Managing Volunteers' Liability and Risk

According to the Administration on Aging, one in every five Americans will be age 65 or older by 2030. Many of these individuals will be placed in skilled nursing facilities and assisted living communities, where help with meals, personal care and transportation is necessary.

Because this statistic has doubled since 2000, senior care organizations will rely on volunteers more than ever to assist residents with daily tasks and to keep them safe, all while providing needed and beneficial companionship.

Although volunteers are an incredible asset to senior care organizations, there are risks associated with having them onsite. Before they step foot in the assisted living or nursing home setting, volunteers should be required to read and sign an agreement that outlines the job description, confidentiality agreement, professional boundaries and safety standards. The volunteer onboarding process is a key ingredient in having a successful and productive volunteer program.

Organizations also should host orientation sessions that focus on training and explain in more detail the roles and expectations of volunteers. This will help avoid the possibility of having a volunteer in a situation that is outside of their job description where they are more likely to be injured or injure someone else.

Maintaining ongoing volunteer education and training is an excellent way to mitigate risk and encourage quality care. Managers at senior care organizations should keep lines of communication open to ensure volunteers are providing services and support in a safe manner.

Volunteers should also follow the guidelines:

1. Wear appropriate attire. Volunteers should wear comfortable clothing and shoes with rubber soles. This type of shoe will reduce the risk of slips and falls both indoors and outdoors and comfortable clothing allows for flexible and efficient movement.

2. Follow infection control protocols. To help to reduce the spread of infection or illness, volunteers should be taught infection control principles with an emphasis on good hand washing techniques. Volunteers should wash their hands before and after direct resident interactions.

3. Remain alert. Because long term care facilities are busy and are often full of resident activity, volunteer orientation should stress the importance of remaining alert. In addition, the orientation should provide tips for volunteers to help them recognize any safety hazards or changing conditions.
4. Report hazards. All volunteers should be taught to immediately flag any safety concerns or hazards with facility management. Implementing a quick response protocol will significantly reduce the potential for risk.

Even if these guidelines are closely followed, injuries can still occur. That is why it is important that senior care organizations work with their insurance broker to develop a risk management plan which outlines how their insurance policy will respond for volunteers. The plan should include how to manage an injury or loss that occurred while a volunteer was performing services for the organization or was caused by another volunteer or resident, and what type of benefits a volunteer is provided if they are injured. It must also address claims filed against the organization that result from harm or loss to a resident caused by a volunteer.

It's critical to understand that volunteers will typically not be covered by an organization's workers compensation policy. That means that if a volunteer is injured, that person could sue your organization and then your organization's general liability policy would respond. An alternative solution would be for the senior care organization to make a strategic decision to include a waiver that all volunteers sign during orientation that waives the organization from typical claims that may arise. In exchange for this, the organization would provide volunteers with accidental death and dismemberment benefits that will respond in the event of an accident that occurred while a volunteer was performing services for the organization. This will allow the organization to provide the volunteer with the following protection while they are performing services for your organization:

1. Accidental death or dismemberment designated benefit amount

2. Medical expense benefit from an accident

In the event of a claim filed against the organization that results from harm or loss to a resident caused by a volunteer, the organization would be covered by its general liability policy. In addition, the volunteer may be also covered under your organization's general liability policy. This is an important point to have clarity on and is one that your insurance broker should thoroughly explain to you. Volunteer screening, training and evaluations are effective risk management tools if these are documented.

As elder resident enrollment in nursing homes and assisted living communities continues to increase, volunteers are valuable assets to senior care organizations. In order to protect both the volunteers and the residents of the facilities, volunteers must be educated and trained on their job duties and how your organization's insurance policies will respond.

Volunteer orientation, along with a thorough plan to address volunteer risk, can reduce exposure and improve care for residents, which in turn can protect the overall bottom line for a skilled nursing facility.

*Article reprinted in part out of McKnight’s and authored by Erin O’Leary.

**Best Laundry Practices to Help Prevent Bed Bugs and Other Pests**

There are many areas within long term care facilities that are at risk for pest infestation. In fact, many of the amenities and services offered to make patients and residents more comfortable are also havens for pests. One often forgotten area is the laundry room. Pest activity can be common because of the warmth, food, moisture and shelter it provides. Stacks of both dirty and freshly cleaned clothes provide warmth and a place for pests to hide. Even in the most organized of laundry rooms, if the room is used daily, finding time to deep clean and potentially treat can be difficult.

Despite having a laundry list of tasks to make each day successful, effective pest management needs to remain a priority. If ignored, you're leaving your facility open to negative publicity, property damages and even potential lawsuits, as well as putting your patients’ health and safety at risk as many pests such as cockroaches and rodents can carry dangerous pathogens and spread diseases.
Fortunately, there are beneficial steps you can take even in the most sensitive of health care environments. As part of an Integrated Pest Management (IPM) plan, ongoing sanitation, monitoring and maintenance of pest “hot spots”—like the laundry room—is a key way to help prevent pest problems. After a thorough inspection, a customized IPM program can be developed specific to your facility and its unique pest pressures, whether it be ants, cockroaches, rodents or other unwelcome guests.

**How to avoid an infestation**
Pests can't infest a place that doesn't provide them what they need to survive. Here are some valuable IPM tactics to help eliminate and prevent pest activity in the laundry room.

- Start from the outside-in. If there are any exterior doors or windows, make sure they fit tightly and install door sweeps that seal the door to the ground.
- In addition, have maintenance caulk any and all crevices to help prevent pest activity. Rats, for example, can find their way inside by means of quarter-sized holes.
- Make sure floors stay free of piles of clothing, litter and other debris. Similarly, don't keep laundry baskets or hampers filled overnight.
- A clean and open floor will allow for regular sweeping and mopping as needed to prevent any residue that can attract ants. Remember to empty those lint traps!
- Line and cover any garbage containers, making sure to empty these daily. Don't forget to clean out the inside of the trash can on a regular basis too.
- If the laundry room is also used to store mops, brooms or other cleaning supplies, keep these off the floor, dry and organized.
- Do not place storage racks flush against the wall. As a general rule, keep an 18-inch gap between the wall and the rack.
- Keep tiled ceilings intact. Broken or missing tiles should be replaced as soon as possible since ceiling voids can be used as a crawl space for rodents or a breeding ground for flies.
- Prior to washing, inspect clothing, bedding and linens for pests or evidence of pest presence such as droppings, chew marks or shed exoskeletons to detect pest activity early on.

**When bed bugs come into the picture**
Proactive, ongoing pest monitoring is the best way to identify and prevent infestations. Bed bugs, for example, are the exception to the rule when it comes to sanitation. While clutter can hide a bed bug introduction into your facility, their presence actually has nothing to do with cleanliness or sanitation practices. Anywhere that humans are, bed bugs can inhabit.

As the number of bed bug cases at health care facilities continues to grow, it's critical to detect and treat for them as early as possible. The laundry room is a key part of this effort. Inspect clothing, bedding and linens for bed bugs (flat, reddish-brown, oval insects about the size of an apple seed) or signs of them, including small, brown ink-colored stains and shed skins.

Bed bugs spread quickly and tend to stay out of sight unless they are feeding. For that reason, it's important to regularly check behind baseboards, outlet covers, torn wall paper and under broken floor or ceiling tiles—any place that bed bugs could easily hide if brought in with the dirty laundry. Since bed bugs are attracted to body heat, don't forget to check around, under and behind the dryers.

If bed bug activity is detected, take the following steps:

- First, alert management immediately and report the issue to your pest management provider.
- Quarantine any room thought to have bed bugs until it has been inspected and treated professionally.
- For items that can be laundered, wash in hot water with detergent and dry potentially infested bed linens, curtains and clothing on the hottest temperature allowed for the fabric. The combination of heat and soap will kill bed bugs.
- Talk to your pest management professional to determine which items should be removed and thrown away.
If left unchecked, bed bugs and other pests can quickly become a full-blown infestation, which is unacceptable for long term care facilities like yours. Partner with a knowledgeable and reliable pest management provider so you know which pests to look for, where to find them and how to prevent them from becoming an issue.

*Article authored by Chelle Hartzer and partially reprinted out of McKnight’s.*

**Focus F-tag – F943 Abuse, Neglect, and Exploitation Training**

This Regulatory Beat’s Focus F-tag is part of the Training Requirements regulatory group. While most of this group of regulations is not effective until Phase 3, F943 Abuse, Neglect and Exploitation Training became effective with Phase 1 of the RoPs. This regulation outlines the requirements related to staff training on abuse, neglect, exploitation and misappropriation of resident property, and defines specific topics that need to be covered as part of this required education. The Interpretive Guidance states that the training program should be determined based on staff needs as well as the Facility Assessment and should be revised when the facility’s resident population changes or when other changes in the facility may require revisions.

Staff orientation and training must cover all forms of abuse, neglect, misappropriation of resident property, exploitation and dementia management. The IG states that it should include, minimally, information on how the facility uses “person-centered thinking, planning and practice skills to contribute to a facility culture of prevention and identification of abuse, neglect and exploitation,” as well as identifying and preventing behavior that constitutes abuse/neglect/exploitation/misappropriation. Education should also include training on identifying physical or psychosocial indicators of abuse/neglect/exploitation/misappropriation – including such issues as responsibility for not sharing resident photos/videos via technology or social media. Areas that should be included in education:

- A review of facility procedures and federal and state requirements for reporting abuse, neglect, exploitation and misappropriation of resident property, including injuries of unknown sources, reporting timeframes and who to report to
- Responsibility for reporting reasonable suspicion of a crime against a resident
- Dementia care and abuse prevention – challenging behaviors to staff can easily increase a resident’s risk for abuse or neglect

Education should also address:

- Conflict resolution and anger management skills
- Identifying and addressing signs of staff burnout, prejudices or negative attitudes related to the population a staff member has been assigned to work with – does your staff know what these terms mean and how to recognize a staff member who is experiencing difficulty?

The IG recommends that surveyors focus on looking at how facility policies ensure that staff training is in compliance with the requirements at F600 Freedom from Abuse, Neglect and Exploitation, under which the Interpretive Guidance was greatly expanded when the RoPs were updated.

There are a whole host of probes as to what should be happening in a facility to prevent abuse, neglect, exploitation and misappropriation of resident property and these probes are worth a second glance. Concerns related to a facility’s mandatory requirements for education, validation of participation in education being available (how do you track attendance?) and assessing how effective the training was can be fraught with identifiable issues if you do not have a comprehensive prevention program in place that includes sound training.
Illinois Ranks 38th in Nation for Seniors' Health

Illinois ranks in the lower quarter of states when it comes to the health of its seniors, according to a new report from the United Health Foundation.

The state ranked 38th in the nation, down two spots from rankings released last year. The report commended the state for having a high prevalence of seniors with a dedicated health care provider. It also had a high prevalence of adults describing themselves as able-bodied.

But fewer seniors get their health screenings compared to other states. There’s also a higher prevalence of obesity. And the percentage of residents in nursing homes receiving high marks from Medicare is low compared to other states.

Dr. Rhonda Randall, senior adviser to the United Health Foundation and chief medical officer and executive vice president for UnitedHealthcare Retiree Solutions, said “there’s some good cause to be optimistic.”

While Illinois has a high percentage of seniors describing themselves as able-bodied, it also has a high level of inactivity. Randall said efforts to help seniors get more active could help.

Read more.

Important Regulations, Notices & News Items of Interest

1) No new Federal CMS Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat.

2) Federal HHS/CMS released the following notices/announcements:

- **SNF Quality Reporting Program: Non-Compliance Letters.** CMS is providing notifications to facilities that were determined to be out of compliance with Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) requirements for CY 2017, which will affect their FY 2019 Annual Payment Update (APU). Non-compliance notifications were mailed by the Medicare Administrative Contractors (MACs) and have been placed into facilities’ CASPER folders in QIES on July 9, 2018. Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 p.m. PST, August 7, 2018. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the [SNF Quality Reporting Reconsideration and Exception & Extension webpage](#).

- **Hospice Quality Reporting Program: Non-Compliance Letters.** CMS is providing notifications to hospices that were determined to be out of compliance with Hospice Quality Reporting Program (HQRP) requirements for CY 2017, which will affect their FY 2019 Annual Payment Update (APU). Non-compliance notifications were mailed by the Medicare Administrative Contractors (MACs) and were placed into hospices’ CASPER folders in QIES on July 9, 2018. Hospices that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 p.m. PST, August 7, 2018. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification and on the [Reconsideration Requests webpage](#).

- **Centers for Medicaid Releases LTSS Report.** The Center for Medicaid and CHIP released a [report](#) on Medicaid coverage of Long Term Services and Supports for fiscal year 2016. The report shows that expenditures for
institutional care fell 2 percent, while payments for Home and Community-Based Services and Managed Care increased.

- **New Bulletin Released on Model Practices for State Oversight of Group Homes.** The Administration for Community Living (ACL) and the HHS Inspector General and Office of Civil Rights released a report in January on health and safety issues in group homes. The ACL reports on a new bulletin released by Center for Medicaid and CHIP Services to encourage states to implement compliance oversight programs.

- **Special Open Door Forum: The IMPACT Act and Standardized Patient Assessment Data Elements - July 25, 2018 1:00-2:00 p.m. Central Time - Conference Call Only.** Participant Dial-In Number: 1-800-837-1935 - Conference ID #: 1298728. This Special Open Door Forum (SODF) will provide information and solicit feedback pertaining to the Standardized Patient Assessment Data Elements (SPADE) work under the Improving Medicare Post-Acute Care Transformation Act of 2014 (commonly referred to as the IMPACT Act). This SODF will provide an update on the recent SPADE activities including progress on national field test data collection, early feedback from providers participating in the beta data collection and upcoming stakeholder engagement activities that will help stakeholders remain engaged and informed during the upcoming year.

- **CMS Takes Action to Modernize Medicare Home Health.** On July 2, CMS proposed significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare, drive value and focus on individual patient needs rather than volume of care. Specifically, CMS is proposing changes to improve access to solutions via remote patient monitoring technology, and to update the payment model for home health care.

  “Today’s proposals would give doctors more time to spend with their patients, allow home health agencies to leverage innovation and drive better results for patients,” said CMS Administrator Seema Verma. “The redesign of the home health payment system encourages value over volume and removes incentives to provide unnecessary care.”

  CMS’ proposed changes promote innovation to modernize home health by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data is shared among patients, their caregivers and their providers. Supporting patients in sharing this data will advance the Administration’s MyHealthEData initiative.

  As required by the Bipartisan Budget Act of 2018, this proposed rule would also implement a new Patient-Driven Groupings Model (PDGM) for home health payments. The proposed rule also includes information on the implementation of home infusion therapy temporary transitional payments as required by the Bipartisan Budget Act of 2018. In addition, the proposed rule solicits comments on elements of the new home infusion therapy benefit category and proposes standards for home infusion therapy suppliers and accrediting organizations of these suppliers as required by the 21st Century Cures Act.

  Physicians who order home health services for their patients would also see administrative burden reduced under this rule. CMS is proposing to eliminate the requirement that the certifying physician estimate how much longer skilled services would be needed when recertifying the need for continuing home health care, as this information is already gathered on a patient’s plan of care.

  The proposed rule helps advance the Trump Administration’s Meaningful Measures Initiative. CMS is proposing changes to the Home Health Quality Reporting Program (HH QRP). The cost impact related to updated data collection processes as a result of the proposed implementation of the PDGM and proposed changes to the HH QRP are estimated to result in a net $60 million in annualized cost savings to Home Health Agencies (HHAs), or $5,150 in annualized cost savings per HHA, beginning in CY 2020.

  In the proposed rule CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering stakeholder feedback on revising the CMS patient
health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. For More Information:

- **Proposed Rule**
- **Fact Sheet**
- **Home Health PPS** website
- **HHA Center** website
- **Home Health Value-Based Purchasing Model** webpage
- **Home Health Quality Reporting Requirements** webpage

See the full text of this excerpted [CMS Press Release](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2022-08-01.html) (issued July 2).

- **New Medicare Card: Use MBI Like HICN.** Use the Medicare Beneficiary Identifier (MBI) the same way you use the Health Insurance Claim Number (HICN) today. Put the MBI in the same field where you have always put the HICN. This also applies to reporting informational only and no-pay claims. Do not use hyphens or spaces for hyphens with the MBI to avoid rejection of your claim. For More Information:
  - **New MBI: Get It, Use It** MLN Matters® Article
  - **Transition to New Medicare Numbers and Cards** MLN Fact Sheet

- **New Medicare Card: MBI Changes.** There are times when a Medicare Beneficiary Identifier (MBI) may change. People with Medicare or their authorized representatives can request an MBI change. CMS can also initiate a change to an MBI (for example, if the MBI is compromised). There are different scenarios for using the old or new MBIs:

  **Fee-For-Service (FFS) claims submissions with:**
  - Dates of service before the MBI change date – use the old or new MBI
  - Span-date claims with a “From Date” before the MBI change date – use the old or new MBI
  - Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI

  **FFS eligibility transactions when the inquiry:**
  - Uses new MBI – we will return all eligibility data
  - Uses the old MBI and request date or date range overlap the active period for the old MBI – we will return all eligibility data and the old MBI termination date
  - Uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we will return an error code (AAA 72) of “invalid member ID”

When the MBI changes, we ask people with Medicare to share the new MBI with you. You can also get the MBI from your Medicare Administrative Contractor’s secure MBI lookup tool.

Remember: To ensure people with Medicare continue to get health care services, you can continue to use the Health Insurance Claim Number through December 31, 2019, or until your patient brings in their new card with the new number.

We finished mailing most cards to people with Medicare who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia. If someone with Medicare says they did not get a card:
  - Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

- **CMS Data Element Library Supports Interoperability.** CMS launched its first [Data Element Library](https://www.cms.gov/Research-Statistics-Data-and-Collections/Data-Element-Library/index.html) (DEL), a resource for providers, vendors, researchers, and other stakeholders that use CMS assessments. Search and obtain reports on CMS post-acute care assessment contents in one location, including:
The DEL supports interoperability and the exchange and reuse of data across post-acute care and other providers by using common assessment standards and definitions to facilitate coordinated care and improved health outcomes. For More Information:

- Press Release
- Fact Sheet

**Qualified Medicare Beneficiary Information on RAs and MSNs.** Medicare providers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Parts A and B deductibles, coinsurance or copays, but state Medicaid programs may pay for those costs. To make it easier to identify the QMB status of your patients, CMS will reintroduce QMB information in provider Remittance Advices (RAs) and Medicare Summary Notices (MSNs) for claims processed on or after July 2, 2018. You can also verify QMB enrollment by using Medicare eligibility information returned by the CMS Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application. For More Information:
  - Reinstating the QMB Indicator MLN Matters Article
  - Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
  - QMB Program webpage
  - Materials from June 6 Medicare Learning Network call, including presentation and FAQs

**Laboratory Date of Service Exception — Reminder.** On July 2, CMS will implement the exception to the laboratory date of service policy for advanced diagnostic laboratory tests and molecular pathology tests excluded from the Medicare hospital outpatient prospective payment system packaging policy. For More Information:
  - Laboratory Test Codes Subject to Date of Service Exception 06/25/2018 - Updated quarterly as needed
  - Laboratory Date of Service Policy webpage

**Administrative Simplification Compliance Resources.** CMS created tools and resources to help you understand and reach compliance:
  - Enforcing HIPAA Administrative Simplification Requirements Video: Learn why and how CMS is enforcing requirements
  - Reaching Compliance with ASETT Video: Learn how to use the Administrative Simplification Enforcement and Testing Tool (ASETT) to test transactions and file a complaint

For More Information:
  - Administrative Simplification webpage
  - Adopted Standards and Operating Rules webpage

**2016 CMS Program Statistics.** 2016 CMS Program Statistics are available, including detailed summary statistics on Medicare populations, utilization and expenditures, as well as counts for Medicare-certified institutional and non-institutional providers. Tables for calendar years 2013 to 2015 are updated to reflect changes to the source data for enrollment and utilization information. Visit the CMS Program Statistics website for more information.

**Pride in Putting Patients First.** While health care organizations have made great strides in collecting certain sociodemographic data, more work needs to be done, particularly when it comes to sexual and gender minorities. During Pride month, which recognizes sexual and gender minorities, CMS wants to highlight a number of resources that are available to assist organizations in collecting better data, including:
  - Training hosted on the Medicare Learning Network: Provides information about the disparities experienced by sexual and gender minorities and ways this data can be collected to improve the quality of care
Sexual and Gender Minority Clearinghouse: Designed to help improve the understanding of sexual and gender minority health and disparities and provide information on health care access, health-related risk behaviors, chronic health conditions and use of preventive services

Practical Guide to Implementing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: This toolkit helps organizations implement the HHS standards to advance health equity, improve quality and help eliminate health care disparities for racial, ethnic and linguistic minorities, people with disabilities and sexual and gender minorities

See the full text of this excerpted CMS blog (issued June 19).

- **Health Care System Response to Mass Shootings.** A rapid, effective health response can save lives in the hours after a mass shooting or other unexpected events. In the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center and Information Exchange (TRACIE) June newsletter, health professionals share lessons learned about pre-hospital care, trauma and emergency response from mass shootings. Review resources on health care system preparedness, and sign up for the ASPR TRACIE listserv.

- **Comprehensive Error Rate Testing: Arthroscopic Rotator Cuff Repair.** As reported in the Medicare Quarterly Compliance Newsletter (October 2017), the Comprehensive Error Rate Testing (CERT) review contractor conducted a study of claims for arthroscopic rotator cuff repairs billed with HCPCS code 29827 submitted from January through March 2016. Most improper payments were due to insufficient documentation. Avoid documentation errors and payment recoveries:
  - Medicare Benefit Policy Manual, Chapter 15, Section 10 on Supplementary Medical Insurance Provisions
  - Medicare Benefit Policy Manual, Chapter 15, Section 30 on Physician Services
  - Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4 on Signature Requirements
  - CERT Program website
  - CERT provider website

- **Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder.** After a stratified random sample review of hospice election statements and certifications of terminal illness, the Office of the Inspector General (OIG) reports that more than one-third of hospice General Inpatient (GIP) stays lack required information or had other vulnerabilities.
  - Hospice election statements did not always mention – as required – that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative
  - In 14 percent of GIP stays, the physician did not meet requirements when certifying that the beneficiary was terminally ill and appeared to have limited involvement in determining that the beneficiary’s condition was appropriate for hospice care

  Hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. Resources:
  - Hospices Should Improve Their Election Statements and Certifications of Illness OIG Report, September 2016.
  - Hospice Payment System Booklet: Includes a section on the hospice election statement
  - Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters® Article
  - Sample Hospice Election Statement MLN Matters Special Edition Article

- **Rejected Claims for Medicare Diabetes Prevention Program Services.** Medicare Administrative Contractors are rejecting claims for Medicare Diabetes Prevention Program (MDPP) services submitted by organizations and existing Medicare providers that are not enrolled separately as MDPP suppliers. Valid claims for MDPP services must be submitted by enrolled MDPP suppliers. Before submitting claims for these services, make sure your organization:
Meets all MDPP supplier requirements and standards, including preliminary or full Centers for Disease Control and Prevention recognition

Has a separate Medicare enrollment as an MDPP supplier

Visit the MDPP webpage for information on supplier enrollment.

- **ESRD Claims Error: Transitional Drug Adjustment Add-On Payment Adjustment.** End Stage Renal Disease (ESRD) claims are incorrectly reimbursed if they:
  - Are eligible for Transitional Drug Adjustment Add-On Payment Adjustment and
  - Contain non-covered charges

After they fix the system on January 1, 2019, your Medicare Administrative Contractor will mass adjust claims that were paid incorrectly. You do not need to take any action.

- **Medicare Coverage for Chiropractic Services MLN Matters Article — Revised.** A revised MLN Matters Article on Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits is available. Learn about coverage and documentation requirements.

- **ESRD PPS: Quarterly Update MLN Matters Article — Revised.** A revised MLN Matters Article on Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) is available. Learn about new codes added for anemia management.

- **Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised.** A revised MLN Matters Article on Revisions to the Telehealth Billing Requirements for Distant Site Services is available. Learn about use of the GT modifier on institutional claims billed under critical access hospital Method II.

- **MLN Learning Management System FAQs Booklet — Revised.** A revised The Medicare Learning Network (MLN) Learning Management System (LMS) FAQs Booklet is available. Learn about:
  - Accessing the LMS
  - Finding products
  - Taking Web-Based Training


- **Comprehensive ESRD Care Model Telehealth: Implementation MLN Matters Article — Revised.** A revised MLN Matters Article on Comprehensive ESRD Care (CEC) Model Telehealth - Implementation is available. Learn about the telehealth waiver.

3) The federal Centers for Disease Control and Prevention (CDC) provided information on Seasonal Flu vs. Pandemic Flu and Fair Season and Swine Flu.

4) The federal HHS Office of the Inspector General announced:

- The OIG Updated Work Plan ([https://go.usa.gov/xQU38](https://go.usa.gov/xQU38)).

- OIG posts 2018 National Health Care Fraud Takedown Information. The Department of Health and Human Services Office of Inspector General, along with state and federal law enforcement partners, participated in the largest health care fraud takedown in history in June 2018. More than 600 defendants in 58 federal districts were charged with participating in fraud schemes involving about $2 billion in losses to Medicare and Medicaid. Since the last takedown, OIG also issued exclusion notices to 587 doctors, nurses and other providers based on
conduct related to opioid diversion and abuse. These enforcement actions protect Medicare and Medicaid and deter fraud -- sending a strong signal that theft from these taxpayer-funded programs will not be tolerated. The money taxpayers spend fighting fraud is an excellent investment: For every $1 spent on health care-related fraud and abuse investigations in the last 3 years, more than $4 has been recovered. Visit 2018 National Health Care Fraud Takedown to Learn More.

5) The federal National Institutes of Health (NIH) released a report entitled Heat-Related Health Dangers for Older Adults Soar During the Summer. As we age, our ability to adequately respond to summer heat can become a serious problem. Older people are at significant increased risk of heat-related illnesses, known collectively as hyperthermia, during the summer months. Hyperthermia can include heat stroke, heat edema (swelling in your ankles and feet when you get hot), heat syncope (sudden dizziness after exercising in the heat), heat cramps and heat exhaustion.

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:

- **Rauner taps Bellock as HFS Secretary.** Gov. Bruce Rauner has tapped Rep. Patti Bellock, R-Hinsdale, as director of the Department of Healthcare and Family Services, according to a statement. Bellock has served in the General Assembly since 1999 and has been deputy minority leader since 2013. She’s the chief budget negotiator for House Republicans and minority spokeswoman on the Human Services Appropriations Committee. “It is an honor to join the talented and dedicated staff of the Department of Healthcare and Family Services,” Bellock said in the statement. “I look forward to working with the governor and my colleagues in the General Assembly to ensure access to quality healthcare for Illinois’ most vulnerable population and making our healthcare delivery systems more efficient and effective.” Bellock starts her new role July 11. She’ll replace interim Director Teresa Hursey, who will remain as Medicaid director. The previous head of the department, Felicia Norwood, left last month to become an executive vice president at Anthem and president of its government business division.

  - HFS posted a new provider notice regarding **LTC Monthly Occupied Bed Provider Assessment.** You may view the notice [here](#).

  - HFS posted a new provider notice regarding **an updated Ambulance Fee Schedule, effective 07/01/2018.** You may view the notice [here](#).

  - HFS posted a new provider notice regarding **Adult Dental Services.** You may view the notice [here](#).

  - HFS posted a new Public Notice regarding **ID/DD and MC/DD Facilities Wage Increase.** You may view the notice [here](#).

  - HFS posted a new Public Notice regarding **ID/DD Medicaid Per Diem Increase.** You may view the notice [here](#).

  - HFS posted a new provider notice regarding **June 2018 Final Reconciliation ACA Assessment Adjustment.** You may view the notice [here](#).

  - HFS posted a new Public Notice regarding **Division of Substance Use Prevention and Recovery Rate Increase.** You may view this notice [here](#).

  - HFS posted a new provider notice regarding **Hospital Rate Sheets Effective July 1, 2018.** You may view the notice [here](#).

  - HFS posted a new provider notice regarding **Wage Rate Increase Effective July 1, 2018 for Specified Personnel Serving Individuals with Developmental Disabilities in Institutional and Community-Based Settings.** You may view the notice [here](#).
• HFS posted **New SMRHF Rates**, Effective 07/01/2018. You may view the new rates [here](#).

• HFS posted an updated **ACA FFS Payment Calculation for July 2018**. You may view the new document [here](#).

7) The **Illinois Department of Public Health (IDPH)** announced the list of **Town Hall Meetings for 2018**. Notices are being sent to the individual providers prior to the meeting in their location. Reservation information is included in that letter. The dates and locations are:

   - August 14, Brookens Bldg, Urbana  1-3 p.m.
   - September 11, Abington of Glenview  1-3 p.m.
   - October 16, Pekin Manor  1-3 p.m.
   - November 14, Oak Trace, Downers Grove  1-3 p.m.

8) The **American Health Care Association (AHCA)** and the **Illinois Health Care Association (IHCA)** recently reported on:

   - CMS has released a revised version of **QSO-17-30** that clarifies expectations for providers, accrediting organizations and surveyors on requirements to reduce **Legionella Risk** in health care center's water systems. This memorandum replaces **S&C-17-30** released on June 2, 2017, and revised on June 9, 2017.

   The memo indicates that facilities must have water management plans and documentation that ensure each center:
   - Conducts a facility risk assessment related to Legionella and other opportunistic waterborne pathogens;
   - Develops and implements a water management program that considers the [ASHRAE industry standard](#) and the [CDC toolkit](#);
   - Specifies testing protocols and acceptable ranges for control measures while documenting testing results and corrective actions when control limits are not maintained; and
   - Maintains compliance with other applicable federal, state and local requirements.

   CMS also clarifies that it *does not require* water cultures for Legionella or other opportunistic waterborne pathogens. Testing protocols are at the discretion of the provider.

   In addition, LTC surveyors will expect that a center’s water management plan, including a risk assessment and testing protocols, is available for review *but will not cite the facility based on the specific risk assessment and testing protocols in use*.

   CMS will provide further surveyor guidance at a future date, and we will share that information with members as soon as it is available.

   The revised guidance is effective immediately.

   For questions related to this memo, please contact **NHSurveyDevelopment@cms.hhs.gov**.

   AHCA Contact: Sara Rudow at **srudow@ahca.org**.

• **Patient-Driven Payment Model – An Overview, AHCA Priority Comments and Outlook for the Final Rule.** On July 16 at 2:00pm (eastern), AHCA staff experts will offer an overview of CMS’ proposed Patient-Driven Payment Model (PDPM) and highlight AHCA comment areas that are of most importance to members. AHCA also will provide an outlook for what may be contained in the final rule. The webinar will be recorded and archived and no CE credit is available.

  **Speakers:** Mike Cheek, Senior Vice President, Reimbursement and Dan Ciolek, Associate Vice President, Therapy Services, AHCA.
• **CMS Update on Payroll-Based Journal.** CMS has announced that starting in July 2018 it will post the number of hours worked by non-nursing staff (all staff listed in Table 1 of the PBJ Policy Manual) submitted through the Payroll-Based Journal (PBJ) system. CMS will also begin to distinguish between hours submitted for direct employees and contract staff.

**Reminders**

Since November 1, 2017, CMS has been posting data on nursing staff (CNAs, Med Aides, LPNs, DONs and RNs) and makes this data available to the public through public use files (PUFs) [here](https://ahcancal.org/p/180716).

In April 2018, CMS published new Five-Star ratings that include PBJ staffing data on its Nursing Home Compare (NHC) [website](https://ahcancal.org/p/180716). AHCA hosted a [webinar](https://ahcancal.org/p/180716) that provided an overview of these new changes. Members are encouraged to access the recorded webinar and other key resources including Frequently Asked Questions and the latest [Technical User’s Guide](https://ahcancal.org/p/180716) on ahcancalED. Please note you will need your AHCA username and password to register. Talking points can be accessed [here](https://ahcancal.org/p/180716).

Facilities that fail to submit any staffing data by the deadline or who have audits that identify significant discrepancies between the hours reported and verified will receive a one-star rating for the Five-Star staffing domain for three months. Also, centers reporting seven or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain starting in July.

Additionally, centers that meet the following exclusions will not have a staffing rating or staffing data reported; NHC will display a "Data Not Available" message for these facilities:

- The nursing home has five or more days with at least one resident but no nurse staffing hours reported. Since nurse aides in training cannot operate independently as nurses, nurse aides in training are not included.
- Total nurse staffing aggregated over all days in the quarter with both nurses and residents is excessively low (<1.5 HRD)
- Total nurse staffing aggregated over all days in the quarter with both nurses and residents is excessively high (>12 HRD)
- Nurse aide staffing aggregated over all days in the quarter with both nurses and residents is excessively high (>5.25 HRD)

Please note that the deadline to submit the PBJ staffing data collected from your center during the April 1- June 30, 2018 reporting period is August 14, 2018. You are encouraged to enter your data into the PBJ portal and run some validation checks to ensure the data’s accuracy before the deadline.

AHCA will continue to provide updates on PBJ and the new ratings as they become available. If you have any questions, please contact the AHCA PBJ team [here](https://ahcancal.org/p/180716).

• **Illinois Dementia Coalition.** CMS is launching an exciting new program to help the Late Adopters (those facilities who are still struggling with reducing antipsychotic use rates) improve dementia care and help lower the use of off-label antipsychotics. The Illinois Dementia Coalition will be sending an email to each of the facilities designated as late adopters and encourage them to apply for this new program as well as personally reaching out to a few facilities that we think would benefit and actively participate. To that end, The Coalition is scheduling a meeting for the end of July so that we can give you some more detailed information about the program, review what facilities applied for the program and what assistance we may be able to provide to help them succeed. So save the date for July 27 at 9 a.m. for a conference call.

9) The latest Telligen events/announcements can be found [here](https://ahcancal.org/p/180716).
• **National Nursing Home Quality Improvement Campaign – Goal Setting.** Each of the Campaign’s nine goals has its own page on the Campaign website that walks you through these seven steps to success. Click through each step to learn more about the goal and the resources that are available to support your community’s quality improvement journey. The website also features success stories from long term care providers around the country. [Read these stories](#) to learn more about how homes have implemented changes to create lasting improvement. Don’t forget to read our [June newsletter](#) for the latest Campaign news, resources and events, as well as other updates within long term care quality improvement.

10) **Health News Illinois** reports that State’s Opioid Supply Levels Decrease. The amount of prescription opioids sold in Illinois fell 9.5 percent from 2016 to 2017, according to a recent [report](#) from Avalere. National levels fell 11 percent during that period. States with laws limiting opioid prescriptions saw steeper declines. The biggest decline was in Maine at 24.8 percent. Avalere used data from the U.S. Drug Enforcement Agency’s Automation of Reports and Consolidated Orders System.

11) **Bloomberg News** reports on Hospitals Using Artificial Intelligence Software to Predict Patient’s Risk of Falling. **Bloomberg News** recently reported that hospitals are using artificial intelligence software to predict when patients are at risk of falling. Analysis of data "exposed patterns, such as the time of day when most falls occur or the sequence of events that typically lead to falls," according to the article. Bloomberg News says that "according to the Department of Health and Human Services’ Agency for Health care Research and Quality, 700,000 to 1 million hospitalized patients fall each year."

12) **The New York Times** reports that Medicare to Provide More Benefits for Chronically Ill. In what the **New York Times** calls "a rare instance of bipartisan cooperation on a major policy initiative," the Administration and Congress are "revamping Medicare to provide extra benefits to people with multiple chronic illnesses, a significant departure from the program’s traditional focus that aims to create a new model of care for millions of older Americans." The changes, says the *Times*, "tackle a vexing and costly problem in American health care: how to deal with long-term illnesses that can build on one another, and the social factors outside the reach of traditional medicine that can contribute to them, like nutrition, transportation and housing." The additional benefits "can include social and medical services, home improvements like wheelchair ramps, transportation to doctor's offices and home delivery of hot meals."

13) **Congressional Quarterly** reports that CMS to “More Closely Scrutinize” How States Spend Medicaid Dollars. **Congressional Quarterly** reports that CMS officials will begin "more closely scrutinizing" how states spend billions of Medicaid dollars, and may penalize those covering people the federal government deems ineligible for the government insurance program. According to CQ, "the new initiatives announced Tuesday are part of a larger effort to improve accountability in the program, which saw spending increase by more than 25 percent in recent years to an estimated $576 billion in 2016, according to the Centers for Medicare and Medicaid Services."

14) **Skilled Nursing News** reports:

• **Providers See In-House Insurance as Path to Success Under PDPM.** **Skilled Nursing News** reports that more skilled nursing providers are turning to "in-house insurance plans to take more control of the care process, and the move could pay off" under CMS’ proposed Patient Driven Payment Model (PDPM). Some providers believe in-house insurance plans are "a good fit as they adapt to the world of Medicare Advantage"; and the increased "focus on care management in PDPM is where experience with Medicare Advantage plans can give providers a significant leg up."

• **Staffing in Nursing Homes Under Scrutiny Following Recent Reporting.** **Skilled Nursing News** reports, "Most U.S. nursing homes experience staffing fluctuations and have been underreporting their nursing and caretaking staff levels for years, according to data analyzed by Kaiser Health News for the *New York Times.*" The federal data illustrated by an interactive map by the Times, "suggest strongly" that CMS’ Five-Star system "exaggerated staffing levels across the country over the past 10 years." The article cites David Gifford, a senior vice president at the American Health Care Association, telling the Times that there are legitimate reasons staff could vary, such as family visits.
15) McKnight’s reports:

- ‘We Have to do Better’ on Infection Prevention, CMS Official Tells LTC Nurse Managers During New Survey Update. Nursing homes’ new survey routine seems to be going smoothly, about half a year in, but infection prevention problems continue to plague the field. That was the message from Evan Schulman, the Centers for Medicare & Medicaid Services’ deputy director for the Division of Nursing Homes, during a presentation at the American Association of Directors of Nursing Services’ annual meeting. Schulman said that infection prevention continues to be big challenge for the field, as it is the No. 1 deficiency under the new survey, just as it was using the prior process. There are upward of 3 million healthcare acquired infections each year. “It’s a very, very challenging problem,” he noted.

- Nursing Home Culture Change Improves Residents’ Depression and Dining. McKnight’s Long Term Care News reports a new study by the LeadingAge LTSS Center @UMASS Boston found that culture change at nursing homes is linked to improvements to “residents’ depressive symptoms and dining experience.” Examining the impact of culture change at nursing homes in New Jersey, researchers “found that comprehensive culture change [also] improves interactions between residents and their care partners.”

16) Interesting Fact: The largest firework show in the United States is the Macy’s "Lights Up the Night" show in New York over the Hudson River on July 4th. The show includes over 40,000 shells, and more than 3 million people watch the spectacle.