RoP Phase 3 Is Coming

It shouldn’t be a shock to know that, beginning November 28, 2019, LTC facilities will be expected to implement Phase 3 of the Requirements of Participation (RoPs). As of the writing of this article, federal CMS has not provided any guidance to surveyors or LTC facilities as to how they are planning on implementing the new Phase 3 requirements. However, this should not preclude LTC facilities from planning and even implementing the Phase 3 requirements. This article will explore the new Phase 3 requirements and provide preliminary guidance on what is expected to be implemented under Phase 3.

- **Quality Assurance and Performance Improvement (QAPI - Section 483.75).**
  - The LTC facility’s Governing Body (Section 483.70) has the responsibility of the QAPI Program.
  - All LTC facilities must develop, implement and maintain an on-going, effective, comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.
  - All LTC facilities must include mandatory training as part of the QAPI program that educates staff on written standards, policies and procedures and implementation of the QAPI program.
  - The QAPI program must be coordinated with the Freedom From Abuse, Neglect and Exploitation Section 483.12.

- **Comprehensive Person-Centered Care Planning (Section 483.21).**
  - This new Section focuses on the requirements to provide the necessary behavioral health care and services to residents in accordance with their comprehensive assessment and plan of care.
  - Incorporates into their comprehensive assessment and care plan, residents with a history of trauma or post-traumatic stress disorder.
  - In the text of this requirements, “Trauma’ refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual well-being.
  - “Trauma-Informed Care’ is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
- Trauma survivors must receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to mitigate triggers.
- Trauma-informed care was added to the Comprehensive Person-Centered Care Planning Section, the Quality of Care Section (483.25), and the Behavioral Health Section (483.40).

**Infection Control (Section 483.80).**
- LTC facilities are required to have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under an arrangement based upon its facility and resident assessments that is reviewed and updated at least annually.
- Each LTC facility must have at least one Infection Preventionist (IP) whose major responsibility is coordinating the facility’s infection control program.
- The Infection Preventionist must have specialized training as required by federal CMS. CMS now offers free IP training (see QSO 19-10).
- The Infection Preventionist serves as a member of the facility’s Quality Assessment and Assurance Committee (QAA).

**Compliance and Ethics Program (Section 483.85).**
- This Section requires the operating organization for each facility to have in operation, a functional compliance and ethics program that has established written compliance and ethics standards, policies and procedures that are capable of reducing the prospect of criminal, civil, and administrative violations in accordance with Section 1128(b) of the Act.
- An effective compliance and ethics program must, at a minimum, include the following:
  - Establish written compliance and ethics standards, policies and procedures;
  - Assign specific management individuals with overall responsibility to oversee compliance;
  - Provide sufficient resources and authority to the specific individual(s) assigned;
  - The LTC facility must take steps to effectively communicate the compliance and ethics program to the entire staff through mandatory training;
  - The LTC facility must take all reasonable steps to achieve compliance with the facility’s compliance and ethics program;
  - Consistent enforcement of the facility’s compliance and ethics program through appropriate disciplinary mechanisms;
  - If a violation is detected, immediately take all reasonable steps to respond appropriately.
- The Operating organization for each facility must review its compliance and ethics program at least annually.
- If an organization has 5 or more facilities, there must be mandatory and annual training for all staff, a designated corporate compliance officer, and designated compliance liaisons at each facility.

**Training Requirements (section 483.95).**
- A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at §483.70(e). Training topics must include but are not limited to—
  - *Communication.* A facility must include effective communications as mandatory training for direct care staff.
  - *Resident’s rights and facility responsibilities.* A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.
Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in §483.12, facilities must also provide training to their staff that at a minimum educates staff on—

- Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at §483.12.
- Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.
- Dementia management and resident abuse prevention.

Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility’s QAPI program as set forth at §483.75.

Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2).

Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85—

- An effective way to communicate that program’s standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.
- Annual training if the operating organization operates five or more facilities.

Required in-service training for nurse aides. In-service training must—

- Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.
  
  - Must include dementia management training and resident abuse prevention training.
  - Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.
  - For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.

Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).

- The Training Requirements comprise a significant part of Phase 3, including the implementation of an ‘effective training program’. The LTC facility is responsible for determining the amount and types of training necessary, both for specific topics as indicated in the regulations, as well as topics that are unique to each facility based on the facility assessment.
- Phase 3 is several months away, but that does not preclude facilities from planning and even implementing a preliminary training program.

Also, please note an item under the AHCA/IHCA entitled, “New Resources Available RoP Phase 3 – Compliance and Ethics Program for further guidance on this issue.

Focus F-Tag – F583 Personal Privacy/Confidentiality of Records

This Regulatory Beat’s Focus F-Tag is F583 Personal Privacy/Confidentiality of Records, which is part of the Resident Rights regulatory group. This regulation covers a wide range of resident’ rights related to privacy and confidentiality. The Interpretive Guidance (IG) clearly states that residents have the right to personal privacy as it relates not only to his/her own physical body, but also his/her personal space, including accommodations and personal care.
Privacy
This regulation requires that each resident has personal privacy, which is defined in the regulation as the “right to meet or communicate with whomever they want without being watched or overheard”, related to:

- Accommodations
- Medical treatments
- Communication (written/telephone)
- Personal care
- Visitation
- Family and Resident group meetings

Related to treatments, the IG notes that only authorized staff who are directly involved in providing care/services for a resident may be present when care is being provided unless the resident has consented to other individuals being present during care delivery. Staff must ensure residents are not in public view, including by closing doors and pulling privacy curtains as well as preventing exposure of body parts.

The IG also states that the posting of signs in resident rooms or in areas where others may seem them that include personal or clinical information may be a violation of a resident’s privacy. The exception to this is when a resident/representative requests that information is posted by the bedside. Signage is also permissible regarding isolation precaution information for public protection as long as the type of infection is not included in the posted information.

It is also noted that photographing or recording a resident and/or his personal space without written consent is considered a violation of the resident’s right to privacy and confidentiality. This includes using any type of equipment to take, keep/store or distribute photographs/videos of residents via multi-media messages or via social media. A facility should have a policy and procedure in place that all staff have been educated on related to social media.

Facilities must respect each resident’s right to personal privacy for:
- Privacy in his/her oral, written and electronic communications
- Right to send and promptly receive unopened mail, letters and packages delivered to the facility for the resident.

Mail and other materials must be delivered to the resident within 24 hours of delivery and delivery of outgoing mail to the post office must occur within 24 hours (except on non-regularly scheduled postal delivery/pickup dates).

Confidentiality
Regulatory guidance defines “confidentiality” as the safeguarding of information from unauthorized disclosure without resident/representative consent.

- The regulatory requirement at F583 states that residents have the right to secure and confidential personal and medical records. Residents have the right to refuse the release of these records except as required under F842 at §483.70(i)(2).
- Providers are also required to allow representatives from the LTC Ombudsman Office to examine resident records in accordance with State law.

Personal information about a resident is required to be communicated in a way that protects the resident’s confidentiality and dignity. The IG states that this includes both verbal and written communications, including things such as lists of residents with certain conditions that are visible to others as well as leaving medical records out for public view.

During survey, surveyors are guided to observe if staff do not honor residents’ privacy during visits, treatments, or leave information such as medical records visible to others. They are also instructed to look to see if there is visible care information posted in resident rooms. How often do we see this as we visit a Nursing Unit? Too often, I think!
**10 Top Patient Safety Concerns for 2019**

Using EHRs to communicate diagnoses and manage test results earned the No. 1 spot on ECRI Institute's list of the Top 10 Patient Safety Concerns for 2019.

ECRI Institute compiled the list based on an analysis of more than 2.8 million patient safety events collected in the ECRI Institute PSO database since 2009, along with expert opinions from a panel of internal and external patient safety leaders.

"The list does not necessarily represent the issues that occur most frequently or are most severe," ECRI Institute wrote. "Rather, this list identifies concerns that might be high priorities for other reasons, such as new risks, existing concerns that are changing because of new technology or care delivery models, and persistent issues that need focused attention or pose new opportunities for intervention."

ECRI Institute suggested healthcare providers use this list as a starting point for launching patient safety discussions and setting priorities at their own facilities.

Here are the 10 top patient safety issues for 2019, as listed by ECRI Institute:

1. Diagnostic stewardship and test result management using EHRs
2. Antimicrobial stewardship in physician practices and aging services
3. Burnout and its effect on patient safety
4. Patient safety concerns involving mobile health
5. Reducing discomfort with behavioral health
6. Identifying changes in a patient's condition
7. Developing and maintaining skills
8. Early sepsis recognition across the care continuum
9. Infections from peripherally inserted IV lines
10. Standardizing safety efforts across large health systems

To download a copy of the report, click here.
Highlights include:

- A new tool to illustrate hospital burden: [Complexity and Burden of Hospital Reporting Ecosystem Map](#)
- Final rules removed duplicative and costly measures from our quality programs and set a new direction for Medicare Accountable Care Organizations
- Contractor Advisory Committee meetings which discuss LCD’s are now open to the public with minutes posted to your Medicare Administrative Contractor’s website
- Proposed rules would support seamless and secure access, exchange, and use of electronic health information
- A new podcast, [CMS: Beyond the Policy](#) highlights updates and changes to policies and programs in an easily accessible and conversational format
- [New Medicare Enrollment Application](#) for physicians and non-physician practitioners

For More Information:

- [Patients Over Paperwork](#) website
- [Past Newsletters](#)

- **New Part D Opioid Overutilization Policies: Myths and Facts.** CMS implemented [new opioid policies](#) for Medicare drug plans effective January 1. Over the next few weeks, we will share common myths about these new policies and the facts for providers.

  Myth: “Medicare is requiring that all opioid prescriptions be limited to a 7-day supply at a time.”
  Fact:
  
  - Medicare Part D enrollees who have not filled an opioid prescription recently, such as within the last 60 days, will be limited to up to a 7-day supply
  - This limit does not apply to enrollees already taking opioids

Medicare Part D opioid policies are not prescribing limits, and generally don’t apply to enrollees who have cancer; get hospice, palliative, or end-of-life care; or who live in a long term care facility. The new policies encourage collaboration and care coordination among Medicare drug plans, pharmacies, prescribers and patients to improve opioid management, prevent opioid misuse and promote safer prescribing practices.

For More Information:

- [Roadmap](#)
- [Letter](#) to providers about reducing opioid misuse
- [Prescriber’s Guide to New Medicare Part D Opioid Overutilization Policies for 2019](#) MLN Matters Article
- Training materials for [prescribers](#), [pharmacists](#) and [patients](#)

- **IRF and SNF Quality Reporting Program: Enhanced Review and Correct Reports.** Enhanced Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) Quality Reporting Program review and correct reports are available in the Certification and Survey Provider Enhanced Reporting (CASPER) application. Access your reports by selecting the CASPER reporting link on the “Welcome to the CMS QIES Systems for Providers” webpage; you must log in using your CMSNet user ID and password. In addition to enhanced sorting functionality, these reports include:

  - Patient level data and automated CSV file creation
  - Quality measure information at the facility level
  - Aggregate performance for the past four quarters (when data are available)
  - Data submitted prior to the applicable quarterly data submission deadlines
  - Information on whether the data correction period is “open” or “closed”

- **Provider Minute Video: The Importance of Proper Documentation.** Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payment and medical review in the [Provider Minute: The Importance of Proper Documentation](#) video. Learn about:

  - Top five documentation errors
How to submit documentation for a Comprehensive Error Rate Testing review
How your Medicare Administrative Contractor can help

- **Hold Hospice Adjustments to Avoid Underpayments.** On July 2, 2018, CMS changed Medicare’s claims processing systems to better identify prior hospice days when calculating hospice routine home care payments after a transfer; see [MLN Matters Article MM10180](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Medicare-Provider-Reimbursement/MMM101804.pdf). This process is not working correctly, resulting in underpayment for these claims. CMS will fix this issue on October 7:
  - Until October 7, do not submit adjustments when there is a transfer within the benefit period
  - Beginning October 7 or after, resume submitting adjustments
  - If the dates of service are beyond the timely filing period, submit a reopening request using Type of Bill 8XQ

- **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:
  - Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
  - Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:
  - 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](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html) and [CDC](https://www.cdc.gov) website for more information
  - Prepare for Medicare enrollment; see the [Enrollment Fact Sheet](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html) and [Checklist](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html)
  - **Apply** to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll), See the [Enrollment Webinar Recording](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html)
  - Furnish MDPP services; see the [Session Journey Map](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html)

Separate NPI for MDPP Enrollment: We strongly encourage you to obtain a separate National Provider Identifier (NPI) for MDPP enrollment; claim rejections and denials may occur if multiple enrollments are associated with a single NPI. If you are a currently enrolled MDPP supplier that elects to obtain a separate NPI, update your enrollment in the Provider Enrollment, Chain and Ownership System (PECOS) with the new NPI. Contact your Medicare Administrative Contractor for assistance if:
  - Your organization is unable to obtain a separate NPI
  - You continue to encounter claims submission and processing issues after you update your enrollment with the new NPI

For More Information:
  - [MDPP Expanded Model](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html) Booklet
  - [Materials](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html) from Medicare Learning Network call on June 20
  - [MDPP](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html) webpage
  - [CDC - CMS Roles Fact Sheet](https://www.cms.gov/medicare/medicare-billing-supplier/enrollment/factsheets.html)
  - Contact the MDPP Help Desk at [mdpp@cms.hhs.gov](mailto:mdpp@cms.hhs.gov)

  - Fraud and abuse definitions and laws
  - How to report suspected fraud
  - Physician business relationships that may raise concerns
• **Promoting Interoperability Programs.** CMS updated the [Promoting Interoperability Programs](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Quality-PromotingInteroperabilityPrograms/Promoting-Interoperability-Programs-FAQs) website with resources for eligible hospitals and critical access hospitals to help you succeed in the 2019 program year:
  - [Scoring Methodology](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/2015Edition.html) Fact Sheet
  - [Electronic Prescribing](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Fact Sheet
  - [Health Information Exchange](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Fact Sheet
  - [Provider to Patient Exchange](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Fact Sheet
  - [Public Health and Clinical Data Exchange](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Fact Sheet
  - Payment Adjustment and Hardship Information [Tip Sheet](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) and [Table](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html)
  - Clinical Quality Measures [Fact Sheet](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) and [Table](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html)
  - Security Risk Analysis [Fact Sheet](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html)

• **Telehealth Services — Revised.** A revised [Telehealth Services](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Medicare Learning Network Booklet is available. Learn about:
  - Requirements
  - Distant site practitioners
  - Billing and payment for the originating site facility

• **Descriptors of G-codes and Modifiers for Therapy Functional Reporting — Revised.** A revised [Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Medicare Learning Network Educational Tool is available. Learn about:
  - 42 functional G-codes
  - Seven severity/complexity modifiers

• **Medicare Fraud & Abuse Poster — Reminder.** The [Medicare Fraud & Abuse Poster](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Medicare Learning Network educational tool is available. Learn about:
  - Ways to avoid fraudulent activities
  - How to contact the Office of the Inspector General Hotline

• **Medicare Overpayments — Revised.** A revised [Medicare Overpayments](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Medicare Learning Network Fact Sheet is available. Learn about:
  - Definition of an overpayment
  - Collection tools and processes
  - Payment options

• **PECOS for Provider and Supplier Organizations — Revised.** A revised [Provider Enrollment, Chain, and Ownership System (PECOS) for Provider and Supplier Organizations](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) Medicare Learning Network Booklet is available. Learn how to:
  - Authenticate credentials
  - Register a surrogate
  - Respond to Medicare Administrative Contractor requests

• **CMS: Beyond the Policy Podcast.** CMS released the latest episode of our podcast, [CMS: Beyond the Policy](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html). This episode brings highlights from the 2019 CMS Quality Conference, including CMS Administrator Seema Verma’s keynote speech where she discussed the vision for Medicare and the agency this year as well as audience reaction. You can also listen to the podcast on [Google Play](https://play.google.com/store) and [iTunes](https://itunes.apple.com).

• **Cost Reports Webcast: Audio Recording and Transcript.** An [audio recording](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) and [transcript](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/EHRIncentivePrograms.html) are available for the March 28 Medicare Learning Network webcast on Submitting Your Medicare Part A Cost Report Electronically. Learn how to use the new Medicare Cost Report e-Filing system.

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov) reports on:
The Centers for Disease Control and Prevention said recently that the 2018-2019 flu season has not concluded in the US, but already has set a record. Data through April 13 show "levels of flu-like illness have been elevated for 21 weeks, one week longer than the previous 10-year high seen during the 2014–2015 season." The CDC also said that as many as 57,300 people have died from the flu this season through April 13.

4) The HHS Office of the Assistant Secretary for Preparedness and Response recently published the April 2019 The Express. Brought to you by HHS ASPR, the Technical Resources, Assistance Center and Information Exchange (TRACIE) was created to meet the information and technical assistance needs of regional ASPR staff, health care coalitions, health care entities, health care providers, emergency managers, public health practitioners and others working in disaster medicine, health care system preparedness and public health emergency preparedness.

5) The National Institute of Health reports on No Benefit for Dietary Supplements. The National Institutes of Health reports on a study published in Annals of Internal Medicine examining the mortality of a large group of individuals reporting regular intake of dietary supplements. The assessment revealed that those who consumed supplements die at about the same rate as those who didn’t. In the case of responders who consumed more than 1000 mg. of supplemental calcium, there was a higher incidence of cancer. See NIH Blog.

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

- The Dental Policy Review Committee meeting originally scheduled for 4/17/19 has been rescheduled to 5/8/19. Please click here for more information.

- HFS posted a new Provider Notice regarding Patient Credit File Download through the Medical Electronic Data Interchange (MEDI) System. You may view the new notice here.

7) The Illinois Department of Public Health (IDPH) reports:

- Schedule for IDPH Town Hall Meetings will be out shortly.

- Memo from Sherry Barr on EPOC Updates: As of today we have 649 out of 727 eligible facilities registered for ePOC. We are at 89%. Attached is the list of the 78 facilities that are not registered. We have two facilities that have not signed the attestation sheet stating they watched the video. Alhambra Care Center and Park Pointe Healthcare and Rehab are the two that have not signed the attestation sheet.

We have reached out to all the facilities not registered multiple times. We are calling every facility that has had a survey that is not registered to attempt to get them registered so we can send the SOD via ePOC.

We have had a few glitches but have worked them out or are working on them.
- CMS changed their web address for ePOC. We did not know that ahead of time and found out when facilities started calling us. CMS had a pop up for a period of time but took that down and the old website only gives an error message. The new ePOC web address is: QTSO.CMS.GOV.
- We had some issues with CMS not sending the temporary password when facilities first register. We worked with CMS and gave facilities the 1-800 CMS number.
- We have had some facilities not get their notification email when their SOD has been placed in ePOC. We have worked with CMS with this.

Overall the ePOC is going well. Facilities have expressed that they like the system and like getting the information more timely.

Please let me know if you have heard of any issues and we will be glad to work on them.
The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) report on:

- **New Resources Available RoP Phase 3 - Compliance and Ethics Program.** The American Health Care Association (AHCA) is pleased to announce new nursing center member resources to support creating or updating a Compliance and Ethics Program per 42 CFR § 483.85 in the Requirements of Participation (RoP) Phase 3. The new resources that are now available [here](#), include:
  - AHCA toolkit
  - Sample checklist for compliance and ethics training
  - Sample tool for monitoring and auditing risk assessment
  - 10 webinars

Although the interpretive guidelines have not yet been published, the RoP Compliance and Ethics Program stems from the Office of Inspector General’s (OIG) long-standing guidance for the seven elements of a compliance program. AHCA’s resources rely on best practices for an effective compliance program, calling out provisions specific to the RoP. These resources also provide practical explanation and tips for how to create or update your compliance program. Starting November 28, 2019, the Centers for Medicare & Medicaid Services (CMS) and state survey agencies will be authorized to issue survey deficiencies under F-Tag F895 to centers that do not have an effective compliance program. Although this requirement does not go into effect until November, members should not wait to update and refine their compliance and ethics programs. We hope these resources will help you along the way.

For any questions on this topic, please email educate@ahca.org.

- **Five-Star Changes Toolkit Now Available.** Later this month, CMS will publish new Five-Star ratings on its Nursing Home Compare (NHC) website. The changes will include updates to all three components of the system - survey, staffing and quality measures - that will cause your star ratings to change. AHCA has developed several resources that will help you in response to these upcoming changes.

  A member toolkit containing talking points, a template media statement, and template letters to families and referral sources/payors is now available on the Five-Star achancalED website [here](#).

  Additional resources that are available to download now on achancalED [here](#), include:
  - AHCA Five-Star Webinar
  - CMS Updated Technical Users' Guide
  - CMS QSO Memo

We will continue to keep you informed on the latest developments. Please contact research@ahca.org if you have any questions.

- **Ensuring Quality and Safety in America’s Nursing Homes.** CMS Administrator Seema Verma issued a blog post this evening on the agency's website, entitled "Ensuring Quality and Safety in America’s Nursing Homes." Any post with that title is certain to receive wide coverage in our trade press and possibly work its way into the mainstream media, as well.

  The post starts with the statement that CMS is committed to ensuring quality and safety, and obviously, we agree with that goal. We’ve all committed our lives to taking care of seniors, and the advancements that we've made in quality speak for themselves. We wish the post would have acknowledged the herculean work that providers have done to materially improve quality across the country, but the improvement is reward enough.

- **Guidance on Emerging Infection Candida Auris.** Some of you may have heard about *Candida auris* in recent media stories based on a Sunday *New York Times* article [here](#). *C. auris* is an emerging yeast that can be misidentified as other organisms, is multidrug-resistant, and can spread in health care settings. It is important to know how to identify, treat, and control the spread of this organism. The resources on the Centers for Disease
Control and Prevention website meant for laboratorians, clinicians, infection control practitioners, and public health professionals are very helpful and we encourage you to review them.

- **AHCA Has ICD-10 Online Training.** With thousands of codes and changes based on the new Patient Driven Payment Model (PDPM), accurate ICD-10 coding is critical. PDPM relies on accurate patient assessments and diagnosis on the MDS and IDC-10 coding to determine payment for each patient. Inaccurate coding can impact your organization’s bottom line and resident care.

  The October 1 implementation deadline is fast approaching, but training key staff just got easier!

  The American Health Care Association (AHCA) and the American Health Information Management Association (AHIMA) is now offering online ICD-10 training. Because staff needs differ based on the responsibilities of coding, two specific trainings have been developed:
  - AHCA/AHIMA ICD-10 Training for PDPM – Coders
  - AHCA/AHIMA ICD-10 Training for PDPM – Non-Coders

- **AHCA/NCAL Social Media Update.** Welcome to the AHCA/NCAL Social Media Update, a biweekly newsletter detailing social media efforts and offering guidance to members on how to get more involved in social media and digital advocacy. We’ve collected several stories from the past couple of weeks as well as drafted some sample posts for you to share on social media. Sharing the positive stories that happen every day in your buildings as well as the hardships you face are the only way to change the narrative about long term and post-acute care. We encourage you to join in.

- **CMS Issues FY 2020 SNF Proposed Payment Rule.** CMS released our 2020 SNF proposed payment rule late today, and it is good news. This is the rule that controls our Medicare payments starting on October 1 of this year. There are two pieces of good news that I want to highlight.
  - We are proposed to receive a net 2.5 percent increase in payments. After all required deductions, our increase is 2.5 percent.
  - The rule proposes to expand the definition of group therapy. Under current law, a group has to be four people. This restricts its use. CMS listened to our rationale that group can be effective with configurations of various sizes, and, as a result, proposes to change the rule. If finalized, groups can consist of between two and six patients starting October 1.

  There are multiple other proposed changes. Mike Cheek and the AHCA team have put together a memo that summarizes these, and we will have a more detailed analysis available soon. Of important note, there are no material changes to PDPM.

- **Five-Star Preview Reports Now Available.** Your new Five-Star data is now available for review through the CMS QIES System. Instructions on how to access your preview report is available on the ahcancaled Five-Star web page here.

  As a reminder, at the beginning of March CMS announced several significant updates to all three components of the system - survey, staffing and quality - that will cause your star ratings to change. The updated Technical Users’ Guide detailing these changes is here. The new star ratings will be published on Nursing Home Compare sometime next week.

  If you need assistance accessing your preview reports, please contact the Five-Star Help Line at 1-800-839-9290 from April 22 through May 3 and May 28 through May 31. BetterCare@cms.hhs.gov is an alternative way to direct inquiries.

  Members should continue to take steps to prepare for these changes. In addition to reviewing your center's new data via the QIES System, we encourage you to download resources, such as AHCA’s Five-Star Webinar and toolkit containing talking points and template materials on the ahcancaled website here.
Please contact research@ahca.org if you have any questions.

9) Telligen reports:

- **This Month at Telligen**

10) Kaiser reports Nursing Homes, Hospitals Combat Superbugs with Special Soap. Kaiser Health News reported that nursing homes and hospitals are "washing patients with a special soap" in an effort to combat superbugs. The efforts, which are being funded "with roughly $8 million from the federal government’s Centers for Disease Control," are "taking place at 50 facilities in those two states." Rush University Medical Center infectious-diseases specialist Dr. Michael Lin said that CREs have "basically spread widely" in Chicago health care facilities, adding, "If MRSA is a superbug, this is the extreme – the super superbug."

11) The Wall Street Journal reports on Contributor Recommends Ways to Discuss Long-Term Care with Aging Loved Ones. Marc Agronin, MD, a geriatric psychiatrist at Miami Jewish Health, writes in a contributor piece in the Wall Street Journal to offer advice on engaging in conversations about seeking long term care for family members and loved ones. Agronin suggests framing the conversation as if discussing insurance, emphasizing the person’s autonomy and choice in the matter, focusing on how to make transitions open and comfortable, using the conversation itself as an outlet and involving care professionals as necessary.

12) Skilled Nursing News report on:

- GAO Urges CMS to Strengthen Oversight of State Nursing Home Investigations. Skilled Nursing News reports that the US Government Accountability Office (GAO) released the findings of an investigation showing that for "at least 15 years, the Centers for Medicare & Medicaid Services (CMS) failed to deal with gaps in the federal oversight of nursing home abuse investigations in Oregon." The GAO said the state survey agency (SSA) responsible for investigating allegations of abuse in nursing homes did not investigate all claims, but that Oregon’s Adult Protective Services (APS) investigated them instead, despite lacking training in investigating abuse under federal nursing home regulations. The piece adds that the US Department of Health and Human Services "reviewed a copy of the GAO’s report and...said it would take steps to confirm that states are using the appropriate personnel to report abuse complaints and facility-reported incidents." The report’s release coincided with CMS Administrator Seema Verma’s order of "a federal review of federal nursing home regulations."

- CMS Extends Medicaid Rate Option for States Under PDPM. Skilled Nursing News recently reported that CMS issued an update to PDPM last week, "indefinitely extending a key workaround for states that base Medicaid rates on the existing Medicare system." CMS extended "the Optional State Assessment (OSA), a kind of adapter that allows state Medicaid programs to continue using the old system while developing new models for a post-RUGs world." The agency wrote, "Once states are able to collect the data necessary to consider a transition to PDPM, CMS will evaluate the continued need for the OSA, in consultation with the states." The piece adds that the shift is causing concern among some providers who worry the "upheaval of PDPM would also create immediate Medicaid problems." The piece notes that research from the American Health Care Association shows "29 states currently use some kind of RUG-based system to determine Medicaid payments to nursing homes."

13) McKnight’s reports on:

- CMS to Make Unpopular Changes to Five-Star Ratings System. McKnight’s Long Term Care News featured an opinion article from Editor James Berklan, who writes that nursing home operators "are being told that, despite good customer service and business practices that were once the talk of the town, they’re being downgraded," after CMS announced that it is expecting to make "it harder for providers to achieve four or five stars, or any other high ranking, in the Five-Star Ratings System." A senior official explained, "As compared to all nursing
homes, some of the top 50 percent in the country should naturally fall into the average (3-star) and above average (4-star) categories. The article cites an "analysis by the American Health Care Association" that "shows that about half of the nation’s 15,000 nursing homes will not see a change to their ratings come April 24, while about one-sixth can expect an increase," but an estimated one-third "will suffer a ratings drop overnight."

- **CMS Releases “Toolkit” With Information on How Hospitals Choose SNF Partners.** *McKnight’s Long Term Care News* reported, "The Centers for Medicare & Medicaid Services is providing skilled nursing facilities with a peek into how some top hospitals are picking preferred skilled nursing partners, with some developing scorecards or even ranking them from ‘bronze’ to ‘gold.’" The agency released a "14-page toolkit" which "also outlines some of the innovative strategies Medicare accountable care organizations are using to cut costs and coordinate care," which reveals that many hospitals only work with SNFs that "demonstrate the ability to consistently provide high-quality care, with a willingness to reform how they deliver services, CMS wrote."

- **What Providers Need to Know Right Now About PDPM.** CMS’ Patient-Driven Payment Model (PDPM) takes effect on October 1. When the reform takes effect, long term post-acute care (LTPAC) facilities will see a big change in how they receive payment for delivering valuable patient care. While the payment reform will inevitably bring challenges, it will also present a significant opportunity to transform the way care is delivered. The key to success? Preparing now. PDPM will create some massive operational challenges for providers already taxed with an aging population, the growing nursing shortage and significant regulations that can create an onerous system for delivering quality patient care. The biggest change is that providers can no longer rely on securing Medicare reimbursement for therapy minutes provided, as they do currently. Instead, repayment will be contingent on a predetermined amount based on a one-time patient assessment of patient progress and successful outcomes. This creates the need for a thoughtful, results-oriented, holistic approach to providing patient care.

- **Deadly Fungus Outbreak Spreading Across SNFs in Multiple States.** Health officials are warning nursing facilities to be on the lookout for a rapidly spreading, drug-resistant disease. New York, Illinois and New Jersey have been hit hardest by *Candida auris*, an emerging fungus that presents a “global threat,” according to the *Centers for Disease Control and Prevention*. *C. auris* is often resistant to drug treatment and can be particularly dangerous for sick older patients who have had invasive medical procedures, the *Chicago Tribune* reported Tuesday. Illinois has experienced 154 cases so far, with the vast majority occurring in SNFs caring for patients on ventilators.

- **Administrator Directs CMS to Conduct ‘Comprehensive Review’ of Nursing Home Regulations.** The top official at CMS said that she has directed the agency to undertake a “comprehensive review” of its regulations, guidelines and processes related to skilled nursing facilities. Administrator Seema Verma said that the goal is to bolster safety and quality in SNFs across the country.

14) **Interesting Fact:** The average American eats approximately 222 pounds of meat per year. This does not include seafood.