an hour after the request has been made. Additional documentation that supports the coding of MDS items that affect reimbursement shall be provided within four hours of the request.

If a facility chooses to have HFS staff review the electronic health record at least two computer terminals with read-only access must be made available to the review team within an hour of the team’s arrival. Within four hours of the team’s arrival and for the duration of the review, there shall be a terminal made available to each reviewer or hard copies shall be provided.
Additional documentation is often required for MDS items to be coded accurately. Make sure to keep any ADL tracking forms or notes made while interviewing staff accessible. If there are disagreements about the preliminary conclusions made by the review team, this documentation will be needed to “prove your case.”

It is vital that staff really “know” their residents. Consistent assignments provide continuity of care and having knowledgeable staff helps MDS Coordinators be more confident that MDS items are coded accurately. When HFS reviewers interview staff to verify data (such as ADL coding), it gives a positive impression when staff confidently answer those questions.

Conduct mock surveys and have staff that normally do not work with the MDS review the data and see if they think there is evidence to prove what has been coded. Interview staff so they will not be intimidated by HFS reviewers, which will help them be at ease during an actual audit.

**New CMS LTC Ombudsman Regulations**
The Administration on Aging (AoA) of the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS) is issuing this final rule in order to implement provisions of the Older Americans Act (the Act) regarding States’ Long-Term Care Ombudsman programs (Ombudsman programs). Since its creation in the 1970s, the functions of the Nursing Home Ombudsman program (later, changed to Long-Term Care Ombudsman program) have been delineated in the Older Americans Act; however, regulations have not been promulgated. In the absence of regulatory guidance, there has been significant variation in the interpretation and implementation of the program among states. Recent inquiries from states and an AoA compliance review in one state have highlighted the difficulty of determining state compliance in carrying out the Long-Term Care Ombudsman program functions. This rule provides the first regulatory guidance for States' Long-Term Care Ombudsman programs to provide clarity about implementation. This final rule will not be effective until July 1, 2016, in order to give states time to make changes. The complete rulemaking can be found [here](#).

The National Consumer Voice for Quality Long Term Care/National Long-Term Care Ombudsman Resource Center has developed a summary overview of the new Long-Term Care Ombudsman Program Regulations ([click here](#)). The summary overview discusses:

- Definition changes
- Office of the State LTC Ombudsman Responsibilities
- State LTC Ombudsman Program Policies and Procedures
- Functions and Responsibilities of the State LTC Ombudsman
- State Agency Responsibilities Related to the State LTC Ombudsman Program
- Responsibilities of Agencies Hosting Local Ombudsman Entities
- Duties of the Representatives of the Local LTC Ombudsman Office
- Conflicts of Interest

As stated above, these rules are not in effect until July 1, 2016. However, LTC providers need to become familiar with these changes and how ombudsman will function and interact with the residents in your facility.

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**Trending Statistics**

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

**Findings from the NCAL 2013 Assisted Living Staff Vacancy, Retention and Turnover Survey**
The National Center for Assisted Living (NCAL) conducted its fifth annual Assisted Living Staff Retention, Vacancy and Turnover study. This study was supported by LeadingAge, the American Seniors Housing Association (ASHA),
and the Assisted Living Federation of America (ALFA). Staff stability is important to providing quality care to residents and is one of the four goals of the AHCA/NCAL Quality Initiative for Assisted Living.

The 2013 Assisted Living Staff Vacancy, Retention and Turnover Survey is a nationwide study to collect retention, vacancy and turnover information among assisted living employees in five major job categories and 16 job positions (see Table 1). The survey questionnaire was available on the NCAL web site in 2014 for all eligible assisted living communities in the United States to complete using data from 2013. This year, 636 surveys were received compared to 580 surveys last year.

Click here for the full report and findings.

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**Important Rules, Regulations & Notices**

1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

   - **S&C 15-11 – This previous S&C was withdrawn and reissued – CLIA:** Directions on the Off-Label/Modified Use of Waived Blood Glucose Monitoring Systems (BGMS) (CLIA – Originally released November 21, 2014; temporarily withdrawn and reissued as draft only March 13, 2015).

2) CMS released several notices/announcements since the last issue of Regulatory Beat. They include:

   - HHS announced a new initiative (click here) from the CMS Innovation Center: The Next Generation Accountable Care Organization (ACO) Model of payment and care delivery. Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program (Shared Savings Program), the Next Generation ACO Model offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.

   - CMS recently updated portions of the CMCS Home and Community-Based Services (HCBS) Toolkit. Updated versions (Version 1.0) of the HCBS Basic Element Review Tool for Statewide Transition Plans and the HCBS Content Review Tool for Statewide Transition Plans are now available. This information is part of the ongoing effort to assist states in meeting regulatory requirements for residential and non-residential home and community-based settings. The full HCBS toolkit, including the updated portions, is available online at [http://www.medicaid.gov/hcbs/](http://www.medicaid.gov/hcbs/).

   - Updates to the Medicare Internet-Only Manual Chapters for Skilled Nursing Facility (SNF) Providers. This instruction (click here) updates various sections of the internet-only manual chapters in regards to SNF policy and billing.

3) The CMS Medicare Learning Network (MLN) had a couple items of interest. They include:

   - During the week of July 20 - 24, 2015, a third sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of
providers. **Note:** Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying. [Click here](#) for additional information and guidance. Take advantage of upcoming ICD-10 testing opportunities with Medicare Fee-For-Service (FFS), including an acknowledgement testing week June 1 - 5, 2015, and a final end-to-end testing week July 20 - 24, 2015. Registration is not required for acknowledgement testing; volunteer forms for the July end-to-end testing are due April 17.

- The Medicare Learning Network® March 2015 Catalog is now available ([click here](#)). In this latest edition, you will find all the products and services now available through the MLN. The catalog is a free, interactive, downloadable document that links you to online versions of MLN products, services and the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on “Formats Available” to quickly access the material you have selected.

4) The US Department of Health and Human Services had several notices/news items of interest. They include:

- HHS’s Office of Disease Prevention and Health Promotion is proud to announce the re-launch of *Partnering to Heal*, a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates. [To view the training, visit http://health.gov/hai/training.asp](http://health.gov/hai/training.asp). Designed for health professional schools and health care facilities, *Partnering to Heal* is a Virtual Experience Immersive Learning Simulation (VEILS®) that addresses the prevention of health care-associated infections and the serious consequences they have on thousands of lives each year. The training highlights effective communication about infection control practices and ideas for creating a "culture of safety" in healthcare institutions to keep patients from getting sicker. Users assume the identity of the five main characters – a physician, nurse, infection prevention expert, patient family member, and medical student – to make decisions about preventing Health Care-Associated Infections (HAIs).

- The HHS Office of the Inspector General recently released their annual report – Health Care Fraud and Abuse Control FY 2014 ([click here](#)). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC or the Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Inspector General, designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. In its eighteenth year of operation, the program’s continued success confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect program beneficiaries.

5) The Illinois Department of Healthcare and Family Services (HFS) released several Informational Notices since the last edition of *Regulatory Beat*. They include:

- **Authorized Representative for Supplemental Nutrition Assistance Program (SNAP).** This Notice informs Supportive Living Program (SLP) providers that as a Supplemental Nutrition Assistance Program (SNAP) Authorized (Approved) Representative, you have been given permission by a resident to act on their behalf when conducting business with the Department of Human Services (DHS), including assisting with an application for SNAP benefits or filing in behalf of the resident. A DHS worker must ask for verification of your identity when you are first designated by the resident as the Authorized (Approved) Representative.
• **Care Coordination Health Plan Identification and Billing Procedures Depending on Health Plan Enrollment.** This Informational Notice provides guidance to providers on how to identify Care Coordination Health Plans in the Medical Electronic Data Interchange (MEDI) system and how to properly bill for services depending on the Medicaid client’s health plan enrollment. As the Department of Healthcare and Family Services (HFS) finalizes the roll-out of Medicaid managed care in five mandatory regions of the state (pdf), it is critical that providers understand that you bill differently depending on the type of managed care entity in which a Medicaid client is enrolled. The four types of managed care entities operating in the five mandatory managed care regions are: 1) Accountable Care Entities (ACEs); 2) Care Coordination Entities (CCEs); 3) Managed Care Community Networks (MCCNs); and 4) Managed Care Organizations (MCOs).

• **Conversion from International Classifications of Disease (ICD) -9 to ICD-10.** This Notice informs providers that the federally-mandated conversion from ICD-9 to ICD-10 codes must be implemented no later than 10/1/2015. Federal Centers for Medicare and Medicaid Services had previously delayed the deadline for implementation from 10/1/2014 to 10/1/2015. Facilities currently provide ICD-9 codes only when submitting a resident’s admission information electronically submitted to the Department of Human Services through the Medicaid Electronic Data Interchange (MEDI) or EDI vendors (formerly referred to as REV). ICD-9 coding is not used to set LTC facility reimbursement rates although it is a required data element that must be provided as part of the admission information.

• **Reporting Requirements for Long Term Care Facilities.** The purpose of this Notice is to remind providers of Long Term Care (LTC) that an individual’s enrollment status in an MCO does not affect the provider’s responsibility to electronically report admissions and changes in the status of Medicaid-eligible LTC residents to the Department using the Electronic Data Interchange (EDI) system, Medical Data Interchange (MEDI) or Recipient Eligibility Verification (REV). Failure to comply may result in the delay or denial of payment or suspension or termination of the facility’s Medicaid certification.

• **Facility Notification of Redeterminations of Eligibility.** This Notice informs providers of an interim process that will notify certain long term care (LTC) facilities when their residents are scheduled for their annual “Redetermination” of Medicaid eligibility. HFS will continue to work to develop a permanent process to provide facilities with Redetermination notifications. Until a permanent process is implemented, providers who want to be notified about forthcoming redeterminations and participate in this process need to follow the instructions described within.

• **Monthly Billing Requirement.** This Notice informs certain long term care facilities, Supportive Living Program providers and facilities eligible for provisional licensure under the Specialized Mental Health Rehabilitation Act of 2013, that HFS plans to release a series of notices that will provide information regarding the provision of P.A. 98-0104 (pdf) to submit monthly billing claims for reimbursement purposes.

6) There were several recent updates forwarded by AHCA. They include:

• **Update to HCBS Toolkit for State Transition Plans.** CMS, Center for Medicaid and CHIP Services (CMCS) issued an update to their toolkit for states as they develop their transition plans. The tool provides additional details around what they are looking for in the state plans and offers some hints about what they will be scrutinizing as the plans are analyzed. The deadline for states to submit their transition plans is one week from today. Here is the link to the updates: [http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-statewide-transition-plan.pdf](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-statewide-transition-plan.pdf).
• **MedPac Releases March Report to Congress.** The Medicare Payment Advisory Commission (MedPAC) released [click here] its March 2015 Report to the Congress: Medicare Payment Policy. MedPAC is legislatively required to issue this report to Congress to evaluate Medicare payment issues and make related recommendations. Of particular interest to AHCA members are two areas of discussion. First, the report recommendations largely are consistent with Commission winter meeting discussions on an IRF/SNF Site Neutral Policy. Second, regarding, SNF payment policy, the Commission reiterates its longstanding proposals to, first, restructure the SNF payment system "to strike a better balance between paying for therapy and nontherapy, ancillary (NTA) services (such as drugs), and then rebase the payment system.

• **2014 Medicaid Underfunding for Nursing Center Care.** AHCA released the 2014 Medicaid shortfall report by Eljay, LLC and Hansen Hunter & Company, PC. Link to Medicaid Shortfall Report.

• The 2014 AHCA Eljay, LLC report is noted above. Thank you to Matt Werner for putting the IL information together for us. Here are some of the highlights (or lowlights depending on how you look at them):
  
  o Illinois 2014 is $136.14, while costs are $169.70 leaving a disparity of $33.57.
  o Illinois ranked 49th or second to only South Dakota, which had a rate of $128.
  o Medicare average rate was $482.86, which does not include Part B or Med Advantage.
  o Nationally, unreimbursed allowable Medicaid costs for 2014 are projected to exceed $6.7 billion.
  o Expressed as a shortfall in reimbursement per Medicaid patient day, the estimated national average Medicaid shortfall for 2014 is projected to be $21.20, which is 12.6 percent lower than the preceding year’s projected shortfall of $24.26. Illinois’ shortfall is $33.57.
  o For a typical 100-bed facility in which 63 percent of residents rely on Medicaid for coverage, this shortfall would mean a loss of more than $487,000 annually.

7) **MedlinePlus** had several articles of interest. They include:

• **New CPR Devices Approved.** A pair of new CPR devices designed to help save people whose hearts stop beating has been approved by the U.S. Food and Drug Administration.

• **Hospitalizations After Severe Blood Infections May Be Preventable.** When people survive life-threatening blood infections, it's common for them to land back in the hospital within a few months. But a new study suggests that could often be avoided.

• **Exercise’s Effect on Brain May Boost Mobility in Old Age.** Staying physically active as you age may ward off brain damage that can limit mobility, a small study says.

• **Healthy Lifestyle May Guard Against Dementia.** A healthy diet, physical activity and brain exercises can help slow mental decline in older people at risk for dementia, a new study suggests.

• **Antipsychotics May Be Deadlier Than Thought for Dementia Patients.** Antipsychotic drugs may increase the risk of premature death in dementia patients more than thought, a new study suggests.

8) A UCLA study shows feasibility of blood-based test for diagnosing Alzheimer’s disease [click here]. UCLA researchers have provided the first evidence that a simple blood test could be developed to confirm the presence of beta amyloid proteins in the brain, which is a hallmark of Alzheimer’s disease.

9) **MedPage Today** recently published an article [click here] entitled, “Vaccine Prevents Pneumonia Among Seniors – Trial Results Have Already Resulted in Changes in U.S. Immunization Policy.” The CDC's Advisory
Committee on Immunization Practices recommended in August that the 13-valent vaccine be routinely used by people 65 and older, largely because of the CAPITA results.

10) McKnight’s recently had a couple of articles of interest. They include:

- **Pain Assessment “Insufficient” for Dementia Patients.** Caregivers have no reliable means to gauge pain in dementia patients, university researchers maintain while calling for new methods to assess chronic pain in those populations. While verbalizing experienced pain levels is the gold standard for caregiver assessments, no such standard exists for dementia patients,

- **SNF Victory in Federal Appeals Court Expected to Cause Review of Other Deficiency Cases.** A federal appeals court has upheld fines emanating from a pair of deficiencies found and affirmed at a California nursing home. But the provider and its legal counsel are thrilled because the court also ruled that 25 other alleged deficiencies should be reviewed for relevance.

11) Interesting Fact: An Italian neurosurgeon predicts that the first total human head transplant will occur within two years.