May 8, 2019 Edition

Feature Focus

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!

What Resources are Available for Identifying and Evaluating Staff Competencies

The Centers for Medicare & Medicaid Services (CMS) recently released an interactive set of staff competency assessments that cover a range of topics relating to facility management, registered and licensed practical nursing staff and certified nurse assistants (CNAs). They were developed by CMS using Civil Money Penalty Reinvestment Program funds with contributions from national associations and subject matter experts.

CMS explains the purpose of the competency assessments in the following manner:
“This competency assessment is designed to help you begin to assess staff competency in order to address competency growth areas. However, this competency assessment is not mandated by CMS, and using it does not guarantee compliance with the Requirements of Participation and the Facility Assessment.”

They are available using this link.

From this site you can download both interactive PDFs and paper forms of the competency assessments for the three types of staff, answer sheets and instructions for using the toolkit. The interactive PDF assessments have option buttons for answers to each question, and once answers are submitted, a score is generated for the assessment.

The toolkit elements have some important strengths and some limitations that should be kept in mind when using them. A major content strength is that the assessments are all based in a person-centered care framework.

Given the importance of person-centered care on the new rule, and elder care in general, the assessments can help to determine if staff understand how it applies to care of different residents.

A second strength is that the tools for each of the three types of staff (management, licensed staff and CNAs) focus on the different roles of staff in the care process.

For example, while there are 11 resident conditions included for both licensed and CNA staff (dementia, pneumonia, for example), the competency questions differ.

Licensed staff questions appropriately address evaluation of conditions and treatments they provide, whereas CNA questions emphasize observations relating to changes of condition and preferences of relevance to the care they provide.
A third strength is that the competencies include behavioral (e.g., communication), technical (e.g., infection prevention and control), and resident conditions (as described above).

Person-centered orientation; competency/training oriented to different levels of staff; and ensuring competency in behavioral, technical, and relevant resident conditions are all important in competency and training activities.

The limitations of these tools are evident from the stated purpose of the toolkit. No single model of competency testing and training fits all organizations at all times. The challenge, in the face of limited time and resources, is to tailor your competency assessments and training program to your resident and staff needs.

The facility assessment is a valuable tool for profiling your resident population and care needs. This information across residents can be used to prioritize both competency assessment and training activities for different staff.

Another important consideration is knowing where you have quality concerns, as reflected in results from your Quality Assurance Performance Improvement program. Integrating these activities with competency testing and training programs will yield substantial efficiencies that will facilitate improving quality of care.

**Authored by Andy Kramer, MD**

**Acuity-Based Staffing: What Does It Mean?**

*Resident acuity* is a frequently used term, but the meaning is very evasive and rarely defined.

This lack of definition is not by accident, because reimbursement, staffing expenses, and profit drive this issue in many eldercare facilities, not nursing assessment and/or medical judgment.

Of course, few professionals are willing to admit that there is no quantitative process in place to calculate direct care staffing levels other than annual budgets controlled by corporate staff.

Most administrators and Directors of Nursing have the discretion to distribute staff as they please, but they cannot exceed facility labor budgets without jeopardizing their bonus plans and employment. Consequently, trying to squeeze high-acute and high-risk residents into lean staffing patterns forces facility staff to leave the bedside care, supervision, and outcomes of some to chance, even when there are financial resources available to avoid such rationing.

Taking staff time away from one resident and giving it another is not acuity-based staffing. The claim that physicians, DONs, and nurses have more control over facility staffing levels than Administrators and corporate staff is rarely true, but it is a popular defense.

I define acuity as the allocation of clinical expertise and caregiver resources necessary to ensure a resident’s quality of care/life, based on their medical complexity, ADL dependency, and behavior challenges, as determined by a formal assessment process.

Have you ever wondered why some facilities have no policy and procedure on acuity-based staffing in their vast library of operating manuals given the critical importance of this issue? What operational issue is more important than resident acuity?

Most eldercare professionals are reluctant to admit that profit expectations are the driving force behind staffing levels in many eldercare facilities, because they recognize that their admission may be viewed as a betrayal of trust to the vulnerable residents for which they are responsible.

I understand their hesitation and the ethical dilemma this issue raises, but what I find disturbing is individuals who promote the false impression that their staffing levels are acuity-based when the only evidence they can offer are undocumented discussions with facility or corporate staff. When pressed for more convincing evidence, they frequently unleash a flurry of defenses such as: Elevating acuity determinations to the protected realm of nursing and/or medical
judgment; insinuating that no individual is more qualified to determine acuity at their facility than they are; using medical records to exaggerate staff contributions; or proclaiming how dedicated their staff is to end the conversation.

However, in the end, they still do not produce any evidence. Like most facility endeavors, acuity-based staffing practices leaves a convincing paper trail.

Many assisted living facilities use level of care rating systems to classify residents according to acuity. However, most are designed to offset the cost of equipment and supplies rather than determine staffing levels. Unfortunately, each LOC is rarely defined by measurable blocks of dedicated caregiver time, so families are expected to trust the judgment of ALF staff, who lack credibility when staffing patterns are derived from annual operating budgets and not LOC assessments.

The problem with these systems is retaining high-risk residents who exceed the capability of an ALF, which cannot be solved by using private sitters or home health agencies. Asking staff for an itemized breakdown of each LOC (i.e., equipment, supplies, and staffing), is a good approach to determine acuity-based staffing practices in ALF’s, especially when you request minutes-per-resident-per-LOC-per-shift.

Regulatory compliance, governmental rating systems, consumer ratings, and feedback from residents, families, and staff offers valuable insight regarding acuity-based staffing practices. For example, the Centers for Medicare & Medicaid Services’ Five Star Quality Rating System can be an excellent tool for analyzing nursing facilities, although some have gamed the system, and rating domains do not currently isolate aide levels, night shifts, or weekends, which can expose severe understaffing problems. A facility with one star operating below state staffing averages is not in a credible position to claim acuity-based practices. Staffing is the foundation of eldercare regulations, which is very important to remember when analyzing the compliance history of troubled facilities. Unfortunately, surveyor tolerance determines the operating practices of some organizations, and not resident acuity or complying with the standard of care.

Another obstacle to resident-centered care, which is the essence of acuity-based staffing, is resistance from direct care staff. If you examine the delivery of bedside care at some facilities you will find that they embrace shift routines and focus their energy on efficiency and tasks, rather than defining their roles and success on whether each resident’s daily needs are met. There are contributing factors to this phenomenon including labor agreements, workloads, high turnover, staff burnout, and absentee management, but the real problem is allowing aides and nurses to structure their assignments around their own priorities. Acuity-based staffing can force them to abandon these self-serving mindsets.

Article authored by Lance Youles and reprinted out of McKnight’s

Focus F-Tag – F770 Laboratory Services

This Regulatory Beat’s Focus F-Tag is F770 Laboratory Services, which is part of the Laboratory, Radiology, and Other Diagnostic Services regulatory group. This regulation has been in effect since November 28, 2017. The regulation states that the facility must provide or obtain laboratory services to meet the needs of its residents and the facility is responsible for the quality and timeliness of services provided. The requirements for facilities that are providing lab services themselves are included under F770 including having an appropriate CLIA certificate for the lab services being provided. Surveyors will simply determine compliance by assessing the following:

- If the facility has a CLIA certificate that reflects the lab testing being done.
- Resident needs are being met with regard to the quality and/or timeliness of providing the services and reporting of lab results.

Failure to provide these services can result in potentially negative outcomes for residents, and when identified on survey, can rise to a Scope/Severity of Immediate Jeopardy or Actual Harm, so this regulation is not one to ignore.

Here are some actual citations identified under the LTCSP related to lab services:
• Facility administered IV antibiotics to multiple residents without the required laboratory testing to determine appropriate dosing (S/S: K) – don’t forget about the tie-in to the facility’s Antibiotic Stewardship Program and appropriate use of antibiotic therapy.

• Facility failed to notify the physician of elevated FSBS levels for 50% of residents sampled during survey for insulin administration. One resident developed uncontrollable diabetes and required IV insulin administration at the hospital (S/S: K) – don’t forget about the importance of notification of changes, either.

• Facility failed to obtain a physician-ordered STAT lab testing when a change in condition was identified, resulting in actual harm to a resident who was transferred to the hospital and admitted with high white blood cell count and septic shock (S/S: G)

• Facility did not obtain timely lab results for residents on anticoagulants and did not obtain a urine culture for a resident with a potential UTI (S/S: D)

If you are not conducting periodic reviews of all ordered labs being completed and results reported in a timely manner, you are making a mistake. Whether you have a provider lab or conduct testing within the facility sound systems needs to be in place for scheduling of lab tests and ensuring testing and reporting results are timely to best meet the needs of each resident.

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**Trending Statistics**

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

**Opioid-Related Emergency Care for Seniors**

Among patients age 65 and older, the number of opioid-related emergency department visits doubled from 18,100 visits in 2010 to 36,200 visits in 2015. (Source: AHRQ, Healthcare Cost and Utilization Project Statistical Brief #244: Opioid-Related Inpatient Stays and Emergency Department Visits Among Patients Aged 65 Years and Older, 2010 and 2015.)

Opioid misuse in older adults is an underappreciated and growing problem. Although opioid misuse overall is lower among older than among younger Americans, the rate of opioid misuse among older adults nearly doubled between 2002 and 2014.¹ In 2016, a third of the more than 40 million Americans enrolled in Medicare Part D received prescription opioids and a substantial number received higher doses than recommended for prolonged periods of time, putting them at increased risk of misuse.² Between 2005 and 2014, the rate of opioid-related hospitalizations increased fastest among patients aged 65 years and older compared with all other age groups.³

Eighty percent of U.S. adults aged 65 years and older have multiple chronic conditions (e.g., heart disease, diabetes, arthritis, and depression) compared with less than 20 percent of adults aged 18-44 years.⁴ Chronic pain is common among older adults,⁵ and more than one-third of older Americans are living with a disability,⁶ making this population more likely than younger adults to receive an opioid prescription.⁷ In addition, complex social needs and mental health issues including depression, substance abuse, cognitive decline, and dementia often go unrecognized and/or complicate clinical management.⁸,⁹ Compounded by the physiologic changes associated with aging, these conditions place older adults using opioid medications at increased risk for adverse events including injurious falls¹⁰ and delirium,¹¹ which may result in ED visits or hospital admissions.

Additionally, older adults are more likely than younger adults to take prescription medications,¹² which increases the likelihood of drug interactions and adverse effects associated with the use of opioids. In the period from 2011-2014, more than 90 percent of Americans aged 65 years and older reported use of a prescription drug in the past 30 days, with over 40 percent reporting use of five or more prescription drugs in the prior 30 days (compared with less than 5 percent of adults aged 18-44 years).¹³ This represents a substantial increase in the proportion of adults aged 65 years and older who used prescription medications compared with 20 years earlier (1988-1994: one prescription medication, 74 percent; five or more prescription medications, 14 percent).¹⁴
This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents statistics on opioid-related hospital stays and ED visits among patients aged 65 years and older in fiscal year (FY) 2010 (from quarter 4 of 2009 through quarter 3 of 2010) and FY 2015 (from quarter 4 of 2014 through quarter 3 of 2015), hereinafter referred to as 2010 and 2015. The number and rate of opioid-related stays and ED visits in 2010 and 2015 are provided for three distinct age groups: 65-74 years, 75-84 years, and 85 years and older. The percentage of opioid-related inpatient stays and ED visits that involved a principal opioid diagnosis is provided for each of the three age groups in 2015. Characteristics of opioid-related stays and ED visits versus nonopioid-related stays and visits among adults aged 65 years and older are presented for 2015. Identification of opioid-related stays and ED visits is based on all-listed diagnoses and includes events associated with prescription opioids or illicit opioids such as heroin. Differences greater than 10 percent between estimates are noted in the text.

1) There were two Federal CMS Quality, Safety and Oversight Letters (formerly known as Survey and Certification (S&C) Letters) released since the last issue of Regulatory Beat:

- **QSO 19-12 – Hospitals** – DRAFT ONLY – Clarification of Ligature Risk Interpretive Guidelines. This draft policy memorandum would update S&C: 18-06-Hospitals released by CMS on December 8, 2017. *This Memo is Being Released in Draft:* We seek comment on these draft revised policies by June 17, 2019 (60 days from the date of this release). *Ligature Risks Compromise Patients’ Right to Receive Care in a Safe Setting:* The care and safety of psychiatric patients at risk of harm to themselves or others, and the staff providing care are our primary concerns. The comprehensive ligature risk interpretive guidance in the CMS State Operations Manual (SOM) Appendix A for Hospitals is being revised to provide direction and clarity for CMS Regional Offices, State Survey Agencies, accrediting organizations and hospitals. *Ligature Risk Extension Request Process Update:* The SOM Chapter 2, Section 2728G - Major Deficiencies Requiring Long-Term Correction in Psychiatric Hospitals and Hospital Psychiatric Units, Ligature Risk - Ligature Risk Extension Requests is also being updated. The section describes the process for deemed and non-deemed hospitals to request a ligature risk extension based on evidence of hardship and inability to complete necessary renovations within 60 days.

- **QSO 19-13 - Hospitals** – DRAFT ONLY – Guidelines for Hospital Co-Location with Other Hospitals or Healthcare Facilities. *Hospital Co-location Interpretive Guidance:* CMS is focused on ensuring the health and safety of patients as it relates to the use of shared space and contracted services by hospitals co-located with another hospital or health care entity. CMS is committed to providing the information hospitals need to make decisions about how they partner with other providers in the health care system to deliver high-quality care. *This Guidance is Being Released in Draft:* To ensure that CMS is fully aware of how our guidance will impact hospital providers, we are releasing the guidance in draft and welcome comments. We seek comment on these draft revised policies by July 2, 2019 (60 days from the date of this release)

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

- **PBJ Audits.** PBJ Audits are starting. The request comes from Myers and Stauffer. The facility has 3 Days to complete the form for web access and 7 days to post the results on the Portal.

- **SNF: FY 2020 Proposed Payment and Policy Changes.** On April 19, CMS issued a proposed rule for FY 2020 that updates the Medicare payment rates and the quality programs for Skilled Nursing Facilities (SNFs). Effective October 1, we will begin using a new case-mix model, the Patient Driven Payment Model (PDPM). The PDPM
focuses on the patient’s condition and resulting care needs, rather than on the amount of care provided, in order to determine Medicare payment.

We project that aggregate payments to SNFs will increase by $887 million, or 2.5 percent, for FY 2020 compared to FY 2019. We attribute this estimated increase to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment.

The proposed rule also includes:
- Sub-regulatory process for ICD-10 code revisions for PDPM
- Aligning SNF PPS group therapy definitions with other post-acute care settings

CMS will accept comments on the proposed rule until June 18. See the full text of this excerpted CMS Fact Sheet (issued April 19).

- **Hospice: FY 2020 Proposed Payment Rate Update.** On April 19, CMS issued a proposed rule that would update the hospice payment rates, wage index, and cap amount for FY 2020. This rule also:
  - Proposes to rebase the continuous home care, general inpatient care, and inpatient respite care per diem payment rates in a budget-neutral manner
  - Proposes to modify the election statement requirements to require the hospice to include additional information aimed at increasing coverage transparency for patients that elect hospice
  - Solicits comments on the interaction of the hospice benefit and various alternative care delivery models

As proposed, hospice payment rates are updated by 2.7 percent ($540 million increase in their payments) for FY 2020. This is based on the proposed FY 2020 hospital market basket increase of 3.2 percent reduced by the multifactor productivity adjustment of 0.5 percentage point, resulting in a proposed 2.7 percent increase in hospice payment rates for FY 2020. Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket update for the year.

The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments per patient made to a hospice annually. The proposed hospice cap amount for the FY 2020 cap year will be $29,993.99, which is equal to the FY 2019 cap amount ($29,205.44) updated by the proposed FY 2020 hospice payment update percentage of 2.7 percent.

CMS will accept comments on the proposed rule until June 18. See the full text of this excerpted CMS Fact Sheet (issued April 19).

- **New Part D Opioid Overutilization Policies: Myths and Facts.** CMS implemented new opioid policies for Medicare drug plans effective January 1. This is the second message in our series on common myths about these new policies and the facts for providers

Myth: “Medicare is forcing all Part D enrollees to taper prescription opioids below a certain amount.”
Fact:
- Prescribers and their patients must carefully consider decisions to taper or stop prescription opioids
- It can be especially challenging to taper opioid use in patients who have been on high dosages of opioids for many years
- The intent of the new opioid policies is to address opioid overuse without a negative impact on the patient-doctor relationship

Medicare Part D opioid policies are not prescribing limits and generally do not 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:
  o Roadmap
  o Letter to providers about reducing opioid misuse
  o Prescriber’s Guide to New Medicare Part D Opioid Overutilization Policies for 2019 MLN Matters Article
  o Training materials for prescribers, pharmacists and patients

- Proposed Rules on Interoperability: Comment Period Extended to June 3. HHS extended the public comment period by 30 days for two proposed regulations aimed at promoting the interoperability of health information technology and enabling patients to electronically access their health information. The new deadline for comments is June 3.

  The extension of the public comment period coincides with release of:
  o Second draft of the Trusted Exchange Framework and Common Agreement and related Notice of Funding Opportunity from the HHS Office of the National Coordinator for Health Information Technology
  o FAQs from the Office for Civil Rights

For More Information:
  o Notice of Proposed Rulemaking to Improve the Interoperability of Health Information webpage
  o CMS Advances Interoperability & Patient Access to Health Data through New Proposals Fact Sheet
  o Interoperability website

- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1. On October 1, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has resources to help you prepare:
  o PDPM webpage, including fact sheets, FAQs, presentation and coding crosswalks/classification logic
  o Materials from the Medicare Learning Network call in December
  o New Medicare Webpage on PDPM MLN Matters Article
  o Implementation of the SNF PDPM MLN Matters Article

- Ensuring Safety and Quality in America’s Nursing Homes. CMS is charged with developing and enforcing quality and safety standards across the nation’s health care system. We are undertaking a comprehensive review of our regulations, guidelines, internal structure and processes related to safety and quality in nursing homes to ensure:
  o Residents are treated with dignity and kept safe from abuse and neglect
  o Nursing homes are rewarded for value and quality
  o Patient outcomes are transparent to consumers
  o Unnecessary paperwork does not keep you from focusing on patients

  Find out what we are doing to:
  o Strengthen oversight
  o Enhance enforcement
  o Increase transparency
  o Improve quality
  o Put patients over paperwork

  See the full text of this excerpted CMS Blog (issued April 15).

- New Medicare Card: Transition Period Ends in 8 Months. Starting January 1, 2020, Medicare will only accept claims submitted with the Medicare Beneficiary Identifier (MBI). Medicare will reject any claims submitted with the Health Insurance Claim Number (HICN) with a few exceptions. Review the MLN Matters Article to learn about getting and using the MBI.
• **Addressing Social Determinants of Health Will Help Achieve Health Equity.** Social determinants of health can include housing, transportation, education, social isolation and more. These factors affect access to care and health care utilization as well as outcomes. Organizations may measure these factors using a number of existing tools, including:
  
  - **Z codes from ICD-10-CM:** Group of codes within the ICD-10 (diagnostic) codes that help capture a patient’s socioeconomic and/or psychosocial needs
  - **Accountable Health Communities Health-Related Social Needs Screening Tool:** Identify needs related to social determinants
  - **Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) Tool:** Collect the data needed to better understand and act on patients’ social determinants of health
  - **Health Leads Screening Toolkit:** Comprehensive way to assess patients for adverse social determinants

Data collection will help CMS strengthen our understanding of the relationship between social determinants of health and health care use across diverse populations, allowing us to develop solutions and better connect patients to much needed services. We are beginning this effort in several post-acute care provider settings this year by proposing that some data elements be collected on standardized patient assessment instruments.

In an effort to reduce expenditures and improve health outcomes, CMS is testing the [Accountable Health Communities Model](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/AHC-Model.html), which is the first model to include social determinants of health. The model is based on emerging evidence that shows addressing health-related social needs through enhanced clinical-community links can improve health outcomes and reduce costs.

For more information, visit the [Office of Minority Health](https://www.hhs.gov/ash/ohp/index.html) website. See the full text of this excerpted [CMS Blog](https://www.cms.gov/Blog) (issued April 26).

• **IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) and Skilled Nursing Facility (SNF) Quality Reporting Programs for the fourth quarter of 2018 is May 15.

For More Information:
  - [IRF Quality Reporting Data Submission Deadlines](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/IRF-Quality-Reporting-Program.html)
  - [LTCH Quality Reporting Data Submission Deadlines](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/LTCH-Quality-Reporting-Program.html)
  - [SNF Quality Reporting Program Data Submission Deadlines](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/SNF-Quality-Reporting-Program.html)

• **Nursing Home Compare Refresh.** The April 2019 Nursing Home Compare refresh is available, including quality measure results based on Skilled Nursing Facility (SNF) Quality Reporting Program data. Visit the [Nursing Home Compare](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/NHCompare.html) website to view the data. For more information, visit the [SNF Quality Public Reporting](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/SNF-Quality-Reporting-Program.html) webpage.

• **Policy Change for Assessment Submission Timeframe.** The current CMS policy for submission of patient assessment records allows providers to submit records for up to 36 months from the assessment target date. Effective October 1, 2019, the CMS policy for patient assessment submission will be changed to 24 months from the assessment target date. The policy change applies to new, modified and inactivated records.

• **Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities.** In a recent report, the Office of the Inspector General (OIG) determined that Medicare inappropriately paid acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities, including long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities and critical access hospitals. As a result, beneficiaries were unnecessarily charged outpatient deductibles and coinsurance payments. All items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. Use the following resources to bill correctly:
  
  - [Provider Compliance Tips for Ordering Hospital Outpatient Services](https://www.cms.gov/Medicare/Quality-Programs/Quality-Payers/Provider-Compliance-Tips-for-Ordering-Hospital-Outpatient-Services.html) Fact Sheet
Promising Practices for Duals with Substance Use Disorders Webinar — Thursday, May 16, 12:30 to 2 pm CST. Register for this webinar. This webinar discusses common Substance Use Disorders (SUDs) among dually eligible older adults; identifies promising practices for screening, treatment and care coordination; and demonstrates practical strategies for meeting the needs of older adults with SUDs. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

Special Open Door Forum – Medicare Documentation Requirement Lookup Service – Tuesday, May 14 from 1:00 to 2 pm CST. The CMS Center for Program Integrity will host a series of Special Open Door Forum (SODF) calls to educate the public about a new initiative underway to develop a Medicare Fee for Service (FFS) Documentation Requirement Lookup Service prototype. Also, to allow physicians, suppliers, IT and Electronic Health Record (EHR) Developers and Vendors, and/or all other interested parties to provide feedback to CMS and inform how interested parties can get involved or track the progress of this initiative.

CMS is collaborating with ongoing industry efforts to streamline workflow access to coverage requirements, starting with developing a prototype Medicare FFS Documentation Requirement Lookup Service and is participating in two workgroups to promote development of standards that will support the Lookup Service. One workgroup is a private sector initiative hosted by Health Level Seven (HL7), the Da Vinci project. The second workgroup is The Office of the National Coordinator for Health Information Technology (ONC) Fast Healthcare Interoperability Resource (FHIR) at Scale Taskforce (FAST).

By working with HL7, ONC, other payers, providers, and EHR vendors, CMS is helping define the requirements and architect the standards-based solutions. In parallel, CMS is preparing to support pilots testing the information exchanges for Medicare FFS programs and possibly coordinate pilots with volunteer participants to verify and test the new FHIR based solutions.

The goals of the Documentation Requirement Lookup Service prototype are to reduce provider burden, reduce improper payments and appeals, and improve "provider to payer" information exchange. The prototype will be made accessible to pilot participants and will allow providers to be able to discover the following at the time of service and within their EHR or practice management system:
   1. If Medicare FFS requires prior authorization for a given item or service; and
   2. Documentation requirements for Oxygen and Continuous Positive Airway Pressure (CPAP) Devices.

For more information and to access the slide presentation for the SODF, please click here.

We look forward to your participation. Special Open Door Participation Instructions:
Participant Dial-In Number: 1-(800)-837-1935
Conference ID: 4457108


New Waived Tests. A new MLN Matters Article MM11231 on New Waived Tests is available. Learn about claims submission updates.

NCD: Next Generation Sequencing — Revised. A revised MLN Matters Article MM10878 on National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS) is available. Learn about missing CPT codes.
- **Implementation to eMDR for Registered Providers via the esMD System — Reissued.** A reissued MLN Matters Article MM11003 on Implementation to Exchange the List of Enrollment in Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System is available. Learn about registration and instructions.

- **Provider Compliance Tips for Ostomy Supplies — Revised.** A revised Provider Compliance Tips for Ostomy Supplies Medicare Learning Network Fact Sheet is available. Learn about:
  - Coverage requirements
  - Reasons for denials
  - How to prevent future claim denials

- **ESRD PPS: Quarterly Update.** A new MLN Matters Article MM11215 on Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) is available. Learn about a new HCPCS code for anemia management.

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

- **Opioid Video.** A video presentation is available for the February 14 Medicare Learning Network call on the New Part D Opioid Overutilization Policies. Learn about the new policies effective January 1.

3) The federal Centers for Disease Control and Prevention (CDC) reports on:

- **Weekly U.S. Influenza Surveillance Report.**

- **Are We Prepared for the Next Flu Pandemic.** Influenza and its ever-present potential to cause global outbreaks of disease, or "flu pandemics," poses one of the world's greatest infectious disease challenges. There has been a lot of progress in pandemic preparedness since the devastating pandemic of 1918, but there is still much to do to improve U. and global readiness for the next flu pandemic.

4) The HHS Office of the Inspector General reports on the National Background Check Program for Long Term Care Providers: Assessment of State Programs Concluded Between 2013 and 2016 (OEI-07-16-00160). The 10 states that had concluded their participation in the program by 2016 varied as to the degree to which they achieved implementation of Program requirements. Seven of these 10 States implemented all or most of the selected requirements. Three states did not have the necessary authority through State legislation and could not fully implement background check programs.

Of the background checks that 8 of the 10 states conducted, nearly 80,000 resulted in determinations of ineligibility for prospective employees. The number of determinations of ineligibility and rates of ineligibility varied among the states (i.e., from less than 1 percent to 8 percent). None of the states reported a reduction in available workforce for long term care facilities or providers as a result of the Program.

- Read the Full Summary [https://go.usa.gov/xmKu2](https://go.usa.gov/xmKu2)
- Read the Report [https://go.usa.gov/xmKu](https://go.usa.gov/xmKu)

5) The National Institute of Health reports, panel highlights need for further innovative research approaches to inform appropriate long-term use of osteoporosis drug therapies. It is projected that by 2025, the total U.S. health care costs attributable to fractures will reach $25 billion annually.

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:
• HFS staff will be conducting **Paternity Establishment refresher training** on the Voluntary Acknowledgement of Paternity (VAP) form on Thursday, May 16 at the Holiday Inn Motel & Restaurant in Olney, 10:00 a.m. - Noon. Please complete the registration by Tuesday, May 14 if you would like to attend. If you have any question please contact Mary Carter at 618-997-5723 or mary.carter@illinois.gov.

• HFS posted Provider Notice regarding **Transportation PowerPoint Presentation for HFS 2270, Physician Certification Statement**. [Click here](#) to view.

• HFS posted a new Provider Notice regarding **Due Date for Payment of the Monthly Occupied Bed Provider Assessment**. [Click here](#) to view.

• HFS posted a new Provider Notice regarding **Universal Provider Roster Submission Requirements for Illinois Medicaid Managed**. [Click here](#) to view.

• HFS posted the meeting agendas for the [May 9, 2019 Waiver Advisory Subcommittee - Adults Agenda](#) and [May 9, 2019 Waiver Advisory Committee - Children's Agenda](#). You may view the agendas [here](#).

• HFS posted a new Provider Notice regarding **Critical Access Pharmacies Self-Attest Period Open for Third Fiscal Quarter of 2019**. [Click here](#) to view.

• HFS has an updated **Preferred Drug List Illinois Medicaid effective April 1, 2019**. You may view the new list [here](#).

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

• Schedule for **IDPH Town Hall Meetings** will be out shortly.

• **IDPH EPOC.** Federal CMS have changed the web address for ePOC. There was a pop-up redirecting to the new web address, however, CMS removed this pop-up and now the old website only gives an error message. Unfortunately, CMS did not notify IDPH that the web address would be changing, they learned through investigation when providers started calling.

The new ePOC web address is [https://qtso.cms.gov/](https://qtso.cms.gov/)

Once there, under the “I’m a Provider” banner, click on “Nursing Home (MDS)/Swing Bed Providers” and then click on “Launch” to connect.

• **Colbert Consent Decree.** On December 21, 2011, the state of Illinois entered into a Consent Decree, settling the *Colbert v. Rauner* class action lawsuit, first filed in August 2007. The lawsuit alleged that individuals are being unnecessarily institutionalized in nursing facilities in Cook County. The Colbert Consent Decree requires the state to provide nursing facility residents of Cook County nursing facilities with the necessary services and supports to move to a community-based setting. Colbert Class Members are defined as Medicaid-eligible adults with disabilities who are being unnecessarily confined to nursing facilities in Cook County, Illinois, and who with appropriate supports and services may be able to live in a community-based setting. Currently the Illinois Department on Aging (DoA) leads the implementation of Decree, in partnership with the Illinois Department of Healthcare and Family Services (HFS), Illinois Department of Human Services (DHS) and the Illinois Department of Public Health (DPH). Further, to accomplish this mandate, the DoA has assigned specific agencies to provide outreach and education to specific nursing facilities.

The Nursing Home Care Act ("Act") requires that “[a]ny employee or agent of a public agency, any representative of a community legal services program, or any other member of the general public shall be permitted access at reasonable hours to any individual resident of any facility, but only if there is neither a commercial purpose nor effect to such access and if the purpose is to do any of the following: (1) Visit, talk with
and make personal, social and legal services available to all residents; (2) Inform residents of their rights and entitlements and their corresponding obligations, under federal and State laws, by means of educational materials and discussion in groups and with individual residents; (3) Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance and social security benefits, as well as in all other matters in which residents are aggrieved. Assistance may include counseling and litigation; or (4) Engage in other methods of asserting, advising and representing residents as to extend to them full enjoyment of their rights.” [210 ILCS 45/2-110]

Section 2-108 of the Act also requires the administrator to “ensure that space for visits is available” as every resident shall be “permitted unimpeded, private and uncensored communication of his choice by...visitation.” [210 ILCS 45/2-108]

In accordance with the Act, facilities must identify a reasonable location for Outreach workers, Ambassadors and Class Members to convene that will afford engagement opportunities without interfering with daily operations or privacy of the Class Member or other residents.

In addition, providers are invited to attend the upcoming, “2019 Co-Occurring Mental Illness and Substance Use Disorders Conference” on Friday, June 7, 2019. While there will be no cost and continuing education units for attendees, seating will be limited.

Any questions regarding either the Colbert Consent Decree or the conference are to be directed to Ms. Felicia Gray at the following address:

Felicia S. Gray, LCSW, Senior Colbert Administrator
Illinois Department on Aging
Division of Transitions and Community Relations
160 North LaSalle Street
Suite 700-N726
Chicago, IL 60601
Phone: 312-814-6815
Email: Felicia.S.Gray@illinois.gov

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

- **Question From AHCA.** We need your help with monitoring the implementation of the new IJ guidance in Appendix Q. CMS would like our feedback on whether facilities are receiving copies of the new IJ Template--one template for each IJ deficiency identified--at the time the IJ is identified before surveyors exit. Also, does the information provided in the templates make it clear how the three criteria for IJ were met? We would also appreciate your input on how other aspects of the guidance are being implemented. For example, are you still seeing instances of copying/pasting of the rationale for more than one deficiency? Are you seeing examples where more than one F-tag is cited stemming from the same incident or issue, but where the deficiencies are cited distinctly and appropriately? Please share you feedback with the community or with me at srudow@ahca.org.

- **New Five-Star Ratings on Nursing Home Compare.** CMS published new Five-Star rankings on its Nursing Home Compare (NHC) website that reflect several significant updates to all three components of the system - survey, staffing and quality. A summary of the changes can be found [here](#).

On April 8, AHCA hosted a webinar that walked through these new changes. Members can access the recorded webinar and the following resources on the Five-Star ahcancalED website [here](#):

- Q&As from the AHCA Five-Star Webinar
- Member toolkit containing the following items:
  - Suggested talking points
State Affiliates can download suggested talking points here.

In addition, AHCA has several tools to help members continue to improve. AHCA/NCAL’s LTC Trend Tracker here is a one-stop-shop that allows members to gain timely information and valuable insight about their own performance as well as the entire profession’s, including reports that capture Five-Star and Quality Measure (QM) rates.

For any additional questions on the new Five-Star ratings, please email research@ahca.org.

- **National Skilled Nursing Care Week.** As a reminder, National Skilled Nursing Care Week (NSNCW) is next week, May 12-18. The 2019 theme is "Live Soulfully," which 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, staff at our nation's centers pay it forward by dedicating themselves to improving quality of life for residents.

  AHCA has several resources at ahcancal.org/NSNCW to help you celebrate NSNCW, including graphics, a planning guide, sample social media posts, newsletter template, and more. Use the hashtag #NSNCW on social media to share how you’re celebrating and follow us on Facebook here and Twitter here.

  We look forward to celebrating with you next week!

- **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.

  We are excited to have several new subscribers to this email. Please help us spread the word! If you have an interested colleague or a suggestion for what to share on social media, please have them send an email at socialmedia@ahca.org so they can join in.

- **AHCA PDPM Academy: More Important Changes.** Due to feedback from the AHCA PDPM Academy Workshop participants as well as recent CMS PDPM webpage resources updates on April 4 and April 11, AHCA has updated the AHCA PDPM Resident Classification Worksheet Template as well as the associated AHCA PDPM Component Variable Per-Diem and RUG-IV Rate Reference Tables on the ahcancalED website. These files can be found in the AHCA PDPM MDS Accuracy Toolkit- Resident Classification and will indicate “4/15/19 Update” in the file heading.

  We have received feedback that the TeamSTEPPS for Long Term Care document that was part of Module 1 of the one-day AHCA PDPM Academy Workshop binder that we had previously posted had broken links. We have updated the ahcancalED site with updated resources, including a PDP copy of the TeamSTEPPS 2.0 overview document that was part of your workshop binder as well as a direct link to the publicly available AHRQ website that contains the entire suite of PDF, power-point, and video resources available. You can access this here.
Comprehensive Person-Centered Care Planning §483.21 tool is now available in the AHCA PDPM Academy.

CMS made a routine update to their FAQ file so that now there are two versions – A redline track-change version, and a clean 508 accessibility compliant version with track changes accepted. You can locate the two files in this link, PDPM Frequently Asked Questions (FAQs).

- **Recording of Webinar: AHCA PDPM Academy Monthly Live Webinars is Ready.** The archived recording of AHCA PDPM Academy Monthly Live Webinars is now ready for you to view at your convenience.

  2. Once the page opens, click on the "View Archived Recording" button on the right hand side of the page. The presentation will open in a new window for you to view and hear the program.
  3. Click on the Handout tab to download your copy of the handouts and other available materials.

For questions or support, please email ahca@commpartners.com

- **AHCA PDPM Academy Weekly Update: May 2.** The new “AHCA PDPM Academy Therapy Staffing/Contracting Considerations Under PDPM Toolkit” is available on the AHCA PDPM Academy Site. Click here to access.

  This toolkit includes 7 key tools and the recording of the April 30th webinar which walked participants through how to use the tools.

  The recording of the April 30th PDPM Academy Monthly Webinar, and downloadable webinar slides and the Q&As document are now available for participants to review at their convenience. Click here to access.

9) **Telligen** reports:

- This Month at Telligen

10) **Skilled Nursing News** reports that Nearly 40% of SNFs See Star-Rating Declines After CMS Changes. Skilled Nursing News reports a new "pair of analyses from the American Health Care Association" and "CarePort, a firm that provides software aimed at improving transitions of care between the acute and post-acute setting," found that about "36% of skilled nursing facilities saw a drop in their overall star ratings" after the changes took effect. While CarePort found about "16% of providers gained at least one star under the ratings overhaul," the AHCA found "about 15% of providers saw a boost."

11) **Politico** reports that HHS Reduces Fines for HIPAA Violations. Politico reports in a brief that recently, HHS’ Office for Civil Rights "published a new legal interpretation that should reduce some fines for HIPAA violations, which until now have been $1.5 million annually for each category." OCR "has historically collected $1.5 million for violations – which could include data breaches or inadequate risk assessments – regardless of their severity." However, "going forward, OCR Director Roger Severino said, only the violators who demonstrate ‘willful neglect’ will pay the highest fine; lower tier offenders would pay $25,000 max for each illegal category." One critic of this move warned it could harm consumers.

12) **HealthDay** reports that Morning Exercise May be Beneficial for Brain Health of Seniors. HealthDay reports researchers found that "a morning session of exercise and short walks throughout the day provide a number of brain benefits for older adults." The findings were published in the British Journal of Sports Medicine.

13) **Provider Magazine** reports:
AHCA AVP Discusses Positive Changes Under CMS' Proposal for Group Therapy Definition. Provider Magazine reports on comments by Daniel Ciolek, Associate Vice President of Therapy Advocacy for the American Health Care Association (AHCA), who discussed the benefits of the 2.5 percent net payment increase to CMS' Fiscal Year 2020 Skilled Nursing Facility (SNF) proposed payment rule and CMS' proposal to "expand the definition of group therapy" with the Patient Driven Payment Model (PDPM). Ciolek said "the standardization across post-acute provider settings for patients with similar characteristics represents an important step in achieving the aspirations of the IMPACT Act in reducing care variability and outcomes across post-acute care settings." He also discussed the AHCA's role in preparing providers for the implementation of PDPM.

AHCA Warns Changes to Five-Star Ratings Will Confuse Consumers. Provider Magazine reports, AHCA Senior Vice President of Quality and Regulatory Affairs David Gifford, MD, said in a statement that the "abrupt change in star ratings" on the CMS Nursing Home Compare website could confuse consumers by "moving the scoring 'goal posts.'" Gifford said in a statement that the changes "for two components of the Five-Star system...will cause more than 30 percent of nursing centers nationwide to lose one or more stars overnight, even though nothing changed in staffing levels and in quality of care, which is still being practiced and delivered every day." He added that while the Five-Star system "can be a helpful tool, consumers should not rely on it exclusively when choosing a nursing center for themselves or a loved one."

Experts Discuss Pathways for RoP Compliance. Provider Magazine reports in the cover story of its May issue that as providers prepare for implementation of Phase 3 of the Requirements of Participation (RoPs) in November amid the transition to the Patient-Driven Payment Model (PDM), they can minimize the impact of managing multiple regulatory changes simultaneously. Speaking on what providers should expect, Director of Regulatory Services at the American Health Care Association Sara Rudow, said, "Phase 3 has some big-ticket items that tie everything together." The piece says that while "Phase 3 may put more stress on facility finances than staff... costs such as paying the salary for a compliance officer and various required training efforts could be burdensome," adding that the AHCA and National Center for Assisted Living offer "free and local training materials and programs." The piece features experts’ comments on other strategies to improve training, recommending resources, ways to prepare staff, and technologies that can keep facilities operating smoothly amid changes.

Accurate, Comprehensive Diagnoses Vital to Success in PDPM. Karl Steinberg, MD, CMD, chief medical officer for Mariner Health Central and medical director of Life Care Center of Vista and Carlsbad by the Sea Care Center, writes in Provider Magazine that in October, "the Patient-Driven Payment Model (PDM) will supplant the Resource Utilization Groups (RUGs) as the paradigm by which a nursing center’s Medicare Part A per diem payment for post-acute (skilled) residents will be calculated." The change will "significantly de-emphasize the impact of therapy minutes, which has been the primary driver of payment for decades and will bring medical complexity to the forefront in determining reimbursement." Steinberg writes that except for "some very medically complex residents," it is likely, especially in light of congressional budgetary concerns, "that for a majority of post-acute residents, the reimbursement under PDPM will be lower than it would have been under the RUGs, at least for ultra-high rehab recipients (who constituted 50 percent or more of the total post-acute population in many facilities)." He asserts that "the importance of correct, comprehensive medical diagnoses to capture all of each resident’s medical problems cannot be overstated." Steinberg adds that "much more information is available through the American Health Care Association and other resources on PDPM."

14) McKnight’s reports:

CMS Cautions SNFs That Star Ratings Could Drop Due to Rule Change. McKnight’s Long Term Care News reports that CMS officials "are reminding providers about changes dropping this week that could have a big impact on nursing homes’ star ratings," noting that the agency "is dropping the threshold that SNFs can go without a registered nurse onsite from seven days to just four." CMS' Lorelai Kahn said, "Nurse staffing has the greatest impact on the quality of care nursing homes deliver. CMS has found that as staffing levels increase, quality increases." An analysis of the industry from the American Health Care Association found "that about half of the
nation's 15,000 nursing homes will not see their star ratings change come Wednesday, while about one-sixth can expect an increase," while an estimated third of them "will suffer a ratings drop overnight."

- **AHCA Submits Comments to HHS Over New Rule Allowing Health Care Workers to Deny Care Over Religious, Moral Objections.** *McKnight’s Senior Living* reports that the HHS will soon allow individual health care workers and organizations to "decline to provide care that conflicts with their religious and moral beliefs or mission under a final rule issued by the Department of Health and Human Services Office for Civil Rights." The American Health Care Association and National Center for Assisted Living submitted comments to the agency requesting that the rule not apply to long-term and post-acute providers. AHCA/NCAL Senior Director of Policy and Program Integrity Lilly Hummel wrote, "Staff, residents, and residents’ families from nursing centers, centers providing care for individuals with intellectual or developmental disabilities, and assisted living communities that accept Medicaid already have multiple outlets for reporting complaints or concerns."

- **Nursing Home Fines to Resume After Moratorium Ends.** *McKnight’s Long Term Care News* reports that in response to the upcoming end of an "18-month moratorium on fines against nursing facilities," nursing home leaders believe "few are likely to be levied." David Gifford, MD, American Health Care Association Senior Vice President for Quality and Regulatory Affairs, indicated, "Lost caregiving time due to compliance activities will likely be the biggest expense most facilities see." Gifford added that CMS continued to survey and cite facilities for deficiencies in certain areas but did not issue monetary fines, writing about 5,000 citations during that period but only 26 would have resulted in a fine or denial of payment. He said, "Centers were cited many times for the eight tags."

15) **Interesting Fact:** Left-handedness is twice as common in twins than in the general population.