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

**Sufficient and Competent Nurse Staffing Review (Part 6 in the Series – Mandatory LTC Survey Pathways)**

Surveyors will evaluate if the facility has sufficient and competent nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

**Coordination:**

- Every surveyor assesses the facility for compliance with the requirements for sufficient and competent nursing staffing throughout the survey.
- At the end of each day, one surveyor consolidates the information related to staffing from other surveyors. This shall include information obtained from any observation or interview conducted as part of the activities in this task listed below, or based on other activities such as general resident interviews or investigations. Information obtained shall include examples that demonstrate a lack of sufficient and/or competent staff with either:
  - the potential for negative outcomes or harm, or
  - actual negative outcomes or harm.
- After consolidating this information, the surveyor assigned to this task then evaluates the information and determines further actions or investigations.

**General Observation and Interview Concepts to Consider When Considering Compliance:**

- Odors, call-lights, census and staff’s ability to complete assignments are used to assess if the facility has sufficient staff to meet the residents’ needs.
- The Facility Assessment is used to assess if the facility appropriately considers the facility’s census and residents’ acuity to determine the number and competency of staff required to meet each resident’s needs.
- The use of position-change alarms, devices that may restrict a resident’s movement and medications that subdue or sedate residents are used to assess if the facility is using these items as potential restraints because they don’t have sufficient staff to monitor each resident effectively.
- Hospitalizations and the staff’s ability to identify and address residents’ changes in condition are used to assess if the facility’s staff possess the required competencies to care for each resident.
- Agency staff are used to assess if agency staff possess the required competencies to care for each resident.
- Trainings are used to assess if staff retained the information provided by training to maintain the required competencies to meet each resident’s needs.
- Turnover and QAA are used to assess if the facility is operating an effective QAA process.
List of Observations Made While Completing the Initial Pool Process and/or Investigations:
During team meetings, the team should discuss whether any of the areas listed below were concerns to alert the team of potential concerns with sufficient or competent staff.

- Are there offensive odors? If so, what is the source?
- If mid-morning (e.g., 9-11 a.m.) or later, are residents still in bed and not dressed?
- Are residents sitting around the nurse’s station, in the hallways, or in front of the television without any interaction from staff?
- Are call lights and alarms responded to timely?
- Are residents displaying behavioral or pain concerns such as being combative, yelling or crying out?
- Are residents who wander unsupervised and susceptible to, or creating, issues?
- Do staff appear rushed when providing resident care? Do licensed nurses help nursing aides when asked for assistance?
- Are residents provided assistance with eating during meals and are nursing staff monitoring the dining area during meals?
- Potential use of restraints:
  - Are residents subdued or sedated, indicating the potential use of chemical restraints; or
  - Are there devices or practices in use that restrict residents’ freedom of movement indicating the potential use of physical restraints?
- Are residents’ choices honored and their dignity maintained? For example:
  - Do residents remain unkempt or unclean for extended periods of time (e.g., after sleeping or eating); or
  - Are residents woken up and assisted with activities, such as eating, bathing or dressing at times that are convenient for staff (e.g., during shift change), rather than at the residents’ preference (within reason)?
- Is there a delay in residents receiving their medications timely?
- Are residents repositioned or turned timely in accordance with their plan of care?
- Is there a high incidence of position-change alarm use?
- Do staff explain to residents what they are doing when assisting or providing services to the resident?
- Are residents experiencing avoidable accidents (e.g., falls), elopements or incidences of resident-to-resident altercations or abuse?
- If concerns about staff responsiveness exist, the surveyor should activate the call light and record the response time of the staff.
- When observing care or services provided to residents by nursing staff, determine if they demonstrate competency. Such as, their abilities to provide care according to professional standards in the following areas:
  Refer to other regulations and IGs as appropriate.
  - Inability for staff to identify any obvious signs of residents’ change in condition;
  - Transfers and Positioning (e.g., use of mechanical lifts, bed to chair);
  - Infection Control Techniques, including wound care and residents on isolation precautions;
  - Tracheostomy, Ventilator care, or Tube feeding; and
  - Incontinence, including Catheter care.

Interviews
Residents/Resident Representatives or Family Members: Staff Sufficiency (list of probes addressed during the initial pool process): During team meetings, the team should discuss whether any of the areas listed below were concerns to alert the team of potential concerns with sufficient or competent staff.

- Do you feel that there is enough staff to meet your needs and concerns, such as answering your call light timely or responding quickly to your alarm if you have one? If not, why, and what care or services do you feel are not provided, such as receiving or refilling a cup of water, toileting, dressing, eating, going to activities? Is there a specific time of day or weekends that are more problematic?
- Has anything occurred because you had to wait for staff to respond and assist you, such as being incontinent, missing a shower or falling? How often does this occur?
- Do you routinely eat in your room? If so, is this your choice and if needed, is assistance provided to help you?
- Are room trays delivered timely? Are you able to wake, dress, eat or engage in other activities at times that are preferable to you?
Does staff interact with you and explain to you what care or services they are providing and why? Does staff rush you when they provide care?

Do you get your medications on time?

Do you now or have you ever had a position-change alarm used -- for example, a device that makes a sound when you change your position while sitting or in bed? If so, do you know why these alarms are used for you?

Do you receive medications that make you sleepy, tired, lethargic or sedated?

**Staff Competency (surveyors should ask residents about staff competency throughout the survey):**

- Do you feel safe and comfortable when staff assist you?
- Do you think the nursing staff are experienced and knowledgeable when providing your care? If not, what concerns have you experienced?
- Do you recall a time when you didn’t feel well? Did you tell a staff member? What happened? For example, did you get better or worse?
- Have you been transferred to the hospital? For what reason?

**Nursing Aide and Licensed Nurse Interview:** If concerns are identified with sufficient or competent staff, complete the following interviews.

**Staff Sufficiency:**

- How many residents are you responsible for on a regular basis during your shift?
- Do you have enough time to complete your required assignments each day? If not, why not, and what assignments are you not able to complete? How often does this occur?
- How often are you asked to stay late, come in early or work overtime?
- Do you use position-change alarms? Why?
- Are there any devices used to help keep residents from falling, moving in certain ways or wandering into certain areas? If so, why? Which residents?
- Are you able to complete rehabilitation services as ordered for the residents?
- How are current staffing needs determined? Does management ask for your input into their facility assessment for sufficient staffing? If so, can you provide some examples of what you provided and if you know whether or not these were considered?

**Staff Competency:**

- How are you made aware of the care and services the residents require as directed in their plan of care and what their individual choices are?
- How do you identify a resident’s change in condition? Can you provide some examples?
- How are changes in a residents’ care communicated to you and how do you communicate a resident’s change in condition or concerns to other staff? Is there a structured tool (e.g., INTERACT or a process for identifying, communicating and caring for changes in a resident’s condition)?
- How often are residents sent to the hospital? For what reasons? Which residents have recently been transferred?
- How have you been trained to provide care, use equipment and ensure proper infection control techniques are used?
- Do you receive periodic evaluations on your skills, knowledge and abilities? If so, how often? For what areas have you been assessed? What areas do you believe you need more assistance or training?
- Do you have regular in-services on abuse, resident rights, dementia care and specific resident needs (e.g., ventilators, dialysis, hospice, medication side effects, pain or changes in condition)? Are you provided training on each resident? How often?
- Does your facility use agency staff? If so, how does that impact your daily activities? Do you have any concerns about resident care when agency staff are used?

**DON and Staff Development Coordinator Interviews:** If concerns are identified with sufficient or competent staff, complete the following interviews.
Does the facility assessment include a determination of the level and competency of staff needed to meet each resident’s needs each day and during emergencies? If so, what does this assessment include? How do you have input into this assessment? How often is this assessment updated?

How are the residents’ acuity, needs and diagnoses considered when determining staffing requirements and assignments?

Staff Sufficiency:
- How does the facility’s census impact staffing levels? For example, are staffing assignments routinely changed based on census? If so, how do you accommodate for the changes and for weekend staffing adjustments? How do you handle call-ins?
- Do staff, residents or families bring workload concerns to you? How do you handle the concerns? Is there a system in place to address these concerns?
- What is your turn-over rate? Do you conduct exit interviews with staff? Do you report interview findings to your QA&A meeting?
- Do you use position-change alarms? Why?
- Are there any devices used to help keep residents from falling, moving in certain ways or wandering into certain areas? If so, why? Which residents?

Staff Competency:
- How do staff identify residents’ changes in condition and what process should they follow if they identify something (e.g., INTERACT, facility-developed tool or process)?
- What are the most common reasons why residents are transferred to the hospital?
- How do you assure that staff are appropriately assigned to meet the needs of residents and are implementing care-planned approaches for each resident on each shift and unit?
- Do you use temporary/contract staff? If so, how often and why? How do you ensure these staff are competent and have the knowledge and skills to care for residents? What is covered in your agreement with the staffing agency regarding the skill set of contract staff? How do you ensure the work assigned to contract staff is within their skill set?
- Is ongoing training provided for all staff, (permanent, temporary/contracted, etc.)? If not, why not? If yes, how often is this conducted and what areas are covered?
- Who is responsible for competency oversight? How often is staff evaluated to access their competencies, skills and knowledge? What type of education or training has been provided based on the outcomes of these reviews?

Record Review: If there are any concerns identified by the observations or interviews noted above, it may be necessary to validate/verify this information by conducting a review of records. Such as:
- Resident Record for residents with position-change alarms, does the record document the rationale for the alarm and the impact on the resident?
- Is the resident receiving any medications that have a sedating, subduing effect? What documentation supports the use of the medication?
- Did the resident experience any changes in condition? If so, was the change identified quickly, reported, and monitored? Were conditions appropriately addressed to prevent further decline in status?
- Was the resident transferred to the hospital for a decline in condition that could have been avoided?

Facility Documents/Records:
- **Review the Facility Assessment:** Does the facility assessment include a determination for the level and competency of staff needed to meet each resident’s needs each day and during emergencies? For example, is staffing based on the census, resident’s acuity, resident assessments, plans of care, needs, diagnoses and the skill sets of the staff? How does the facility assessment compare to the observations of the resident population, staffing structure and competency of staff?
- Review the staffing schedule, including call-ins and staff postings for the past month. Depending on identified concerns, it may be necessary to expand your review.
• Review the list of nursing staff compared to the staffing schedule the facility provided/posted. If there are discrepancies between the duty roster and the staff observed onsite, ask the person in charge to explain the discrepancies.
• Review specific policies related to resident rights, quality of life, quality of care concerns identified (e.g., change of condition, position-change alarms, assessments, pressure ulcers, incontinence care, ADLs).
• Are hospital transfers occurring for conditions that should be identified and addressed earlier that would avoid the need for a transfer? Review transfer log if one exists.
• Staff evaluations and/or training records, including in-services that may demonstrate an assessment of nurse staffing competencies, skills and knowledge.
• Based on identified concerns, consider reviewing documents such as nurse aide assignment schedule, resident care sheets or resident-specific information like care plans, bathing records, restorative schedule, toileting and behavior monitoring.

Other Requirements:
• Does the nursing schedule reflect the following required coverage:
  o 24-hour licensed nurse;
  o 8-hour registered nurse, 7 days a week; and
  o Full-time DON. Is nursing staffing posted daily?

Surveyors will review the following tags with respect to the Sufficient and Competent Nurse Staffing Review:
• Does the facility have sufficient nursing staff on a 24-hour basis to care for residents’ needs, as identified through resident assessments and the plan of care (not including #3 below)? (F725).
• Does the facility’s nursing staff have the competencies required to care for residents’ needs, as identified through resident assessments and the plan of care (not including #3 below)? (F726).
• Does the facility’s nursing staff have sufficient and competent staff to provide the necessary behavioral health, psychosocial and dementia care to residents? (F741).
• Unless the facility has a waiver, has the facility designated a licensed nurse to serve as a charge nurse on each tour of duty? (F727).
• Unless the facility has a waiver, does the facility have an RN at least 8 hours a day, 7 days a week? (F727).
• Unless the facility has a waiver, does the facility have a registered nurse to serve as the DON on a full time basis? (F727).
• Did the facility ensure the DON served as a charge nurse only when the facility had an average daily occupancy of 60 or fewer residents? (F727).
• Have nurse aides demonstrated competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in their care plans? (F726).
• Are nurse aides re-trained either by completing (1) a new training and competency evaluation program or (2) a new competency evaluation program, if there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation? (F729).
• Does the facility ensure full-time nurse aides have become certified within 4 months of nurse aide training? (F728).
• Does the facility provide nurse aide in-services, at least 12 hours in a year, including dementia training, abuse prevention training, areas of weakness as determined in the nursing aides’ performance reviews, facility assessment, special needs of residents determined by facility staff and care of the cognitively impaired resident for those nursing aides providing cares for individuals with cognitive impairments? (F730).
• If the facility has a waiver to provide licensed nurses on a 24 hour basis, is there evidence that it is approved and reviewed by the state annually and has the facility notified the residents or representatives of the waiver? (F731).
• For SNFs, if the facility has a waiver to provide a registered nurse for more than 40 hours a week, is there evidence that it is approved and reviewed by the state annually and has the facility notified the residents or representatives of the waiver? (F731).
• Is nurse staffing posted daily? (F732).
• Does the facility have sufficient and competent direct care staff to provide nursing and related services to meet the behavioral health needs of the residents as determined by resident assessments, care plans and facility assessment? (F741).

• Does the facility have an annual documented facility assessment, and does the facility assessment include information on the level and competency of staff needed to meet the needs of each resident? (F838).

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Pressure Ulcer (CA), Bladder and Bowel (CA), Dental (CA), Positioning/Mobility/ROM (CA), Accidents (CA), Nutrition (CA), Catheter/UTI (CA), Tube Feeding (CA), Respiratory (CA), ADLs (CA), Environment (Task), Abuse (CA), Neglect (CA), Physical Restraints (CA), Chemical Restraints F605, Behavioral-Emotional Status (CA), Infection Control (Task), Required In-Service Training Nurse Aides F947, QAA/QAPI (Task).

Focus F-Tag – F565 Resident/Family Group and Response

This Regulatory Beat’s Focus F-tag is F565 Resident/Family Group and Response, which is part of the Resident Rights regulatory group. This regulation outlines the rights of residents to both organize and participate in resident groups without the facility interfering, but also addresses the facility’s response to issues raised.

The facility is required to provide a resident or family group with private space if it has it, for them to meet, with staff/visitors/others attending the meetings only if they have been invited. Residents, per the regulation, have the right to participate in family meetings. Residents also have the right to have family members/resident representatives meet in the facility with other families/resident representatives. It is also the responsibility of the facility to take “reasonable” steps to let residents/families know when there will be meetings taking place.

The facility has to designate a member of the staff to help assist with and respond to written requests/complaints/grievances that result from the meeting. The staff member must be approved by the group members. The requirements for grievances were greatly expanded under the RoPs, and this is evident in F565 as well. The facility, under this regulation, is required to act promptly on the grievances and recommendations of the groups. The Interpretive Guidance states that to the extent practicable, facility staff must consider their recommendations and attempt to accommodate them, including revising or developing new policies related to resident life and care. The facility’s decisions need to be discussed with the resident/family group and the facility’s decision also needs to be documented, including rationale, as required at F585 Grievances.

On survey, during the Entrance Conference, the surveyors will check if there is a Resident or Family Council. If there is, they will interview representatives from the group. They will ask how grievances and recommendations are considered, addressed (or not addressed) and acted upon, and how the facility provides its responses to the residents. Below is a sampling of actual survey citations regarding resident grievances identified during meetings that were not responded to by the facility – sometimes for lengthy periods of time:

- Lengthy wait times for call bells – staff telling residents “you’re not my patient” and turning the call bell off, or telling residents “I’m too busy”
- Lack of sufficient staffing – showers, not getting up in time for morning activities
- Dining room staff ignoring resident requests for help and chatting amongst themselves instead of interacting with residents
- Food temperatures, late food deliveries and poor food quality
- Insufficient available linens
- Suggestions for activities programming

Looking at the residents’ and families’ grievances and suggestions provides insight into potential systems issues. A savvy surveyor would look at these issues, see they weren’t followed up on and then go take a look at these areas, which could results in the identification of deficient practices. Shouldn’t you do the same and ensure grievances are promptly followed up on?
Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.

**Number of Health Care Practitioners**

In 2017, there were 951,000 active medical doctors in the United States. In 2016 (the latest year for which statistics were available), there were 2.9 million registered nurses, 2.4 million health technologists and 2.6 million nursing and other aides. An additional 361,000 health practitioners provided care, including more than 104,000 physician assistants. (Source: AHRQ, [2017 National Healthcare Quality and Disparities Report](https://doi.org/10.1894/1098-744X-45-6-1).

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**Important Regulations, Notices & News Items of Interest**

1) No new Federal CMS [Quality, Safety and Oversight Letters](https://www.cms.gov/Regulations-and-Guidance/Guidance/Letters) (formerly known as Survey and Certification (S&C) Letters) were released since the last issue of Regulatory Beat.

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

- **New Medicare Card: Questions?** Do you have questions about the transition to the Medicare Beneficiary Identifier (MBI)? Find the answers in these resources:
  - [Transition to New Medicare Numbers and Cards](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MBI.html) Fact Sheet
  - [New MBI: Get It, Use It](https://www.cms.gov) MLN Matters® Article
  - [Frequently Asked Questions](https://www.cms.gov)
  - [Provider and Office Manager, Getting MBIs, Using MBIs](https://www.cms.gov) webpages

- **SNF Provider Preview Reports: Review Your Data by November 30.** Skilled Nursing Facility (SNF) Provider Preview Reports are available on quality measures based on second quarter 2017 through first quarter 2018 data. Review your performance data by November 30, prior to public display on [Nursing Home Compare](https://www.cms.gov/NursingHomeCompare) in January 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate. For more information and directions to access your report, visit the [SNF Quality Public Reporting](https://www.cms.gov) webpage.

- **Quality Payment Program: Multi-Payer Other Payer Advanced APMs List.** CMS published a list of payment arrangements with CMS Multi-Payer Models that we determined to be Other Payer Advanced Alternative Payment Models (APMs) for the CY 2019 QP Performance Period. For More Information:
  - [2019 QPP Multi-Payer Other Payer Advanced APMs](https://www.cms.gov)
  - [APMs Overview](https://www.cms.gov) webpage
  - Contact the Quality Payment Program at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

- **Quality Payment Program: Visit the Resource Library Website.** Visit the redesigned [Quality Payment Program Resource Library](https://www.cms.gov) webpage. Search for resources by year, reporting track, performance category and document type.

- **Patients Over Paperwork November Newsletter.** Read the CMS Patients Over Paperwork [November newsletter](https://www.cms.gov), part of their ongoing effort to reduce administrative burden and improve the customer experience, while putting patients first. The main article provides an update on how CMS is reducing burden experienced by Medicare beneficiaries during care transitions. In this edition, learn how they are simplifying documentation requirements:
  - Physicians acting as suppliers do not need to write orders to themselves
Physicians do not need to reference page numbers in their certification or recertification statements.
A signature and date is acceptable verification of a medical student’s documentation of an evaluation and management visit performed by a physician.

The newsletter also discusses:
- Where they are meeting with stakeholders to talk about burden
- How to provide feedback through Requests for Information and proposed rules

For More Information:
- Patients Over Paperwork website
- Past Newsletters

**Quality Payment Program Year 1 Performance Results.** CMS released 2017 performance data for the Quality Payment Program. They announced the preliminary data earlier this year, and have now released additional data elements that show significant success and participation in both the Merit-based Incentive Payment System and Advanced Alternative Payment Model tracks. For a complete breakdown of the 2017 performance data, see the blog and infographic. For More Information:
  - Visit the Quality Payment Program website
  - Find your local support organization for no-cost technical assistance
  - Contact qpp@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

**Quality Payment Program: Participation Status Tool Updated.** CMS updated the Quality Payment Program Participation Status Tool based on calculations from the second snapshot of Medicare Part B claims data to calculate the Alternative Payment Model (APM) entities threshold scores. The second snapshot is for dates of participation between January 1 and June 30, 2018. The tool includes 2018 Qualifying APM Participant (QP) and Merit-based Incentive Payment System APM status. For More Information:
  - Quality Payment Program website
  - Resource Library webpage
  - QP Methodology Fact Sheet
  - List of APMs
  - Contact qpp@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

**Hospice Quality Reporting Program: Quarterly Update Document.** The Hospice Quality Reporting Program (HQR) Quarterly Update document is available for the third quarter of 2018, including:
  - Frequently asked questions received by the Hospice Quality Help Desk
  - Updates and events from the third quarter
  - Upcoming events in the fourth quarter

Visit the HQRP Requirements and Best Practices webpage for more information.

**Hospices: 4.5 Month Data Correction Deadline for Public Reporting.** CMS instituted a 4.5 month data correction deadline for hospice public reporting beginning January 1, 2019. See the Fact Sheet and Public Reporting: Key Dates webpage for information on this new policy.

**Hospice Item Set Freeze Date: November 15.** The freeze date for Hospice Item Set (HIS) data that will be included in quality measure calculations for the February 2019 Hospice Compare refresh is November 15. The February refresh will include HIS data from the second quarter of 2017 to the first quarter of 2018. All HIS records, including modifications/corrections and inactivations, need to be submitted and accepted by the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system by 11:59 pm on November 15 to be reflected in the Hospice Provider Preview Report that will be available on December 3. It is your responsibility to ensure that records are complete and accurate prior to submission to the QIES ASAP system. Review quality measure data often using your quality measure reports and submit any necessary HIS corrections. For More Information:
• Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier. Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:
  o Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
  o Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:
  o Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; see the Supplier Fact Sheet and visit the CDC website for more information
  o Prepare for Medicare enrollment; see the Enrollment Fact Sheet and Checklist
  o Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll)
  o Furnish MDPP services; see the Session Journey Map
  o Submit claims to Medicare; see the Billing and Claims Fact Sheet and Billing and Payment Quick Reference Guide

For More Information:
  o MDPP Expanded Model Booklet
  o Materials from Medicare Learning Network call on June 20
  o MDPP webpage
  o CDC - CMS Roles Fact Sheet
  o Contact mdpp@cms.hhs.gov

• Reducing Clinician Burden. CMS released a letter to clinicians outlining how the agency is reducing burden through reform of documentation and coding requirements. They encourage you to read and share with your stakeholders.

• HHS Releases Physical Activity Guidelines for Americans, 2nd Edition. Adm. Brett P. Giroir, M.D., assistant secretary for health, announced the release of the U.S. Department of Health and Human Services’ second edition of the Physical Activity Guidelines for Americans at the American Heart Association’s Scientific Sessions (click here). The second edition provides evidence-based recommendations for youth ages 3 through 17 and adults to safely get the physical activity they need to stay healthy. There are new key guidelines for children ages 3 through 5 and updated guidelines for youth ages 6 through 17, adults, older adults, women during pregnancy and the postpartum period, adults with chronic health conditions and adults with disabilities.

• New Fact Sheet Available: NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (“Hospice Comprehensive Assessment Measure”) Fact Sheet. A fact sheet on the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235), also known as “the Hospice Comprehensive Assessment Measure,” is now available for download. This fact sheet provides information on the background of this measure, how this measure is calculated and how providers can use their CASPER QM reports to understand their hospice’s performance on this measure. The full title of this fact sheet is the “Hospice Comprehensive Assessment QM Background and Methodology Fact Sheet.” To download the fact sheet, please refer to the Downloads section of the Current Measures webpage.

• New Version of HIS Manual (V2.01) Now Available. The HIS Manual has been updated with refined guidance for completing the HIS based on frequently asked questions from the Hospice Quality Help Desk. Note that no updates were made to HIS items or the HIS itself (i.e., no HIS items have been added, deleted or changed).
Instead, additional guidance based on provider feedback from the Hospice Quality Help Desk has been added to the manual to clarify HIS coding instructions. To download the new version of the HIS Manual and the associated change table, please refer to the Downloads section of the Hospice Item Set (HIS) webpage.

- **Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder.** In November 2016, the Office of the Inspector General (OIG) reported that hospitals did not always comply with Medicare requirements for reporting cochlear devices replaced without cost to the hospital or beneficiary. In 116 of 149 claims reviewed, hospitals did not report the appropriate modifiers and charges or a combination of the appropriate value code and condition codes. Medicare Administrative Contractors use this information to adjust payment; incorrect billing led to Medicare overpayments of $2.7 million. Services furnished on or after January 1, 2014: outpatient hospitals should report value code “FD” along with condition code 49 or 50. Services furnished prior to January 1, 2014: outpatient hospitals should report the modifier “FB” on the same line as the procedure code (not the Cochlear Device code). Use the following resources to bill correctly and avoid overpayment recoveries:
  - Hospitals Did Not Always Comply With Medicare Requirements for Reporting Cochlear Devices Replaced Without Cost OIG Report, November 2016
  - List of CMS resources

- **Reporting Changes in Ownership — Reminder.** A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges. Resources:
  - Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure OIG Report, May 2016
  - Timely Reporting of Provider Enrollment Information Changes MLN Matters Article
  - Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article
  - 42 CFR 424.516
  - PECOS Enrollment Tutorial - Change of Information for an Individual Provider
  - PECOS Enrollment Tutorial - Change of Information for an Organization/Supplier

- **IMPACT Act: National Beta Test of Candidate SPADEs Meeting — Tuesday, November 27, 11 - 3 pm CST.** In-person at RAND Corporation in Arlington, VA or via phone. Register for this meeting. During this meeting, learn about early findings from the Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) national beta test of candidate Standardized Patient Assessment Data Elements (SPADEs). On behalf of CMS, the RAND Corporation:
  - Hosts an overview of the results from the national test related to data element standardization for post-acute care providers
  - Discusses areas of support and key concerns raised by stakeholders during prior engagement activities
  - Answer questions from attendees

- **DME: Denial of Serial Claims.** CMS identified Durable Medical Equipment (DME) items that are serial in nature. For these items, we generally review the first claim in the series and:
  - Pay subsequent claims in the series after passing existing validation edits, or
  - Deny subsequent claims in the series unless you submit additional documentation with the subsequent claim line

  If a serial claim is denied after a complex medical review, subsequent claims in the series will be denied unless additional documentation is submitted to demonstrate that the services are reasonable and medically necessary.
  - If a paper claim is submitted, attach any additional documentation to the claim form
  - If an electronic claim is submitted, follow the existing PWK process and include the word “serial” in the NTE02 segment of the claim; refer to MLN Matters® Article MM7041
Check your Medicare Administrative Contractor’s website for additional information, including a list of impacted HCPCS codes.

- **Implementation of HCPCS Code J3591 and Changes for ESRD Claims MLN Matters Article — New.** A new MLN Matters Article MM10851 on Implementation of Healthcare Common Procedure Coding System (HCPCS) Code J3591 and Additional Changes for End-Stage Renal Disease (ESRD) Claims is available. Learn about implementation of a new unclassified drug or biological for ESRD.

- **DMEPOS Update MLN Matters Article — New.** A new MLN Matters Article MM10838 on Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update is available. Learn about updating the ViPS Medicare System to process claims.

- **Medicare Deductible, Coinsurance and Premium Rates: 2019 Update MLN Matters Article — New.** A new MLN Matters Article MM11025 on Update to Medicare Deductible, Coinsurance and Premium Rates for 2019 is available. Learn about updating the claims processing system with the new deductible, coinsurance and premium rates.

- **MCRFx MLN Matters Article — Revised.** A revised MLN Matters Article MM10611 on Medicare Cost Report E-Filing (MCRFx) is available. Learn about streamlining of the filing process.

- **ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised.** A revised MLN Matters Article MM10859 on International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) is available. Learn about coding updates.

- **Certifying Patients for the Medicare Home Health Benefit MLN Matters Article — Revised.** A revised MLN Matters Article SE1436 on Certifying Patients for the Medicare Home Health Benefit is available. Learn about patient eligibility and certification/recertification requirements.

- **Certificate of Medical Necessity Web-Based Training Course — Revised.** With Continuing Education Credit. A revised Certificate of Medical Necessity (CMN) Web-Based Training Course is available through the Learning Management System. Learn:
  - How to submit and verify a CMN
  - Documentation guidelines

- **Medicare Part B Immunization Billing Educational Tool — Revised.** A revised Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool is available. Learn about:
  - Administration and diagnosis codes
  - Vaccine codes and descriptors
  - Frequency of administration


- **NGACO Model Post Discharge Home Visit HCPCS MLN Matters Article — New.** A new MLN Matters Article MM10907 on Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS is available. Learn about modifications to the operations of a current benefit enhancement.

- **Hospital and CAH Swing-Bed Manual Revisions MLN Matters Article — New.** A new MLN Matters Article MM10962 on Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions is available. Learn about clarified policies.
- **Manual Updates to Correct SNF Errors and Omissions: 2018 Q4 MLN Matters Article — New.** A new MLN Matters Article MM11004 on [Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)] is available. Learn about revisions to clarify Skilled Nursing Facility (SNF) policy.

- **Revision of SNF CB Edits for Ambulance Services in a Part A Facility Stay MLN Matters Article — New.** A new MLN Matters Article MM10955 on [Revision of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Services Rendered to Beneficiaries in a Part A Skilled Nursing Facility Stay] is available. Learn about revision to edits to ensure accurate payments.

- **Medicare Diabetes Prevention Program Expanded Model Booklet — New.** A new Medicare Diabetes Prevention Program (MDPP) Expanded Model Booklet is available. Learn:
  - How to become a Medicare-enrolled MDPP supplier
  - How to help beneficiaries with prediabetes decrease diabetes risk
  - How to look for an MDPP supplier

- **Medicare Billing: CMS Form CMS-1450 and the 837 Institutional Booklet — Revised.** A revised Medicare Billing: CMS Form CMS-1450 and the 837 Institutional Booklet is available. Learn:
  - When Medicare will accept a hard copy claim form
  - Filing requirements
  - How to submit and code claims

- **Medicare Billing: CMS Form CMS-1500 and the 837 Professional Booklet — Revised.** A revised Medicare Billing: CMS Form CMS-1500 and the 837 Professional Booklet is available. Learn:
  - When Medicare will accept a hard copy claim form
  - Filing requirements
  - How to submit and code claims

- **Medicare Preventive Services National Educational Products Listing — Revised.** The Medicare Preventive Services National Educational Products Listing is available. Learn about:
  - Coverage
  - Coding
  - Billing

3) The federal Centers for Disease Control and Prevention (CDC) provides updates on the 2018-2019 Flu Season:

- **Weekly U.S. Influenza Surveillance Report** ([click here](#)).

4) The federal Agency for Healthcare Research and Quality (AHRQ) reports on:

- **Researchers Propose Framework for Tools to Identify Diagnosis Errors.** A group of AHRQ-funded researchers has proposed a framework for evaluating electronic trigger tools to find diagnostic errors. E-trigger tools, which mine patient data to identify a likely error or adverse event, are considered a promising method to identify diagnostic errors efficiently. The researchers, writing in *BMJ Quality & Safety*, identified a framework consisting of seven elements: identification and prioritization of diagnostic error of interest; definition of criteria to detect an error; determination of potential data sources; construction of an algorithm to obtain data cohort; testing and data review; assessment of e-trigger performance; and iterative refinements. Access the [abstract](#).

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

- HFS posted an updated Practitioner Fee Schedule and Practitioner Fee Schedule Key. Fee Schedule updates include: ASP/Non-ASP price updates, deletion of the 99070 supply code and addition of the billable supply codes. The Fee Schedule Key update includes only a change to note 'K', which incorrectly stated a Prior
Approval (PA) was required for assistant surgeons. PA is required only for the surgeon, and co-surgeon if applicable. The new fee schedule and fee schedule key can be viewed here.

- HFS posted a new provider notice regarding **Supportive Living Program Room and Board Amounts for 2019**. You may view the notice here.

- HFS posted a new provider notice regarding **Due Date for Payment of the Monthly Occupied Bed Provider Assessment**. You may view the notice here.

- HFS posted a new provider notice regarding **Approved and Authorized Representative Forms**. You may view the notice here.

- HFS posted a **Provisional Eligibility Webinar**. You may access the webinar here.

- HFS posted a new provider notice regarding **Ordering, Referring, Prescribing - National Provider Identifier (NPI) Requirements**. You may view the notice here.

- HFS posted the meeting minutes from the August 1, 2018 meeting, as well as the 2019 meeting dates. You may view both here.

- HFS posted an updated **Integrated Health Homes Frequently Asked Questions document**. You may view the updated document here.

- HFS posted a new Public Notice regarding an upcoming **Integrated Health Home Provider Enrollment webinar**. You may view this notice here.

6) The **Illinois Department of Public Health** reports on:

- **IDPH has concluded its Town Hall Meetings for 2018**. They will soon be establishing a schedule for the **Town Hall Meetings for 2019**. As soon as the schedule is announced, we will make it known to our members.

- **Special Note from IDPH**: IDPH is having an issue with staffing agencies refusing to obtain access to the Department’s web portal to conduct background checks or enter work history for the CNAs and other unlicensed staff they hire to work in health care facilities. As you know, section 955.135 of the Code says that the facility may initiate the background checks and enter work history where the staffing agency is “unable” to access the portal. They are worried that this issue may become a problem for facilities in that a surveyor could cite them for failure to do the background checks or update work history. Just wondering if your organization could provide some assistance in reminding your clients about this provision of the Code.

7) The **Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA)** report on:

- **Split Decision: Democrats Win the House, Republicans Win the Senate**. There were two conflicting historical constructs heading into the 2018 election. On the one hand, the midterm election of a president with a popularity number under 50 is usually a disaster. On the other hand, the midterm of a party in power when the economy is humming is usually a success. With the exception of 1966, very rarely have we had the president unpopular and the economy strong. For that reason, no one really knew what would happen.

   In the end, there was no clear winner. These two historical realities collided, and we ended up with a mixed result. The Democrats won control of the House, and the Republicans grew the Senate majority.

   This will have enormous ramifications on us. This memo will begin the discussion of those impacts and provide some thought on how we can best prepare for the next couple of years.
2019 National Skilled Nursing Care Week Theme: Live Soulfully. The American Health Care Association (AHCA) is happy to announce the 2019 theme for National Skilled Nursing Care Week (NSNCW) is "Live Soulfully."

National Skilled Nursing Care Week will take place May 12-18, 2019, and the theme, "Live Soulfully," will celebrate skilled nursing centers, and their residents and staff, by showcasing how they achieve happy minds and healthy souls. Every day, skilled nursing centers assist frail, elderly and disabled individuals in living their happiest lives. Whether it’s planting, cooking, reading or listening to music, our nation’s centers pay it forward by dedicating themselves to quality care and improving quality of life for its residents.

AHCA has added several resources to our website to promote the new theme, and the NSNCW Facebook page has also been updated to reflect this information.

Join us for the 4th Annual AHCA/NCAL Quality Summit, a gathering of long term and post-acute care quality leaders. The conference occurs March 18-20, 2019 in the sunny Tampa, Florida.

8) Telligen reports on:

- Final Rule for QPP Year 3 (2109) Released. To learn more about the Year 3 Quality Payment Program policies, review the following resources:
  - Press release – includes more details about the announcement
  - Executive Summary – provides a high-level summary of the Quality Payment Program Year 3 final rule policies
  - Fact Sheet – offers an overview of the policies for Year 3 (2019) and compares these policies to the current Year 2 (2018) requirements

9) MedlinePlus reports on Lab Test Information. Learn about your laboratory tests, including what the lab test is used for, why your doctor ordered it, how the test will feel and what the results may mean. A laboratory test checks a sample of blood, urine, other bodily fluid or tissue to get more information about your health. Your doctor may order these tests as part of a routine checkup, to check for certain diseases and conditions or to monitor your health.

10) Becker’s Hospital Review reports on PwC’s 5 Takeaways for Healthcare Leaders from 2018 Midterms. The 2018 midterm elections shifted some control back into the hands of Democrats, who flipped the House and won some governorships, which will have mixed results for the healthcare industry, according to PwC’s Health Research Institute.

11) Senior Housing News reports that Commercial Liability Insurance Rates for Providers to Spike in 2019. Senior Housing News recently reported that according to a new analysis from risk management, insurance brokerage and advisory company Willis Towers Watson, senior living and long term care industries will see increases of as much as 30 percent in 2019 to commercial liability insurance rates. The report indicates that across the US, these providers will see increases of five to 30 percent, with "sizable" increases in California, Illinois and Florida.

12) Reuters reports on Nursing Home Compare Lacks Clear Data on Safety. Reuters reports that according to new research published in the journal Health Affairs, CMS' Nursing Home Compare website lacks metrics accurately indicating facility safety. According to senior author R. Tamara Konetzka of the University of Chicago, "Some standard patient safety measures – falls, UTIs and pressure sores – are indeed on NHC. ... However, they don’t play a large role in determining the overall star levels, which is why we say that NHC does not reflect patient safety well." Researchers also said the data can be difficult for consumers to find.

13) McKnight’s reports, CMS Seeks Information on Whether HIPAA Obstructs SNF Care Coordination. McKnight’s Long Term Care News reported that CMS has submitted a proposed request for information to the White House Office of Management and Budget to inquire whether "patient privacy laws are preventing coordination among nursing homes
and other providers." The office now has 90 days to review the request, and stakeholders "are asked to comment on whether Health Insurance Portability and Accountability Act (HIPAA) rules are impeding them from working in tandem."

14) **Skilled Nursing News** reports:

- **Higher Star Ratings Don’t Always Correlate to Medicare Census Gains.** Skilled Nursing News reports that a new study suggests, "getting higher star ratings from the Centers for Medicare & Medicaid Services does have some relationship to improved Medicare census at skilled nursing facilities that are more than 15 years old." The study's authors said, "Each additional star was associated with, on average, 1.3 additional Medicare ADC [average daily census], but that relationship wasn't necessarily direct." Some SNFs received more ADC, "while others got nothing; other factors at play included proximity to hospitals, having private rooms and how close referral relationships were to the hospitals." Senior Housing Analytics principal Larry Rouvelas said, "Don’t rely on improving your star ratings alone and believe that’s a clear path to improving the Medicare census."

- **Long Term Care Group President Discusses Future of Therapy Under PDPM.** Skilled Nursing News reports on an interview with Martha Schram, President and CEO of Aegis Therapies and newly-elected President of the National Association for the Support of Long-Term Care, who discussed the role of therapy in the new Patient-Driven Payment Model (PDPM), her organization’s "long- and near-term priorities...and why providers may be foolish to look at therapy purely as a cost center." Schram emphasized that regarding therapy and programs, "collaboration with the facility" will be critical, and that rehab providers also must identify their "special competencies, or clinical programs, or pathways that are going to be aligned with whatever those strategic decisions are from the provider."

- **New Medicare Advantage Telehealth Rules Open Opportunities for Skilled Nursing.** Skilled Nursing News reports experts are heralding the new Medicare Advantage telehealth rules as an opportunity for the skilled nursing industry to receive "direct reimbursement...regardless of location," in contrast to current rules that "traditional Medicare only covers remote health tech in rural facilities." Timothy Peck, co-founder and CEO of Call9, a platform which "'embeds' emergency medical technicians in skilled nursing facilities and enables direct communication with remote doctors," said the new rule "cuts a whole bunch of red tape away to enable telemedicine to be used in nursing."

- **Consumer Perception of Nursing Homes Remains Low.** Skilled Nursing News reports that during the American Health Care Association’s annual conference and expo last month, experts discussed the "major perception problem" long term care continues to face with regard to how consumers select facilities. Ryan Donohue, strategic adviser at the research firm NRC Health, said that concerning consumer perception, "only about 24% trust or have confidence in long-term care on in nursing homes." However, Donohue noted, data show that "88% of people who have actually been residents would recommend the experience," the piece adds. Donohue recommended that providers become their own source of information and engage with consumers more directly to dispel myths.

15) **Interesting Fact:** The first Thanksgiving was held in the autumn of 1621 and included 50 Pilgrims and 90 Wampanoag Indians and lasted three days. Many historians believe that only five women were present at that first Thanksgiving, as many women settlers didn’t survive that difficult first year in the U.S. Thanksgiving didn’t become a national holiday until over 200 years later! Sarah Josepha Hale, the woman who actually wrote the classic song “Mary Had a Little Lamb,” convinced President Lincoln in 1863 to make Thanksgiving a national holiday, after writing letters for 17 years campaigning for this to happen.

*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!*