August
2018

Federal and State Regulations Guide

LeadingAge PA
an association of not-for-profit senior services

PA State and Federal Regulations Guide

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ASSISTED LIVING RESIDENCES

Assisted Living Residences (ALR)

Summary:

Pennsylvania Assisted Living Residences (ALRs) are a significant long-term care alternative to allow individuals to age in place. Residents who live in ALRs receive the assistance they need to age in place and develop and maintain maximum independence, exercise decision-making and personal choice. ALRs are inspected and licensed by the Department of Human Services (DHS) under the requirements contained in 55 Pa.Code Chapter 2800 (ALR).

Sources of Additional Information:

- CLICK HERE to read 55 Pa.Code Chapter 2800 (ALR) and the Regulatory Compliance Guide (RCG)
- CLICK HERE to view the DHS Regulatory Question and Answers for Assisted Living Residences
- CLICK HERE for the Influenza Vaccine posting requirement (2016 Act 173)
- CLICK HERE to access DHS Bureau of Human Services Licensing (BHSL) information on the Carbon Monoxide Detector Act, including a copy of the Act.
- CLICK HERE for additional guidance from BHSL on Carbon Monoxide Detectors
- CLICK HERE for updated (reduced) licensing fees published June 9, 2018

CONTINUING CARE RETIREMENT COMMUNITIES (CCRCs)

Continuing Care Retirement Communities (CCRCs)

Summary:

Continuing Care Retirement Communities (CCRCs) in Pennsylvania receive a certificate of authority from the PA Insurance Department. Most CCRCs offer a tiered approach: independent living, personal care homes or assisted living residences, and skilled nursing care. Many adults enter a CCRC and live independently in a house, apartment or condominium on the CCRC campus. As needs change, the CCRC offers access to assisted living services and skilled nursing care.

Sources of Additional Information:

- CLICK HERE to read 31 PA Code Chapter 151 (Continuing Care Providers)
- CLICK HERE for more information on CCRCs in Pennsylvania from the PA Insurance Department
- CLICK HERE to read 2010 Act 66 (Continuing-Care Provider Registration and Disclosure Act)

HOME AND COMMUNITY-BASED SERVICES (HCBS)

Home and Community-Based Services

Summary:

Home and Community-Based Services (HCBS) enable a person to remain in a community setting rather than entering a Long-Term Care Facility. HCBS is paid for by private funds or Medical Assistance. Currently the Department of Human Services (DHS) administers four Office of Long-Term Living (OLTL) HCBS Programs. Each HCBS program has its own eligibility requirements and services.

Sources of Additional Information:

- CLICK HERE to view more information from the PA Department of Human Service on HCBS
- CLICK HERE to read 55 Pa.Code Chapter 52 (Long-Term Living Home and Community-Based Services)

HOME AND COMMUNITY-BASED SERVICES (HCBS)

Home Care

Summary:

Pennsylvania Home Care Agencies and Home Care Registries are regulated by the PA Department of Health. These entities provide non-skilled services to individuals in their homes and independent living environments. Entities established after December 12, 2009 must obtain a license prior to providing home care services.

Sources of Additional Information:

- CLICK HERE to see more information on Home Care from the PA Department of Health
- CLICK HERE to read 28 Pa.Code Chapter 611 (Home Care Agencies And Home Care Registries)

Home Health Care

Summary:

Pennsylvania Home Health Agencies are regulated by the PA Department of Health. These entities provide health care services to ill, disabled, or vulnerable individuals in their homes or places of residence, enabling them to live as independently as possible.

Sources of Additional Information:

- CLICK HERE to view information on PA Home Health Care Agencies
- CLICK HERE to read 28 Pa.Code Chapter 601 (Home Health Care Agencies)
- **View the LeadingAge Summary for:**
  Implementation of the Home Health Conditions of Participation Final Rule
  2018 Medicare Hospice Payment Rule
- Medicaid Rule Requiring Face-to-Face Physician Visits Before Home Health Services
- CLICK HERE to read the Home Health Rules of Participation Final Rule that went into effect Jan. 2018

Home and Community-Based Services Settings Rule

Summary:

The Centers for Medicare and Medicaid Services (CMS) released an HCBS Settings Requirements Final Rule on Jan. 10, 2014 that imposes new requirements on states on how they are able to use federal Medicaid funds to pay for home and community-based services to meet the needs of Medicaid enrollees, particularly the elderly and disabled.

Sources of Additional Information:

- CICK HERE to view the CMS notice extending the compliance deadline until March 17, 2022
- CLICK HERE to view the LeadingAge article on the impact of the final rule
- CLICK HERE to view FAQs on the rule's effect on new construction of assisted living and adult day services
- CLICK HERE to view LeadingAge article on CMS guidance regarding dementia care in HCBS
- CLICK HERE to read the HCBS Setting Requirements final rule (CMS–2249–F; CMS–2296–F)
- CLICK HERE to read the DHS Bulletin on HCBS Settings Requirements

HOME AND COMMUNITY-BASED SERVICES (HCBS)

Adult Day Services

Summary:

Pennsylvania Adult Day Services (ADS) are a community-based program that provides a structured setting for adults, who are cognitively or functionally impaired, but receive their principal care at home from family and/or friends. Often used for respite care, ADS generally operate during regular business hours and provide socialization, meals, assistance with medication and therapies. ADS is licensed by the PA Department of Aging.

Sources of Additional Information:

- CLICK HERE for more information on Adult Day Centers from the PA Department of Aging
- CLICK HERE to read 6 Pa.Code Chapter 11 (Older Adult Daily Living Centers)

HOUSING

Housing

Summary:

LeadingAge PA and its members have long viewed affordable supportive housing for seniors as a valuable component in the array of service offerings. Utilizing the U.S. Department of Housing and Urban Development's (HUD's) Section 202 Housing for the Elderly program, the Low Income Housing Tax Credit Program, which is overseen by the Pennsylvania Housing Finance Agency (PHFA), and various other programs, LeadingAge PA members have built affordable housing properties and have made available services to address the chronic health and supportive services needs of their residents.

The Department of Human Services (DHS), PHFA and the Department of Community and Economic Development (DCED), have recently created a five-year strategy to address housing issues. The Commonwealth also provides a five-year Consolidated Plan, an Annual Plan and a Performance Report on the use of federal housing-related funds, as required by HUD, which discuss housing needs, priorities, plans, and accomplishments. These planning documents and links to some of the major funding sources are listed below.

Sources of Additional Information:

- CLICK HERE to view the DHS 5-Year Housing Strategy, 2018 update
- CLICK HERE to view the Multifamily Housing Professionals section of the PHFA website
- CLICK HERE to view Pennsylvania's 2019-2020 Low Income Housing Tax Credit Allocation Plan
- CLICK HERE for the DCED Library, then select Action Plans to view
  - the Consolidated Plan for 2014-2018, Substantial Amendment Aug. 2016
  - the 2018 draft Annual Action Plan describing Housing activities
  - the 2016 Consolidated Annual Performance and Evaluation Report (CAPER)
- CLICK HERE to view the HUD Section 202 program
- CLICK HERE to view the U.S. Dept. of Agriculture programs, including multifamily housing programs

NURSING FACILITIES

Licensing, Certification, Other

Medicare and Medicaid Requirements of Participation for Long-Term Care Facilities

Summary:

This Final rule revises the requirements that nursing facilities must meet to participate in the Medicare and Medicaid programs. It updates or reorganizes nearly all existing regulatory requirements and creates new requirements and new Federal, or F-, Tags. The Centers for Medicare & Medicaid Services (CMS) views the rule as necessary to reflect advances in the theory and practice of service delivery and safety, and to achieve quality improvement.

Sources of Additional Information:

- CLICK HERE to read the Requirements of Participation final rule (81 FR 68688) published Oct. 4, 2016
  - CLICK HERE to access a summary of the final rule by LeadingAge.
  - CLICK HERE to access a comprehensive overview of the final rule that breaks out each section with key points, changes to the regulation, and what you need to do
  - CLICK HERE to access LeadingAge resources for implementing the final rule, which now include tools for developing the facility assessment
- CLICK HERE to access the CMS website on the requirements of participation (RoP) final rule, with survey resources, Appendix PP, Job Aide that provides a crosswalk from old F-tags to new, FAQs, etc.
- CLICK HERE to access CMS' Survey & Certification Training for surveyors
- CLICK HERE to review CMS Critical Element Pathways for insights into new survey process and RoP
- CLICK HERE to access the Quality Improvement Organizations' sample Facility Assessment
- CLICK HERE to read CMS Survey & Certification (S&C) memo 17-27-NH with new definition of Substandard Quality of Care and clarification on notification to State Ombudsman for transfer and discharge
- CLICK HERE to read CMS S&C memo 17-36-NH with an advance copy of State Operations Manual Appendix PP, F-Tag revisions, F-tag crosswalk, and notice of limited enforcement remedies for certain Phase 2 provisions for the first year of implementation
- CLICK HERE for CMS' July 13, 2017 Final Rule clarifying that the compliance and ethics program required by the RoPs final rule must be operational by Nov. 28, 2019
- CLICK HERE for S&C Memo 18-04-NH, temporary enforcement delays for certain Phase 2 F-Tags – Please note that nursing facilities must be in compliance but that some enforcement remedies (such as CMPs) will not be applied for noncompliance with selected F-tags listed in the document.
- CLICK HERE to view the Code of Federal Regulations (483 CFR) that governs Nursing Facilities

Important Dates and Deadlines:

- Oct. 4, 2016: CMS published the Final Rule
- July 13, 2017: CMS published technical corrections to the Final Rule
- 3-stage phase-in for implementation:
  - Nov. 28, 2016: The regulations included in Phase 1 must be implemented
  - Nov. 28, 2017: The regulations included in Phase 2 must be implemented
  - Nov. 28, 2019: The regulations included in Phase 3 must be implemented
- New CMS survey process
  - Nov. 28, 2017: CMS began implementing revised survey process

NURSING FACILITIES

Licensing, Certification, Other

Nursing Facility Survey Process

Summary:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance to receive payment under the Medicare or Medicaid programs. Nursing Facilities must complete both a Life Safety Code Survey and a Standard Survey. CMS began to use the new nursing facility survey process on Nov. 28, 2017, with the goal of moving to a uniform national system that blends traditional survey processes with the Quality Indicator Survey (QIS) process. In addition, in compliance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, CMS published an interim final rule in Sept. 2016 that increases the amounts of Civil Monetary Penalties (CMPs) and affects nursing homes, home health agencies and LIFE (PACE) providers. CMS published annual CMP adjustments on Feb. 3, 2017, as required by the Act. Please note that CMS recently changed the name of the Survey & Certification Group to the Quality Safety and Oversight Group, thus the memos will now be called QSO memos rather than S&C memos.

The PA Health Care Facilities Act requires the PA Department of Health (DOH) to regulate the licensing and State survey process of Long-Term Care Facilities. A facility must complete only a state survey process of it does not receive either Medicare or Medicaid funding. The federal Survey Protocol for Long-Term Care Facilities and Guidance to Surveyors for Long-Term Care Facilities are found on the DOH website. Section 817 of the PA Health Care Facilities Act includes information on state civil penalties (CPs) for deficiencies.

Sources of Additional Information:

- CLICK HERE to access the Pennsylvania Code Title 28 (Health and Safety) Regulations and current Appendixes P (contents erased and reserved for future use) & PP from the State Operations Manual related to Federal Nursing Home Regulations, effective Nov. 28, 2017
- CLICK HERE to view the interpretive guidelines for state regulations
- CLICK HERE to access the Pennsylvania Health Care Facilities Act
- CLICK HERE to access the DOH Message Board website for important messages from the Division of Nursing Care Facilities
- CLICK HERE to access DOH's Provider Bulletins
- CLICK HERE to read the interim final rule (81 FR 61537) on CMPs published on June 30, 2016
- CLICK HERE to view the CMS webpage on the annual CMP Adjustments
- CLICK HERE to view the annual CMP inflation adjustment regulation published on Feb. 3, 2017
- CLICK HERE to read the July 7, 2017 S&C Memo 17-37-NH, which discusses CMPs and the analytic tool
- CLICK HERE to read the CMP Analytic Tool User's Guide
- CLICK HERE to read LeadingAge's summary of the S&C Memo 17-37-NH and the CMP Analytic Tool
- CLICK HERE to read S&C (now QSO) Memo 18-18-NH, Final Revised Policies Regarding the Immediate Imposition of Federal Remedies, which replaces S&C Memos 18-01-NH and 16-31-NH

Life Safety & Fire Safety

Summary:

CMS has adopted the National Fire Protection Association's (NFPA) 2012 edition of the Life Safety Code (LSC) as well as provisions of the NFPA's 2012 edition of the Health Care Facilities Code. The rule covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The 2012 LSC includes important changes from the 2000 edition of the LSC.

Sources of Additional Information:

- CLICK HERE to read the Fire Safety Requirements final rule (81 FR 26871) published by CMS on May 4, 2016
- CLICK HERE for a summary of the final rule prepared by LeadingAge
- CLICK HERE for CMS's announcement that it will begin surveying for compliance with the 2012 LSC and HCFC on November 1, 2016 and see below for deadline extension for fire door testing
- CLICK HERE for CMS Survey and Certification memo 17-38-LSC clarifying requirements for the annual inspection and testing of fire doors and extending the deadline for compliance by six months from July 6, 2017 to January 1, 2018 and CLICK HERE for LeadingAge summary.
- CLICK HERE for LeadingAge summary of issue with time limited waivers for compliance with new LSC
- CLICK HERE to read the PA Code (Ch. 209) Fire Protection And Safety Programs For Long-Term Care Nursing Facilities

Important Dates and Deadlines:

- Jan.1, 2018: New effective date for annual inspection and testing of fire doors
- Sept. 21, 2016: Effective date for carbon monoxide detectors to be required in personal care homes, assisted living residences, and nursing facilities (2016 Act 48)

Resident Assessment Process

Summary:

The Minimum Data Set (MDS) is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment tool is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for Medicare reimbursement, Pennsylvania's Medicaid reimbursement system, and the monitoring the quality of care provided to residents.

The Resident Assessment Instrument (RAI) consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.

Sources of Additional Information:

- CLICK HERE to access the Resident Assessment Instrument (RAI) Manual v1.15R, effective Oct. 1, 2017
- CLICK HERE to view LeadingAge (national) summary of v1.15R changes in three key areas of MDS
- CLICK HERE to view CMS' web page for RAI Manual updates and information
- CLICK HERE to view CMS' MDS technical specifications and updates, including the draft version of the MDS to be implemented Oct. 1, 2018.

NURSING FACILITIES

Licensing, Certification, Other

Payroll Based Journal Reporting

Summary:

The Centers for Medicare & Medicaid Services (CMS) has developed a new system for facilities to submit staffing and census information called Payroll-Based Journal (PBJ). Effective July 1, 2016, nursing facilities must electronically submit direct care staffing information, including information for agency and contract staff, based on payroll and other auditable data according to specifications established by CMS. PBJ data will be incorporated into Nursing Home Compare and the Five-Star Quality Rating System in 2018.

FISCAL QUARTER	REPORTING PERIOD	DUE DATE
1	October 1 –December 31	February 14
2	January 1 –March 31	May 15
3	April 1 –June 30	August 14
4	July 1 –September 30	November 14

Sources of Additional Information:

- CLICK HERE to view CMS Survey and Certification memo 17-25-NH for background on PBJ
- CLICK HERE to visit the CMS PBJ webpage, where the agency has posted its PBJ policy manual, frequently asked questions, technical specifications, system registration information and more.
- CLICK HERE to read QSO Memo 18-17-NH on how CMS will transition to PBJ staffing measures on Nursing Home Compare and the Five Star Quality Rating System, and information on PBJ audits

Important Dates and Deadlines:

- Apr. 2018: CMS began using PBJ for Nursing Home Compare and the Five Star Quality Rating System
- June 2018: CMS no longer collects facility staffing data through the CMS-671 form
- July 2018: Nursing homes reporting 7 or more days in a quarter with no RN hours began receiving a one-star rating in the staffing domain
- July 2018: CMS began posting the number of hours worked by other staff (i.e., non-nursing)

Nursing Home Compare & PA Nursing Facility Location Tool

Summary:

Nursing Home Compare is a service provided by Medicare.gov that allows consumers to compare information about nursing homes. It contains quality of care and staffing information for the more than 15,000 Medicare- and Medicaid-participating nursing homes. The Pennsylvania Department of Health has created a tool to search for and compare nursing facilities throughout the Commonwealth. The tool includes information provided on each facility, access to survey results and additional services, and the option to compare facilities based on State inspections over the previous 30-month period.

Sources of Additional Information:

- CLICK HERE to visit the Medicare.gov Nursing Home Compare website
- CLICK HERE to view the PA Nursing Facility Locator and Information website

Important Dates and Deadlines:

- July 2018 updated claims-based quality measures reported on the Nursing Home Compare website
- July 2018: CMS began providing rates of hospitalizations for long-stay residents in each facility's confidential *Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report.*
- Oct. 2018: the long-stay hospitalization measure posted on the Nursing Home Compare website
- Spring 2019: long-stay hospitalization measure included in the Five Star Quality Rating System

NURSING FACILITIES

Licensing, Certification, Other

Five-Star Quality Rating System

Summary:

In December 2008, The Centers for Medicare & Medicaid Services (CMS) added a set of quality ratings to its *Nursing Home Compare* public reporting site for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to make meaningful distinctions between high and low performing nursing homes. In June, 2017, CMS announced it would hold the Nursing Home Compare health inspection rating constant for health inspections conducted between Nov. 28, 2017 and Nov. 28, 2018 as it implemented its new survey system.

Sources of Additional Information:

- CLICK HERE to access the Five-Star Technical User's Guide
- CLICK HERE and scroll down to access documents and data related to the Five-Star Quality Rating System, including the most recent Technical User's Guide, The State-Level Cut Points, and technical specifications for the six new measures established in 2016
- CLICK HERE to view Survey and Certification Memo 17-36-NH announcing that CMS will be holding constant the Nursing Home Compare health inspection rating for one year while providing limited enforcement remedies for certain Phase 2 provisions of the Requirements of Participation final rule

Important Dates and Deadlines:

- Nov. 28, 2017 – Nov. 28, 2018 Nursing Home Compare health inspection rating will be held constant as CMS implements its new survey system
- Apr. 2018: CMS replaced the staffing measures based on the CMS 671 form and case mix based on RUG-III with PBJ data, resident census derived from MDS assessments and case mix based on RUG-IV
- July 2018: CMS began applying a 1-star rating to facilities that do not report PBJ data, facilities that submit staffing data indicating that there were seven or more days in the quarter with no RN staffing but on which there were one or more residents in the facility; and facilities that do not respond to PBJ audit requests.
- July 2018: CMS began providing rates of hospitalizations for long-stay residents in each facility's confidential *Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report.*
- Spring 2019: long-stay resident hospitalization measure will be included in the Five Star Quality Rating System.

NURSING FACILITIES

Licensing, Certification, Other

Skilled Nursing Facility Quality Reporting Program

Summary:

The IMPACT Act mandates a quality reporting program (QRP) for skilled nursing facilities. For federal fiscal year 2018 (FY18), SNFs that do not report required quality data to CMS will have their market basket updates reduced by two percent. CMS has finalized three measures affecting payment in FY18 and beyond: (1) falls with major injury; (2) pressure ulcers that are new or worsened; and (3) assessments and care planning relating to a resident's level of function. CMS has proposed three additional measures affecting payment in FY2018 and beyond: (4) Medicare spending per beneficiary-post acute care, (5) discharge to community; and (6) potentially preventable readmissions. CMS has proposed a seventh measure – drug regimen review – that may affect payment beginning in FFY2019, which begins Oct. 1, 2018.

In August 2017, CMS discovered two issues with the QRP submissions and announced an extension of the data submission deadlines, stating that all data for assessment-based measures required in the SNF QRP in CY2017 would remain open to modifications until May 15, 2018. CMS sent notices of noncompliance in July 2018 and facilities had until Aug. 7, 2018 to request that CMS reconsider. Facilities must report quarterly throughout the calendar year. For example, for FFY 2020, ,

Jan. 1, 2018 – March 31, 2018

Sources of Additional Information:

- CLICK HERE to view CMS' quick reference guide to the QRP, released Sept. 2017
- CLICK HERE to view CMS Fact Sheet regarding QRP for federal fiscal year (FFY) 2019 beginning Oct. 1, 2018 payment information, based on calendar year 2017 data.
- CLICK HERE for an overview of the QRP Program for FFY 2020, with contacts, measure specifications, reporting dates, etc.
- CLICK HERE for 2017 data submission deadline (May 15, 2018 for all quarters) for FY 2019 QRP
- CLICK HERE for the measures, reporting timeframes, and data submission deadlines for FY 2020 QRP
- CLICK HERE to visit the CMS SNF QRP webpage, which includes an overview of the program and technical specifications for the adopted and proposed measures
- CLICK HERE to view Chapter 13 of the CASPER Reporting MDS User's Guide which describes how to report data for the SNF QRP

Important Dates and Deadlines:

- May 15, 2018: SNF QRP data on measures for CY 2017 Q1, Q2, Q3, and Q4 will have a single submission deadline of May 15, 2018 (deadline for CY2017 Q4) for SNF QRP FY 2019
- Aug. 7, 2018 – requests for reconsideration due to CMS
- Aug. 15, 2018: Quarter 1 reports due (Jan. 1 - Mar. 31, 2018)
- Nov. 15, 2018: Quarter 2 reports due (Apr. 1 – June 30, 2018)
- Feb. 15, 2019: Quarter 3 reports due (July 1 – Sept. 30, 2018)
- May 15, 2019: Quarter 4 reports due (Oct. 1 – Dec. 31, 2018)

NURSING FACILITIES

Licensing, Certification, Other

CASPER

Summary:

The Certification and Survey Provider Enhanced Reporting (CASPER) system and the Quality Improvement Evaluation System (QIES) became effective in July 2012 to replace the Online Survey Certification and Reporting (OSCAR) system. CASPER/QIES survey data is used to support the survey and certification of long-term care providers. CASPER data is updated every Monday with all current submissions through the previous week.

Sources of Additional Information:

- CLICK HERE to view the CASPER reporting guide

PEPPER

Summary:

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a facility's compliance efforts by identifying where it is an outlier for these risk areas.

Sources of Additional Information:

- CLICK HERE to visit the PEPPER Resources webpage
- CLICK HERE to view the PEPPER distribution schedule

Hospital Discharge Planning Requirements

Summary:

CMS has issued a proposed rule that would require hospitals to assist patients in selecting a post-acute care provider by using and sharing SNF quality measures data. For patients enrolled in managed care, if the hospital has information regarding which providers participate in the managed care organization's network, it must share this information with the patient.

Sources of Additional Information:

- CLICK HERE to review the proposed rule published by CMS.
- CLICK HERE to read a summary and commentary on the proposed rule prepared by LeadingAge.
- CLICK HERE to read PA Code 028 Chapter 105 Admission and Discharge

Important Dates and Deadlines:

- Nov. 2015: CMS Published Proposed Rule
- Expected Date for CMS to Release Final Rule: unknown

Nursing Home Transition

Summary:

The Nursing Home Transition (NHT) Program assists consumers who want to move from a nursing facility to a home of their choice in the community. NHT provides individuals with information on all long-term services and supports options, including home and community-based services (HCBS).

Sources of Additional Information:

- CLICK HERE to view the DHS webpage for providers on the NHT Program
- CLICK HERE to read the OLTL Bulletin on NHT Program Changes effective 12/1/2016

NURSING FACILITIES

Medicare

Skilled Nursing Facility Medicare Prospective Payment System (SNF PPS)

Summary:

Skilled Nursing Facilities (SNFs) are paid on the basis of a prospective payment system (PPS). The PPS payment rates are adjusted for case mix and geographic variation in wages to cover the costs of furnishing covered SNF services. SNFs use a per diem PPS that covers all costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. CMS has published a final rule that will implement a new payment system called Patient Driven Payment Model (PDPM) to begin on Oct. 1, 2019. The rule also makes updates to the Quality Reporting Program (QRP) and Value-Based Purchasing Program (VBP).

Sources of Additional Information:

- CLICK HERE to read the CMS Final Rule for FFY 2019
- CLICK HERE to read the LeadingAge summary of the Final Rule regarding QRP and VBP
- CLICK HERE to read LeadingAge's summary of PDPM in the proposed rule and HERE for a discussion of the final rule and LeadingAge educational materials on the Learning Hub
- View CMS' Provider Specific Impact Analysis of the proposed PDPM
- CLICK HERE to view the CMS webpage on SNF PPS

Medicare Overpayments Rule

Summary:

CMS has implemented a rule implementing the Affordable Care Act (ACA) requirement to identify and return Medicare overpayments to CMS within 60 days. Providers, including Skilled Nursing Facilities, are required to use "reasonable diligence" to identify overpayments and to see that they are returned within the time frame to avoid penalties.

Sources of Additional Information:

- CLICK HERE to read the Medicare Program; Reporting and Returning of Overpayments; Final Rule published Feb. 12, 2016
- CLICK HERE for a summary of the rule from LeadingAge

Important Dates and Deadlines:

- Providers must have processes to identify and return overpayments within 60 days

Medicare SNF Value-Based Purchasing

Summary:

This program will begin with the rate year starting on October 1, 2018. In the first year, the only quality measure used will be 30-day all cause readmission rates (both the overall rate and improvement by each facility). The first measurement period will be calendar year 2017. The system is designed as a 2 percent withhold of SNF Part A payments that can be earned back based on readmissions scores.

Sources of Additional Information:

- CLICK HERE to see the FY2017 Medicare SNF PPS Rule (released Aug. 5, 2016) with details on VBP
- CLICK HERE to read the CMS Final Rule for FFY 2018, and HERE for the FFY 2019 final rule updates
- CLICK HERE to read the LeadingAge summary of the VBP changes in the SNF PPS FFY 2019 Final Rule
- CLICK HERE to view the CMS web site page on SNF VBP

Important Dates and Deadlines:

- Calendar Year 2017: Readmission penalty measurement period
- Oct. 1, 2018: First Rate Year Impacted by VBP
- Transition to a "potentially preventable" readmission measure in the future

NURSING FACILITIES

Medicare

Medicare Shared Savings Program

Summary:

Accountable Care Organizations (ACOs), typically led by health systems or physician groups, are the entities that enroll in the shared savings program and are judged based on the cost and quality of services provided to an assigned population. ACOs that meet quality goals and produce savings in Medicare costs (including post-acute costs) receive shared savings payments. Some shared savings models include risk for the ACO and can result in payments owed to CMS if costs increase.

Sources of Additional Information:

- CLICK HERE to see the CMS web site page on the shared savings program.

Bundled Payments for Care Improvement

Summary:

This model tests four voluntary models of bundled payment for episodes of care that include hospitals, physicians and/or post-acute care. Since the program started on Oct. 1, 2013, more than 1,500 providers, including almost 700 nursing facilities, have participated in bundled payments. The goals of the program include better coordination of care, reduced costs and improved outcomes for patients. There are 117 Health Care facilities in PA where models are being tested.

Sources of Additional Information:

- CLICK HERE to see the CMS web site page on the voluntary bundling model.
- CLICK HERE for details about the bundling process and participation by provider types.
- CLICK HERE to read LeadingAge PA's information sheet on Bundling Payments

Bundled Payments: Comprehensive Care for Joint Replacement

Summary:

The Comprehensive Care for Joint Replacement (CCJR) model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. CMS implemented this model in 67 Metropolitan Statistical Areas (MSAs). Three of the MSAs in the mandatory demonstration are in Pennsylvania: Harrisburg-Carlisle, Pittsburgh, and Reading.

On Dec. 1, 2017, CMS issued a final rule that revised the CCJR model, giving certain hospitals selected for participation in the CCJR model a one-time option to choose whether to continue their participation in the model. The CJR model will automatically terminate for participant hospitals located in the 33 voluntary participation MSAs, low volume hospitals, and rural hospitals as of February 1, 2018 UNLESS these hospitals notify CMS of their election to continue their participation in the CJR model.

Sources of Additional Information:

- CLICK HERE to see the CMS web site page on the Comprehensive Joint Replacement bundling model
- CLICK HERE to view Final Rule that makes CCJR voluntary
- CLICK HERE for details about how the bundling process works from a provider perspective.

Important Dates and Deadlines:

- 2016 to 2020: Model continues to be used in chosen MSAs
- Dec. 1, 2017: Final rule issued to make CCJR Model optional, establish opt-in process
- Jan. 1 – 31, 2018: Opt-in period for hospitals that wish to continue to participate in the CCJR model

NURSING FACILITIES

Medicare

Status of EPMs, CR and CCJR Bundling Models, BPCI Advanced

Summary:

On July 25, 2016, CMS proposed three new models that continued the trend of episodic payment demonstrations for Medicare reimbursement. These three models included two new cardiac conditions, heart attack and bypass surgery, and expanded the previously established hip and knee joint replacement by adding hip and femur fracture surgeries to the Comprehensive Care for Joint Replacement (CCJR) Model. On Mar. 20, 2017, CMS issued an Interim Final Rule delaying the effective date of these new models, a proposed rule on Aug. 17, and a final rule on Dec. 1, 2017 canceling the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model and rescinding the regulations governing these models. The final rule also revises certain aspects of the Comprehensive Care for Joint Replacement (CCJR) model, noted above. On Jan. 9, 2018, CMS announced a new voluntary bundled payment model called Bundled Payments for Care Improvement Advanced (BPCI Advanced), which includes outpatient bundles and qualifies as an Advanced Alternative Payment Model under the Quality Payment Program. LeadingAge (national)'s preliminary research indicates that Post-Acute Care Providers may not be able to lead the bundle.

Sources of Additional Information:

- CLICK HERE to read the Jan. 3, 2017 final rule establishing the programs
- CLICK HERE to read the May 19, 2017 final rule delaying the effective date to Jan. 1, 2018
- CLICK HERE to view the Aug. 17, 2017 proposed rule to cancel the EPM and CR programs
- CLICK HERE for Dec. 1, 2017 final rule canceling EPM and CR models, making changes to CCJR.
- CLICK HERE for the LeadingAge Guide to the New CMS Bundled Payment Models
- CLICK HERE for CMS' announcement of the new BPCI-Advanced model, with links to the application.

Important Dates and Deadlines:

- Jan. 3, 2017: Final rule published
- Dec. 1, 2017: Final Rule proposed to cancel the EPM and CR programs, revise CCJR
- Jan. 9, 2018: CMS announced voluntary BPCI-Advanced

New Medicare Number

Summary:

CMS removed Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In April 2018, Medicare providers were ready for the change from the Social Security Number-based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number).

Sources of Additional Information:

- CLICK HERE to view the CMS provider webpage on the new Medicare Cards.
- CLICK HERE to see CMS guidance on how to discuss the new card with Medicare patients.
- CLICK HERE for CMS' Medicare Card homepage.

Important Dates and Deadlines:

- Apr. 1, 2018 – New Medicare Cards implemented for all Medicare beneficiaries

NURSING FACILITIES

Medicaid

Medicaid Nursing Facility Reimbursement

Summary:

The PA Department of Human Services (DHS) implemented 55 Pa. Code Chapter 1187: Nursing Facility Services; Case-Mix Reimbursement System, on January 1, 1996. These regulations outline the primary Medical Assistance (MA) payment methodology for nursing facilities in Pennsylvania. The Resident Data Reporting Manual provides further explanation of the payment system. PA also has a separate nursing facility provider assessment (NFA). Medicaid reimbursement is changing due to the phase-in of Community HealthChoices, the Commonwealth's mandatory managed care program for long-term services and supports.

Sources of Additional Information:

- CLICK HERE to read 55 PA Code Chapter 1187 Subchapter G Rate Setting
- CLICK HERE to read 55 PA Code Chapter 1189 Subchapter D Rate Setting for County Nursing Facilities
- CLICK HERE to view the DHS Case-Mix Rates page
- CLICK HERE to view the DHS website on Medicaid Payment Information
- CLICK HERE to view the NF Report Portal for information on MA cost and resident data reporting
- CLICK HERE to view the DHS NFA page that includes important dates and the NFA End User Manual

Community HealthChoices (CHC)

Summary:

Community HealthChoices (CHC) is PA's mandatory managed care program through which participants will receive Medical Assistance (MA) physical health services and Long-Term Services and Supports (LTSS). CHC will use Managed Care Organizations (MCOs) to coordinate the physical health, behavioral health, and long-term services needs of participants, with the goal of improving access, efficiency, and quality to qualifying populations.

Sources of Additional Information:

- CLICK HERE to view the DHS website on CHC
- CLICK HERE to view LeadingAge PA's website on CHC
- CLICK HERE to view the DHS presentations for the Phase 2 CHC Provider Summits held in June 2018
- CLICK HERE to view the LeadingAge summary on the Federal Medicaid and managed care final rule

Important Dates and Deadlines:

- Jan. 1, 2018 – Phase 1 implemented in Southwest PA
- Jan. 1, 2019 – Phase 2 implemented in Southeast PA
- Jan. 1, 2020 – Phase 3 implemented in the remaining parts of the state (Northwest, Lehigh/Capital area, and Northeast)

PERSONAL CARE HOMES (PCH)

Personal Care Homes (PCH)

Summary:

Pennsylvania Personal Care Homes are designed to provide safe, humane, comfortable, and supportive residential settings for adults who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision with activities of daily living. Residents who live in personal care homes receive assistance to develop and maintain maximum independence and self-determination. Personal Care Homes are inspected and licensed by the Department of Human Services (DHS) under the requirements contained in 55 Pa.Code Chapter 2600 (PCH).

Sources of Additional Information:

- CLICK HERE to read 55 Pa.Code Chapter 2600 (PCH) and the Regulatory Compliance Guide (RCG)
- CLICK HERE to see the PA Department of Human Services webpage about Personal Care Homes
- CLICK HERE to read the Regulatory Questions and Answers for Personal Care Homes
- CLICK HERE to view the Influenza Vaccine posting requirements (2016 Act 173) and poster
- CLICK HERE to access DHS Bureau of Human Services Licensing (BHSL) information on the Carbon Monoxide Detector Act, including a copy of the Act.
- CLICK HERE for additional guidance from BHSL on Carbon Monoxide Detectors

GENERAL

ACO Quality Measures and Performance

Summary:

Before an Accountable Care Organization (ACO) can share in any savings generated, it must demonstrate that it met the quality performance standard for that year. The 33 current quality measures span four quality domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. Skilled Nursing Facility (SNF) hospital readmission rates is one of the measures used.

Sources of Additional Information:

- CLICK HERE to see the CMS web site page on the quality measures and performance standards
- CLICK HERE for details about the calculation of the measures

Important Dates and Deadlines:

- Reporting Year 2015: 33 measures used
- 2016 and 2017: 34 measures used
- 2018 and beyond: additional measures could be added

Medicare Advantage (MA) Star Ratings

Summary:

Each year, the Centers for Medicare & Medicaid Services (CMS) conducts a comprehensive review of the measures that make up the Star Ratings for Medicare Advantage Prescription Drug contracts, Medicare Advantage-only contracts, and stand-alone Prescription Drug Plan Contract. CMS considers the reliability of the measures, clinical recommendations, feedback received from stakeholders, and data issues. The Star Ratings measures span five broad categories including outcomes, intermediate outcomes, patient experience, access and process.

Sources of Additional Information:

- CLICK HERE to view the CMS 2017 Star Ratings Fact Sheet posted Oct. 12, 2016.

GENERAL

OSHA Tracking of Workplace Injuries/Illnesses, DOL Penalty Increases

Summary:

Finalized May 12, 2016, this Occupational Safety and Health Administration (OSHA) rule calls for electronic submission of injury and illness reports, and states that reports will be posted in a publicly accessible website. It also includes provisions requiring employer policies to support prompt and accurate reporting. The rule impacts commonly used incentive programs that may deter reporting of illnesses or injuries, and affects employers' ability to perform post-accident and post-injury drug and alcohol testing. Please Note: In a proposed rule, OSHA stated its intention to delay the July 1, 2017 compliance date for the electronic submission of the 2016 Form300A report of injuries and illnesses until December 1, 2017. The agency also stated that it intends to issue a separate proposal to "reconsider, revise or remove other provisions" of the 2016 final rule. In December, OSHA moved back the deadline for submitting these forms to Dec. 15, then to Dec. 31, 2017. On July 30, 2018, OSHA published a proposed rule indicating it may make changes to limit the information to be reported electronically by certain employers.

The DOL published a Final Rule on Jan. 2, 2018, to adjust for inflation the civil monetary penalties (CMPs) assessed or enforced in its regulations, as required by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. The Final Rule multiplies by 1.02041 the penalties imposed by the Interim Final Rule published on July 1, 2016 in which civil penalties for DOL agencies, including OSHA, were increased substantially for penalties assessed on or after Aug. 1, 2016. The updated CMPs apply to penalties assessed after Jan. 2, 2018, if violations occurred after Nov. 2, 2015.

Sources of Additional Information:

- CLICK HERE to read the final rule published by OSHA for electronic reporting
- CLICK HERE to read the proposed rule delaying the compliance date for electronic reporting
- CLICK HERE to read OSHA announcement delaying the compliance deadline for electronic reporting
- CLICK HERE to read an OHSA Fact Sheet about the Final Rule for electronic reporting
- CLICK HERE to read a LeadingAge article on OSHA's proposal to limit information to be reported electronically
- CLICK HERE to read the LeadingAge Summary on OSHA Penalties Increase
- CLICK HERE to read the DOL Final Rule adjusting CMPs for inflation

Important Dates and Deadlines:

- Dec. 31, 2017: Updated effective date for tracking of workplace injuries/illnesses reporting
- Jan. 2, 2018: Effective date of Final Rule updating DOL CMPs for inflation

Emergency Preparedness Requirements

Summary:

This federal rule establishes emergency preparedness requirements for Medicare and Medicaid providers. The goal is for providers to prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations. Requirements address development of an emergency plan based on a risk assessment; policies and procedures based on the plan and risk assessment; and a communication plan that ensures coordination of care within the facility and with external providers and emergency systems; and training and testing. Nursing Facilities, Home Health, Hospice, and LIFE programs must comply with this rule.

Sources of Additional Information:

- CLICK HERE to read the Emergency Preparedness final rule (81 FR 63859) published Sept. 16, 2016
- CLICK HERE to access LeadingAge PA's Emergency Preparedness web page
- CLICK HERE to read more information from CMS on the final rule, including sample transfer agreements, FAQs, an advance copy of Appendix Z (CMS' interpretive guidance), online training for surveyors, and links to local health care coalitions
- CLICK HERE to access the ASPR-TRACIE Healthcare Emergency Preparedness Information Gateway
- CLICK HERE to access description and contacts for Pennsylvania's Health Care Coalitions, which can assist in planning as a community for emergency response

GENERAL

Nondiscrimination Rule (ACA Section 1557)

Summary:

The U.S. Department of Health and Human Services, Office of Civil Rights, has finalized a regulation that implements nondiscrimination provisions enacted as part of the Affordable Care Act of 2010. Those provisions state that an individual shall not be discriminated against under any health program or activity that receives federal financial assistance (e.g., Medicare and Medicaid) on the basis of race, color, national origin, sex, age or disability. Most notably, the final rule prohibits discrimination against transgendered persons as a form of sex discrimination and includes requirements regarding translated materials to participants with limited English proficiency. The regulation became effective July 18, 2016.

Sources of Additional Information:

- CLICK HERE to access the Office of Civil Rights summary and fact sheets, and a link to the final rule.
- CLICK HERE to review a summary of the final rule prepared by LeadingAge.

Important Dates and Deadlines:

- May 13, 2016: CMS issued final rule.
- July 18, 2016: Final rule took effect.

Hazardous Pharmaceutical Waste Disposal

Summary:

The U.S. Environmental Protection Agency (EPA) has proposed a rule that would increase regulations regarding disposal of pharmaceuticals classified as hazardous waste. The rule argues that long-term care facilities should be subject to more stringent requirements, including that facilities would be prohibited from disposing of hazardous waste pharmaceuticals by flushing them down the toilet or into a drain. The rule applies to assisted living facilities, hospices, nursing homes, skilled nursing facilities, and the assisted living and skilled nursing care portions of continuing care retirement facilities.

Sources of Additional Information:

- CLICK HERE to read the proposed rule published by the EPA.
- CLICK HERE to read a summary of the rule prepared by LeadingAge.
- CLICK HERE to access the EPA webpage on requirements for pharmaceutical hazardous waste.

Important Dates and Deadlines:

- Sept. 2015: EPA Published Proposed Rule
- Publication of Final Rule expected in 2017; not published as of Oct. 2017

GENERAL

Older Adults Protective Services Act (OAPSA) and Adult Protective Services

Summary:

The Department of Aging is responsible for oversight and implementation of the Older Adults Protective Services Act (OAPSA) for individuals over the age of 60. The Act has been amended to include mandatory abuse reporting and criminal history background checks for specific types of facilities, including nursing facilities, older adult daily living centers, personal care homes, assisted living residences, domiciliary care homes, and home health agencies.

In *Peake v. Commonwealth of Pennsylvania, et al., 216 M.D. 2015* the Commonwealth Court held that it is unconstitutional for the offenses listed in the Older Protective Services Act to result in a lifetime employment ban without further evaluation. The PA Department of Aging website notes that Background Checks are still required and provides additional guidance in light of the decision.

Sources of Additional Information:

- CLICK HERE to view the PA Department of Aging website on OAPSA
- CLICK HERE to read the Older Adults Protective Services Act
- CLICK HERE to read 6 Pa.Code Chapter 15 (Protective Services For Older Adults)
- CLICK HERE for information on the Adult Protective Service Act (Act 70 of 2010)

Medical Cannabis

Summary:

Pennsylvania's Medical Marijuana Program was signed into law on April 17, 2016. The program is now operational, allowing Pennsylvanians with serious medical conditions that are identified in Act 16 to have access to medical marijuana.

Sources of Additional Information:

- CLICK HERE to read Act 16, Medical Marijuana Act
- CLICK HERE for the PA Department of Health's website on the Medical Marijuana Program

Important Dates and Deadlines:

- Apr. 17, 2016: Act 16 signed into law
- 2018: Program to be operational