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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Long-Term Care Facilities: Reform of Requirements Call
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements and Introduction

Hazeline Roulac: Thank you, Holley.

Good afternoon, everyone. I am Hazeline Roulac from the Provider Communications Group here at CMS. I am your moderator today. Welcome to this MLN Connects National Provider Call on the Long-Term Care Facilities Reform of Requirements. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, we will discuss the final rule to reform the requirements for long-term care facilities. These requirements are the Federal health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid program. You will hear about the changes included in the final rule, the implementation and survey process, and provider training and resources. A question-and-answer session will follow the presentation.

Before we begin, I have a few announcements.

There is a slide presentation for this call. You should have received the link to the presentation in your registration emails. If you have not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc—that's go.cms.gov/npc—and select today's call from the list and click on the slide presentation under Call Materials.

Last, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. You will receive an email when these are available.

At this time, it is my pleasure to turn the call over to our first presenter, Sheila Blackstock. Sheila?

Presentation

Sheila Blackstock: Thank you.

Good afternoon, everybody. As Hazeline said, I'm Sheila Blackstock, and I'm the Deputy Director of the Clinical Standards Group. With me today, I have Lisa Parker, who is the Director of the Division of Institutional Quality Standards; Ronisha Blackstone and Diane Corning, who are members of the Long-Term Care team; and Karen Tritz and Evan Shulman, who are the Director and the Deputy Director of the Division of Nursing Homes in our Survey and Certification Group.

We thank you for joining us today, and we hope you find our presentation helpful. We appreciate in particular the questions that people submitted in advance of this call, and we thank everybody who took the time to do so. We will do our best to answer those questions throughout our presentation and during a question-and-answer period at the end of the call. We also will answer some questions from the audience as time permits.

Background

Let me start with a little bit of background and some overarching information about this rule, and then Karen and Evan will follow with more detail. I will be starting at slide 4, and this provides some background.

As Hazeline mentioned, the requirements for long-term care facilities are the health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid programs. It's important to remember that these standards generally apply to all residents in a nursing home and just not to Medicare or Medicaid residents.

The requirements for participation can be found at 42 CFR 483 Subpart B. And that's the *Code of Federal Regulations*, and that is publicly available online. Additional guidance can also be found in the State Operations Manual, Appendix PP. And that's also available online. And you'll get some more information related to that later in this presentation.

I should note that we have found some incorrect cross-references in the final rule. So, some of you noted that in the Q&As that you submitted. We are aware of that. And we will be doing what we need on our part to make sure that necessary corrections are made. So, that will be forthcoming.

In terms of more background—I'm moving on to slide 5—the changes to the long-term care requirements of participation and the impetus that set us to carry this out. The requirements hadn't been updated comprehensively since 1991 despite significant changes in the industry. We issued a proposed rule last July. And it received over 9,800 public comments, which resulted in a number of revisions to those proposed requirements and that you see in the final rule. The finalized provisions reflect advances in the theory and practice of service delivery and safety and implement sections of the Affordable Care Act.

Moving on to slide 6. When we wrote this rule, there were a number of things that we had in mind, a number of themes. Perhaps first and foremost are person-centered care and quality. And these reflect our understanding that both facilities and resident populations in the long-term care setting are very diverse. So, everything we did, we tried to remember that as we did it.

Based on that, we took a facility assessment competency-based approach that helped, we believe, focus on the populations of the individual facilities. We also worked to align with other HHS priorities because we know there are multiple activities going on out there. And we wanted to ensure that it was a comprehensive review and modernization based on the fact that the requirements hadn't been updated in so long. And, finally, it was necessary to implement certain pieces of legislation.

In terms of person-centered care, the things we kept in mind were residents and representatives. We wanted them to be informed, involved, and in control. So, based on feedback we had received, we maintained existing protections. We wanted to ensure that residents had choices. We wanted to focus on care planning and discharge planning to make sure that that was completed with a person-centered perspective. And we prohibited pre-dispute binding arbitration agreements and established requirements for post-dispute binding arbitration agreements to ensure that residents were aware of the choice that they were making.

Moving on to slide 8. In terms of quality, we focused on quality of care and quality of life as overarching principles for every service that is delivered in the nursing home. And both of these are very important. In terms of quality of life and quality of care, some things that we did were looking at additional special issues related to these -- so, restraints, pain management, bowel incontinence, dialysis services, and trauma-informed care.

In terms of quality assurance and performance improvement, I think everybody is aware that there had been a previous pilot related to quality assurance and performance improvement. There have been resources out there. This was part of the ACA legislation. And so what we developed in the rule was really based on that pilot. And we would note that there are a lot of resources available for providers in implementing QAPI. And the website is on the slide, slide number 8.

Next, we looked at the facility assessment and competency-based approach. And, again, this was something that was pervasive throughout the regulation. We want to make sure that facilities know themselves, know their staff, and know their residents because that is how you best achieve person-centered care. We recognize that one-size-fits-all approach was not the best way to go. And we wanted to account for and allow for diversity in both populations and facilities. We want to focus on each resident achieving their highest practicable physical, mental, and social -- psychosocial well-being. And that is consistent with the statute.

Next, we move on to slide 10. We note we wanted to align with current HHS initiatives. And we have listed here several of those initiatives. So things like reducing unnecessary hospital readmissions, reducing the incidents of health-care-acquired infections, improving behavioral health care, and safeguarding nursing home residents from the use of unnecessary psychotropic medications.

Finally, comprehensive review and modernization and really bringing these rules into the 21st century. They were reorganized. They were updated. And we wanted to make them consistent with current health and safety knowledge.

As we noted, this rule also was intended to implement several pieces of legislation. And we have listed each of the specific sections of the Affordable Care Act as well as the IMPACT Act. I would note the address that those address so you -- and that are in the

final regulation include compliance and ethics, as I mentioned previously, quality assurance and performance improvement, requirements relating to reporting suspicions of crimes. And that had -- there had been a previous survey and certification letter on that issue that we largely paralleled in establishing the final rule.

And, then, dementia -- requiring dementia and abuse training. As everybody knows, dementia is becoming an ever-increasing issue in nursing homes. And so that was very important. And, finally, Section 2 of the IMPACT Act, which addressed discharge planning requirements.

Having given you this background information, I'm now going to turn it over to Karen Tritz. And she's going to go over some of the more detailed information you all are probably waiting for.

Final Rule Details and Phase-In Implementation

Karen Tritz: Thanks, Sheila. I very much appreciate that.

Hi. This is Karen Tritz. I'm going to be talking with you today about – we're going to be walking through each section of the regulation. I'll hit the highlights and I'll also talk a little bit about the phase-in implementation of each of these sections. So, I am starting on page 13.

The -- just as a background, as you probably know if you've looked at any of the public comments, the phase in of implementation or the length of time that providers would be given to implement the rule was a significant concern. And we received a lot -- the agency received a lot of public comments of that.

And the final rule establishes three phase-in periods starting -- the first phase is 60 days, which is the effective date of the regulation. Phase 1 requirements include primarily existing requirements -- so those requirements that are carried forward from the existing rule, those requirements that are relatively straightforward to implement and require minor changes to the survey process. So, that is -- that due date is about -- or effective date is about a month from now.

The second phase, Phase 2, will include all Phase 1 requirements and, then, those requirements where we think providers will need more time to develop policies and

procedures, they're foundational elements such as the facility assessment that Sheila talked about that really carry throughout the final rule, that the expectations that the different services provided are based on a facility assessment -- and that's effective in Phase 2.

And, then, we're also going to be talking today a little bit about the new survey process that will assess compliance with the requirements and we will -- that we will be rolling out at the same time. And we included those elements in Phase 2 that really needed a new survey process to appropriately identify compliance with those areas.

And, then, there's a number of requirements that were moved to Phase 3, which is -- the due date for that is November 28, 2019, which includes -- at that point, it will include all Phase 1 and Phase 2 requirements and, then, those requirements that need more time for facilities to implement. So, areas there include some of the personnel hiring and training related to the Infection Preventionist, implementation of systems' approaches to quality where the QAPI plan would be effective in Phase 2, but the actual implementation of that system approach to quality would be due in Phase 3.

So, moving on to slide 14. This is really a high level of those sections that are relevant for Phase 1 and, then, those sections where -- and in subsequent slides, we go over Phase 2 and Phase 3. But, we have each of the regulatory sections listed here with an asterisk by those that also have -- are partially implemented in Phase 2.

So, let me give you an example. Physical environment. Most of these requirements are existing requirements. They mostly will be implemented in Phase 1. There are a couple of things that will be implemented later, such as smoking policies, which may -- we believe will require some time to develop. In Phase 2, that will be effective.

And, then, in Phase 3, the resident call bell at the bedside versus in the room, which may require rewiring within the buildings -- and that has a Phase 3 effective date. So, within each regulatory section we tried to look at what are those pieces that are carrying forward that could be effective in Phase 1 and what are those pieces that really require a longer time to implement.

So, if you move to slide 15, that has the Phase 2 and Phase 3 requirements for -- as I mentioned, the QAPI plan would be required in Phase 2 as well as infection control, the

facility assessment and antibiotic stewardship programs and, again, the smoking policies for physical environment as well as some other areas. Phase 3 has a number of items listed as well -- QAPI implementation, the Infection Control Preventionist, compliance and ethics, call lights at the resident bedside, and training.

So, next, I'd like to talk through each section of the regulation and just highlight some key differences for you. So, let's move to slide 16. The first section of the regulation is the definition section. And, usually, that's an area that, from a survey process standpoint, doesn't -- isn't integrated in the same way that some of the other requirements are. But it is an important component for the interpretive guidance in looking at compliance with each of these sections.

And the final rule did update some of the definitions related to abuse, neglect, exploitation and mistreatment. It defines an adverse event, which is critical for how facilities will be designing their QAPI programs. It has a definition of nurse aide and really brings forward the theme that Sheila mentioned related to defining person-centered, which is focusing on the resident as the locus of control and supporting the resident in making their own choices as they live their lives in the building.

Moving on to slide 17, the Resident Rights and Facility Responsibilities section. This is -- in the proposed rule, Resident Rights and Facility Responsibilities were separate sections. In the final rule, these were combined. It does have significant existing language. These are resident rights and facility responsibilities that were carried forward. Some of these were previously in the Administration section, in other sections of the current rule. All of these changes -- all of these components of the resident rights and facility responsibilities are effective in Phase 1, except for providing contact information for certain organizational units related to the Aging and Disability Resource Center and the Medicaid Fraud Control Unit.

So there's a number of components in the existing rule that -- they have these normal points of contact for residents, such as the State Survey Agency, the Ombudsman. But, the contact information for these other organizations would be new for facilities and something that would have to be put into place in terms of a referral process or contact process.

Moving on to slide 18, Freedom from Abuse, Neglect, and Exploitation. This area is one that has been substantially updated. It strengthens the existing protections. So, in addition to the review of the policies and procedures, it adds language related to residents having the right to be free from neglect, exploitation, misappropriation of resident property. Previously, the requirements for participation had the right to be free from abuse and the other components were in -- were worded differently in the requirements. So, it definitely strengthens the existing protections in this section.

As Sheila mentioned, it includes the 1150B requirements, which we had operationalized through a survey and cert memo. This is the reporting of reasonable suspicion of a crime, an existing requirement under statute that now becomes integrated into the survey and certification process that it previously had not been.

And, finally, in this area of Phase 3, QAPI must be involved in the review of allegations, incidences of abuse, neglect, and exploitation. And as I mentioned previously, the implementation of QAPI is a Phase 3 requirement and, therefore, other areas of the reg that refer to the implementation of QAPI are also Phase 3 requirements.

Moving on to slide 19, the Admission, Transfer, and Discharge Rights. All of these sections are Phase 1 effective dates, except for the transfer/discharge documentation, which substantially has the requirements for the transitions of care and what must -- what information must be provided to a receiving facility. A couple of other pieces I would highlight here in this section is, one, that residents may not be required to waive liability for the loss of personal property, that the facility has to disclose any special characteristics in the -- in the services that it provides, and that this section keeps the language in the reasons that a resident can be discharged but really expands on the expectations for what is considered a proper discharge of a resident to another setting. So, those are -- those are the pieces that I'd like to highlight in this section.

Moving on to slide 20, the Resident Assessment component.

This is the section of the requirements that have the requirement for the minimum data set and the expectations for completing the resident assessment. There weren't that many changes to this section. But, it did strengthen the PASARR section and the expect -- and clarified the coordination responsibilities between the parties for PASARR. And that's Pre-Admission Screening and Resident Review for individuals with mental

disorders or for individuals with intellectual disabilities. And this section is implemented in Phase 1.

Moving to slide 21. This really maintains many of the requirements that are -- were previously in the reg and talks more explicitly, though, about, as Sheila mentioned, the involvement of the resident and his or her representative in the care planning process. So, there are some new Phase 1 requirements there related to those expectations.

The additional pieces here is the baseline care plan. That will be implemented in Phase 2. The requirement for the baseline care plan is when a resident comes into the facility, that that care plan must be completed within 48 hours and provide -- and it has some minimum requirements for that baseline care plan and then a summary provided to the resident or his or her representative as well. So all of those are Phase 2 requirements.

And then, again, the trauma-informed care component of the care plan is implemented in Phase 3. And this is another component of the reg that shows up in a couple of places across the different regulatory categories. And, so, all of those areas are Phase 3 requirements.

Moving on to slide 22. There aren't any brand-new requirements in this section. Let me just highlight a couple of things. One, it includes the highest practicable well-being language that is currently in the statute and regulation. The Quality of Life section is now sort of the core home for what many of us know as S309 in terms of the -- of that language. It includes activities of daily living. It includes expectations related to basic life support and CPR. It includes language around activities and requirements related to activities and the program director for activities.

So, all of these sections are implemented in Phase 1. As I mentioned, they are not new. The basic life support is not a -- was not previously regulatory language. But it was something that, through sub-regulatory guidance, has been an expectation in terms of the ability of the facility to identify the resident's desire to have CPR and other life-sustaining treatments.

So moving to slide 23. This regulatory group has many of the special care issues which were previously cited under 309 if there were quality of care issues identified. So, as

Sheila mentioned, it does -- there are some specific care issues broken out under this section related to restraints, pain management. Bowel incontinence was added to the regulatory group that was previously just bladder incontinence. Dialysis services and expectations around dialysis services was added as an explicit requirement and then, again, trauma informed care as a special care requirement. This section does contain other care issues such as vision and hearing, skin integrity, and foot care issues as well. All of these sections are essentially existing requirements for quality of care services and are going to be -- the expectation is that these would be implemented in Phase 1, except for trauma-informed care, which, again, I mentioned, will be a Phase 3 requirement.

Moving on to slide 24. This is Physician Services. So, as you may remember, the proposed rule had language in it related to a physician visit prior to a transfer. This was another area that received a number of public comments, and the final removed language in this regard. It added language related to the ability to delegate dietary orders. And all of this section will be implemented in Phase 1.

Moving on to slide 25. Nursing services previously -- has always had the requirement for there to be a sufficient number of staff based on the resident population. The final rule adds requirements related for both sufficient and competent staffing based on the resident population. And this gets back to what Sheila mentioned related to the facility assessment, which is that the facilities are expected to know themselves, know their residents, know their staff and the resources and competencies needed to provide appropriate care to individuals.

And, so, the requirement -- the overall requirement for sufficient and competent staffing is in Phase 1. The determination and the linkage to the facility assessment, which is a Phase 2 requirement, will be made in Phase 2, next year, November 28, 2017. So, again, it contains many of the existing requirements related to Phase 1 and has -- continues to have some of the language related to nurse aide registries and other components of it.

Moving on to slide 26, the Behavioral Health Services. This is a new regulatory grouping. And given the changing population and, as Sheila mentioned, the alignment with other HHS initiatives, this is an important area that we're going to be taking a look at in the years to come related to the compliance process. It is -- it does continue to incorporate

the highest practical well-being and specialized rehabilitation and medically related social services, which are existing requirements that are broadened to this section and highlighted in this section. It also has the requirement for sufficient and competent staff. So, similar to the nursing services section, it has language in here that there must be sufficient and competent staff.

The final rule added a component related to dementia -- specifically identifying dementia and indicates that a resident with dementia has treatment and services needed to meet his or her needs in this specific section. The final rule also explicitly addresses non-pharmacological interventions and establishes the expectations that facilities are actively identifying these non-pharmacological interventions and providing care and services to its residents. This has been identified in the sub-regulatory guidance for several years in terms of providing good dementia care and addressing these issues related to -- in advance of providing medication. But the final rule really codifies that expectation in the regulatory requirements and creates some explicit linkages here related to these issues.

Most of these are in -- the implementation of most of this section is in Phase 2, except for the existing requirements in Phase 1, which is the comprehensive assessment. So, that's not new and we're expecting that that area is going to continue to be provided even in Phase 1, and then the medically related social services, which is also not new in terms of regulatory requirements. And then, in Phase 3, again, the residents with a history of trauma or PTSD would be added as an explicit expectation in Phase 3.

So, moving on to slide 27, Pharmacy Services. This continues the protections under pharmacy services that are in the current rule, which is freedom from unnecessary medications, identification or freedom from significant medication errors, and appropriate medication storage and labeling. All of these are Phase 1 requirements that are carried forward from the existing rule. We -- there has -- we have added -- expanded on the drug regiment review and reporting of irregularities, that's a Phase 2 requirement, and have added the requirement that there be a review of the medical chart along with the drug regimen review to ensure that the drug regimen review is appropriate related to the conditions identified—and documentation related—in the medical chart itself.

Phase – there's also an expanded definition of psychotropic medication, which has -- identifies a number of additional -- of drugs that have similar properties, such as hypnotics and antipsychotic medications and has some specific requirements in there related to PRN usage of psychotropic medication. It has – there's a 14-day limit.

The final rule differentiates between psychotropic medication as a whole and antipsychotic medication specifically. And this is in response to a number of comments we received related to those medications. And, so, there's a -- for psychotropic medication as a whole, if the practitioner believes it's appropriate, they can extend the PRN order beyond 14 days. For antipsychotic medication, the drugs are limited to 14 days and can't be renewed without an evaluation by the practitioner. So, there's difference in how the final rule treats those medications.

Moving on to slide 28. I'm going to -- instead of going through each of these ones, I'm going to group a number of regulatory groups where was somewhat minor changes. These are mostly Phase 1 areas.

So, lab and X-ray. There was some additional language to reduce burden and identify the ability for non-physician practitioner orders related to a physician assistant, a nurse practitioner, a clinical nurse specialist. Dental services were largely unchanged, except for new requirements related to replacing lost dentures and referrals for denture fittings in phase -- that are -- will be effective in Phase 2. The specialized rehabilitation services -- we added respiratory services to that definition and strengthened the PASRR requirements as well related to the resident assessment component.

Moving on to slide 29, Food and Nutrition Services. These are many of the same requirements continuing forward. It's primarily Phase 1. It continues the food and nutrition protections. It, again, talks about qualified dietary staff and has the theme of that language of having sufficient and competent staff for qualified dietary staff. It updates the education requirements for the Dietician and Food Service Manager, establishing a 5-year ability for the -- to meet the education requirements for current employees and 1 year for new hires. It adds a provision related -- again, that person-centered care that Sheila talked about, reasonable efforts to address religious, cultural, and ethnic needs in terms of food and nutrition. It has some explicit provisions around snacks, nourishing alternative meals, and for individuals who want to eat at non-traditional times. And, then, it has requirements to establish a policy regarding use

and storage of food that is brought by families and visitors. So those are the main changes to that area.

Moving on to slide 30 in the Administration section. This is, again, primarily Phase 1. It maintains existing requirements related to the administration of the facility. It adds explicit language around having a licensed Nursing Home Administrator. There is a -- again, going back, this is actually the facility assessment home. It's referenced in a number of places throughout the rule. But the facility assessment home and explicit language for this is in the Administration section.

And, again, that is in Phase 2. And it really talks about the facility assessment, identifying the resources necessary to provide care to the residents, and has some subsections around the facility, understanding its resident population; staff competencies; again, the ethnic, cultural and religious factors related to activities and food; and, then, the facility resources available to provide services to those individuals.

The use of arbitration that Sheila mentioned previously is also housed in this section, where the prohibition on the use of pre-dispute binding arbitration and requirements for post-dispute. This clarifies the -- or this also has language related to the full-time social worker for facilities that have more than 120 beds and updates qualifications related to that social worker.

We also -- there were recent regulations in a number of areas that are now housed in this section. These are not new requirements but now have a home within the framework of the Administration section related to facility closure, the hospice agreement for residents who are receiving care from a Medicare-certified hospice and, then, the payroll-based journal requirements as well, which is the reporting of staffing data electronically. That is the -- what the -- the first due date for that is upcoming. So, all of those requirements were previously existing and are now found in the Administration section within the final rule.

Moving on to slide 31, the QAPI, which Sheila mentioned. Phase 1, we maintain existing QA&A requirements. So, the QAA Committee does not go away. Phase 1 creates the expectation that those committees are continuing. It also continues the provisions around disclosure and good faith attempts to correct issues. Phase 2 establishes the requirement for the QAPI plan to be ready and available to submit as required by the

Affordable Care Act. And then Phase 3 is the full implementation of QAPI and the integration of the Infection Preventionist.

And this really -- Phase 3 QAPI -- this really expands on the expectations to have a systematic approach to quality where there is -- the facility is identifying the scope of quality issues, monitoring data, getting feedback on its performance, and getting feedback from residents and staff, performance -- developing performance improvement projects and then establishes a specific link to the governing body and the leadership of the facility in being involved in and accountable for that quality assurance program.

Moving on to slide 32, the Infection Control component. This section maintains existing requirements related to having an infection control program, infection control around linens and flu and pneumonia vaccines and relocates those from other areas of the reg -- that were previously in other areas of the regulation. Let me identify where there're specific changes.

One, it really more clearly articulates and identifies expectations for what is an infection control program, having written standards, a system for reporting, investigating, and controlling infection issues. It identifies the need for an Infection Control Preventionist with specialized training, which is a Phase 3 requirement. It identifies which types of -- the types of backgrounds that that Infection Control Preventionist needs to have. It indicates that they have to work at the facility on a part-time basis at least and really creates a framework for an individual who is responsible for looking at infection control issues within the building, linking them into the QAPI plan, and being a point person for reporting of any infection control issues.

The -- As all of you probably know, the issue of antibiotic stewardship is an important public health issue and is carried forward in the final rule, that facilities must have an antibiotic stewardship program, establish protocols, and a system for monitoring use of antibiotics. And I will tell you from the Survey and Certs standpoints, we have been working closely with the CDC, who has issued guidance around antibiotic stewardship programs in long-term care facilities and is a good resource for facilities who are looking at developing their own program in this area.

And, again, as I mentioned, the flu and pneumonia vaccines carried forward and, then, expectations for an annual review of this program.

Moving on to slide 33, the Compliance and Ethics Program. There is in the -- I will note in the rule -- and this is a question that came in from a number of you -- that the rule itself talks about implementation November 28, 2017. The implementation chart in the rule identifies compliance and ethics as a Phase 3 requirement. We are aware of this disconnect. And in terms of the -- our different communications with facilities on this, we are looking at this issue, as Sheila mentioned, related to their -- to work on correction notice at some point in the future. I will say that from our perspective, we are not expecting facilities at this time to be moving forward on this with the expectation that it's a -- it will be implemented shortly.

The provision as a whole -- we would indicate that -- the final rule has that the program must be reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the act and promote quality of care and include appointing a representative for a facility and organization, enforcing operating standards, responding to violations, and reviewing the program annually. There are -- I would note that there are different expectations set forth in the rule for facilities that have -- that are part of a chain of five or more homes. And I would encourage folks to take a look at that in the final rule.

Slide 34 is Physical Environment. It's primarily Phase 1. It maintains -- as I mentioned, it maintains many of the existing protections, emergency power. It does create requirements related to two residents to a room for new construction or reconstruction for facilities approved after November 28, 2016 -- so, a Phase 1 requirement. Again, the resident call light next to the bed is a Phase 3 requirement, and facilities' smoking policies is Phase 2.

The last section I want to talk about is the Training Requirements, which is an explicit section in the rule that establishes training requirements for all staff, contractors, and volunteers. This is a Phase 3 requirement, except for those areas which were previously essentially elsewhere. So it incorporates the required training for nurse aides, prohibition of abuse and neglect, and adds in dementia care training as a Phase 1 requirement from the Affordable Care Act.

CMS Implementation Plans

So, moving on to slide 36. So we just talked through all of the different sections of the regulation. So, we got a lot of questions in about how exactly is this going to be implemented and when are we going to receive interpretive -- draft interpretive guidance and that kind of thing. So, let me talk through a couple of things related to Phase 1 and Phase 2. We'll put Phase 3 on hold for now. And then I'll turn it over to Evan to talk a little bit about the alignment with the survey process itself.

So if we go to slide 37 to talk about just Phase 1 and Phase 2. Phase 1. So, the effective date of the rule—November 28, 2016. We will add the new regulatory language for Phase 1 requirements under current F tags. So, if you remember when I was talking about the quality of care section where I mentioned that F309 was -- care issues previously identified under 309 are broken out in the final rule into separate regulatory sections, for Phase 1, that will be -- those regulatory sections will be rolled back under F309. The text in our information system, ASPEN, will be -- will have the different -- the new regulatory citations, and any compliance issues found in that will still be cited under F309. So, we -- each of the new regulatory requirements that will be in Phase 1 will have a "home" somewhere in the current F tag coding system.

For Phase 2, we are going to be renumbering the F tags so that it follows the order of the new rule. And we are also going to be releasing interpretive guidance and a survey process that assesses compliance with Phase 1 and Phase 2 requirements. So -- and that will occur November 28, 2017.

So, just to address a couple of questions head on, some questions we've got are "Why did you have to change the F tags," that people know the F tags, they've been around for a couple of decades, and it really is a big -- will be a big learning shift for all of us. And the answer to that is that we really -- from a regulatory standpoint, it is helpful to have the F tags follow the regulatory structure so that everybody, you know, knows that -- if it's 601 and 602, you can look in the regulations and 602, for the most part, comes after 601 from a regulatory standpoint.

The other question that we got was: "Why can't you just add like 300 so that F309 becomes F609?" And because of the reorganization of the rule that -- you could start there. But then you quickly have to -- if you want to keep the same order, you are not

able to keep -- just add 300. It just -- it doesn't work from a -- from a regulatory order standpoint.

So, the last thing that I want to just dive into a little bit, and then I'll turn it over to Evan, if you move to slide 38. I just want to talk through a hypothetical scenario, which is, you know, for example, the facility must provide purple attire for residents to wear on Sunday. So, just to be clear, this is not a requirement. Don't -- please don't write the CMS Administrator and talk to him about this. It's just for illustration purposes.

So if you move to slide 39, for Phase 1, we are going to be adding the new requirement into the tag where there is the closest regulatory fit. So, in our review of the regs in this area, it would F156, which is that the facility must inform the resident both orally and in writing in a language the resident understands of his or her rights and rules and regulations governing conduct and responsibilities during the stay in the facility. So, the new version of Appendix PP that we will be releasing for Phase 1 would have F156. It would have the old language. The regulatory citation may be updated. And then it would have the new regulatory requirement in red that -- so that you can clearly identify what the new regulatory requirement is.

Again, the intent, the interpretive guidance and the survey process doesn't change. But, I would say that there are -- the surveyors will look at compliance issues related to what is the effective regulation. So, in this case, if there's complaints that come in around the purple attire or if there -- if these issues come up, it can be cited under F156.

If you move to slide 40, the expected impact for Phase 2, again, we would take whatever existing requirement there is for F156. That may get a new number, say F980, which would have the previous language. And, then, the intent, interpretive guidance, and survey process may change. We are using this opportunity to look at existing interpretive guidance even for requirements that may -- where the regulatory language may not have changed and using it to do the same kinds of things that occurred with the rule. Are we reflecting current standards of practice? Are we being as clear as we need to be in terms of compliance and identifying those issues? So, the interpretive guidance survey process may change.

And, then, if you move to slide 41, the previous -- the new requirement may have a new tag, F981, where we would indicate what the new requirement is. We would have new

interpretive guidance there, and then we would have a new survey process to look at, you know, how will surveyors, for example, be interviewing residents and making observations related to this new requirement.

So, that's a high level of how we're looking to implement the requirements for the different regulatory groups that I just went over.

And, now I'm going to turn it over to Evan Shulman to talk about the survey process itself.

Survey Process Changes

Evan Shulman: Thank you, Karen.

Good afternoon, everyone. I'm just going to spend a couple of minutes going over a few slides on how this integrates with the survey process.

Many of you know that today we have two survey processes throughout the country. We have the Quality Indicator Survey, or the QIS, and we have the traditional survey. And roughly half the states are on QIS, while the other half are on the traditional. We've been studying the differences between these two survey processes for the last few years. We released a memo—it is S&C: 15-40-NH—and we've been looking at what are the best practices or what are the -- what can we leverage that are within each one of these surveys to improve the survey process overall. And we have found some differences. So, for example, we've identified that the QIS process tends to be better at identifying unnecessary medications. And we've identified that the traditional survey process has tended to be a little bit better at identifying infection control issues.

Aside from findings, there are also some operational differences. The QIS process is computer-based and has a regimented structure that surveyors follow, whereas the traditional process is paper-based and surveyors may experience more flexibility. So, we've taken a look at both of these processes, and we're trying to identify the best practices for them all, for both of them.

When you look at both of these, it also compels you to think of the -- any gains in efficiency that can be brought to the country and to the survey -- to survey agencies and CMS throughout the country. When you have two survey processes that you're trying to

manage, we think that one survey process may create more efficiency. So, along the same time we've been looking at data, the findings from the survey process and also other findings such as quality measures, whether they would be claims-based or MDS-based, we're using that to see what are the trends that are occurring in nursing homes today. And then on top of that we have the regulatory changes that Sheila and Karen just outlined.

So when you put all of this together, it really compels us to look at and revise the survey process, and we'll launch a new survey process that will be implemented nationwide. So this is intended to replace both the QIS and traditional survey process so that all states are using the same survey process throughout the country.

Moving on to slide 43, some just high-level overview of what this new survey process will be.

First, it will be computer-based such as the QIS -- such as the QIS is. However, we will also try to implement as much flexibility as needed so surveyors can feel that they can investigate issues when they need to. We're going to be using data to select -- to help select residents offsite -- so using the various data sources that are available to identify potential issues that are occurring with the residents.

And then onsite, surveyors will complete their sample and then start to begin the other part of the survey protocol, which will be the investigations. The investigations and the rest of the survey sample are based on observations and interviews that the surveyors do while they're onsite.

The next slide, slide 44. So, here's a little bit about timing about the survey process. So, as I mentioned, with all these things happening at the same time, we felt that it would be natural to have the new survey process be launched along with the implementation date of Phase 2 of this new regulation. So this is expected to start on November 28, 2017. This will incorporate the new requirements.

So this means that it will include any new requirements that are in Phase 1 and Phase 2, so -- and also, all -- any new interpretive guidance. So as Karen explained, this would include new interpretive guidance for any new requirements in Phase 1, new interpretive guidance for any requirements that are in Phase 2, and new interpretive

guidance that are for any existing requirements that we have taken the opportunity to take a look at and try to improve.

All of these, again, will be associated with new F tags. So also, as Karen mentioned, there'll be a new coding system and the numbering will totally change there. It is not going to be a one-for-one, just so you know. So even if there is an existing regulation yesterday and there is the same regulation tomorrow, there may be some instances where that one tag has been split into more than one tag, where, conversely, there may be a few tags previously that we have chosen to combine into a fewer number of tags. And of course, there will be added tags for the new regulations.

Moving on to slide 46. So, what training will be available for providers? So, last week we released a memo, S&C: 17-03-NH, that described the location for the material. We expect to release information related to Phase 1 of the new regulation changes in mid-November. The location for that, again, is in the memo.

For Phase 2, we intend to release information in the summer of 2017 -- so, somewhere in the July–August timeframe. This will include information related to the new tags, the new interpretive guidance that you've heard us talk about, and also information about the new survey process. So this will be the new survey process and all the revised interpretive guidance that is included in Appendix PP. Our intent is to be transparent with tools and training so providers have a clear understanding of how to become and remain compliant. So we recommend that you also keep an eye out for S&C memos announcing the posting or releasing of many of these materials.

And, finally, on slide 47 is an email address that you can send questions to about anything that you 've heard today or anything that you -- and that you haven't heard today.

And, lastly, just from all of us here, a sincere thank you for all of your hard work to serve this population. We know it's not easy at times. And we look forward to working with you to help deliver high-quality care to the residents of long-term care facilities.

Now, I'm going to turn it back to Hazeline.

Keypad Polling

Hazeline Roulac: Thank you, Evan.

In just a moment, we will start the question-and-answer portion of our call. But before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

And please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Hazeline Roulac.

Question-and-Answer Session

Hazeline Roulac: Thank you, Holley.

So, before we start taking questions from our participants, our subject matter experts will address questions received during the registration process. Karen?

Karen Tritz: Great. Thank you, Hazeline.

So, just a couple of questions that we received in the mailbox. We're just going to answer a few and then open up the phone lines.

The first question is: "Because there are so many changes, will there be a table of what each new regulation entails when it becomes effective and where to find it in the register?"

So, there's a multi-part answer that I would share with you. So, first, would encourage you to take a look at two sections of the *Federal Register* notice, which is -- the first is the implementation chart in Section B, which has the -- when each provision becomes effective. But, I'd also encourage you to take a look at Table 1, which is the cross-references to Part 483, Subpart B, which identifies the old -- what the previous regulatory section was and what the new CFR section is.

I would also clarify that, as Evan mentioned, we are going to be a releasing a version of Appendix PP in the coming weeks that will have the new regulation identified with the existing regulations. So as you know from the *Federal Register*, there is some sections that remained unchanged, which were identified by asterisks. We will be incorporating those sections. We will be keeping the existing sections and then adding the new language into a version of Appendix PP that individuals will be able to look at to look at the new requirements for the different regulatory areas. And as Evan mentioned, we will be releasing that in the coming weeks.

The second area that -- question that came in was: "Please clarify that the Infection Preventionist requirement is Phase 3." They received communication that it was required to be on the QAA Committee during Phase 1 despite the final rule noting Phase 3.

This is a Phase 3 requirement. We realize that there are provisions within the QAPI section that identifies that that Infection Control Preventionist is on the QAA Committee. And we'll take a look at that for any technical changes needed. But it is a Phase 3 requirement to have the Infection Preventionist.

The last question before we open up the phone lines is: "Please also clarify the implementation date for the compliance and ethics program requirement."

As I mentioned, this is a known issue, one we've received a number of questions about related to whether or not it's in Phase 2 and Phase 3. We will address -- as Sheila mentioned, we are not expecting facilities to act at this moment, and surveyors are not going to be looking at this issue in the -- in the coming surveys that they will be conducting. So more to come on that issue.

Hazeline?

Hazeline Roulac: Thank you, Karen.

We are ready to start the question-and-answer session. I want to remind everyone that this call is being recorded and transcribed. Before asking your question, please give your name and the name of your organization. In an effort to get to as many questions as possible, we ask that you limit your question to just one. If you would like to ask a follow-up question or have more than one question, you may press star, one—that's star, one—to get back into the queue, and we'll address additional questions as time permits.

All right, Holley, we are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Our first question comes from Maureen Baker.

Maureen Baker: Yes. Can you tell me the number of the memo for the training?

Hazeline Roulac: Just a moment, Maureen.

Evan Shulman: Sure, S&C: 17-03-NH, as in nursing home.

Maureen Baker: Okay. And that's found on what website? The CMS website?

Evan Shulman: Correct.

Maureen Baker: Okay. Thank you.

Hazeline Roulac: Thank you, Maureen. Next question.

Operator: Our next question comes from the line of Mary Gracie White.

Mary Gracie White: Good afternoon, and thank you for the call and the information. It's much appreciated. One question that I have was regarding the facility assessment. And I know you mentioned no size fits all etc. But will there be any guidance in how a facility will go about developing an assessment that might meet, you know, the criteria needed?

Karen Tritz: Hi. Thanks for the question. Yes, we are going to be developing interpretive guidance -- sub-regulatory guidance for each of the new provisions. And we know that the facility assessment is an area of significant interest for folks in terms of what the expectations will be. And we'll be able to share that in the coming months so that facilities have sufficient information to work on as they're developing the facility assessment.

I think, I would advise that taking a look at the regulatory requirements and the preamble related to the intent of the facility assessment is a good starting place. But we will be releasing sub-regulatory guidance on the facility assessment as well.

Mary Gracie White: Thank you very much. I appreciate it.

Hazeline Roulac: Thank you, Mary Gracie. Next question.

Operator: Our next will come from the line of Sherri Nicholson.

Sherri Nicholson: Hi. Yes. I'm wondering about the physical environment changes where it talks about new construction or reconstruction. If you could explain maybe a little bit about what is the extent of reconstruction to meet the guidelines for two-bed rooms and single bathroom.

Sheila Blackstock: Hi. This is Sheila Blackstock. I would encourage you to actually look in the final rule. There is some discussion of that in the preamble. Generally, reconstruction would be something that to the extent that that area couldn't be inhabited by the residents. So this is absolutely not intended to deter people from renovating. It is intended to be more extensive than that.

Operator: Your next question comes from the line of Connie Miller.

Connie Miller: Yes. You mentioned the PRN usage of psychotropic medications being limited to 14 days. Could you clarify which phase that's effective in? Hello?

Hazeline Roulac: Yes. Just a moment, Connie.

Karen Tritz: Hi. Thanks for your question. So, the entire psychotropic drug provision—Subsection E, 483.45—is implemented in Phase 2. And the PRN requirements for the use of psychotropic drugs would also be in Phase 2.

Connie Miller: Thank you.

Hazeline Roulac: Thanks, Connie.

Operator: Our next question will come from the line of Casey Blumenthal.

Casey Blumenthal: Hi. Thank you. Can you clarify the -- one of the very last provisions of the rule that references the requirements for swing bed providers and clinical access hospitals?

When I looked at the references there for which cases of the rule would be revised, there were no cross reference numbers that correspond (inaudible). So, it is very hard to know which (inaudible).

Sheila Blackstock: Hi. This is Sheila Blackstock. With regard to swing beds, the section that you need to look at actually is not Part 483 specifically. If you go to Part 482.58, that lays out the requirements for swing beds and the cross reference -- and gives you the specific cross references to Part 483. I will say, generally, that section requires substantial compliance with residents' rights—admission, discharge, and transfer rights—freedom from abuse, neglect, and exploitation—patient activity, social services, specialized rehab, and dental services.

But as part of writing the final rule, we updated cross references in other parts of Title 42 of the CFR. So we have updated those cross references. I will say, as I mentioned earlier, we do recognize that we did not accurately translate all of the cross references.

So, if you look there and don't see what you're expecting or see that it's wrong, that is not one I'm aware that we've identified. But do please feel free to submit any question or comment related to that specifically to the email address that was provided in the slide deck.

Casey Blumenthal: Okay. Thank you.

Operator: And our next question will come from the line of Virginia Kamal.

Virginia Kamal: Hi. Good afternoon. My question is to differentiate between the QA Committee and the quality assurance meeting that is held monthly by SNF facilities. Is the committee completely different from the monthly meetings?

Karen Tritz: Hi. So, we're -- can you clarify your question? We have -- so, the QAA Committee requirements are retained as an organizational unit. Can you talk about the monthly meetings that you're thinking about and asking about the -- whether that has changes related to the QAA Committee?

Virginia Kamal: The facility holds a monthly QA meeting that all members of staff -- technically department heads -- attend. Is that completely different from setting up a separate committee to address other QA concerns?

Sheila Blackstock: So -- this is Sheila. And if you look in the regulation, what is required by the regulation is that the facility have a QA and a committee and that that committee

meet at least quarterly. To the extent that your monthly meetings would meet that requirement, it would have to meet the requirements that are laid out in the regulation. So, it's very difficult to tell you on the phone with limited information, yes, that meets, or no, it doesn't. But, broadly, it *could* if it otherwise meets the requirements of the regulation. But, again, the regulations only require that the QAA committee meet quarterly.

Virginia Kamal: Thank you.

Hazeline Roulac: Thanks, Virginia.

Operator: Our next question will come from the line of Lisa Davis.

Lisa Davis: Hello. I just had a quick clarifying question regarding the dietary staff training requirements. It says that current staff have 5 years to meet that education requirement, and I was wondering when the cutoff for current was. Is it as of 11/28 of this year, meaning anybody hired between now and then is still considered current or has it already passed? What is considered current?

Sheila Blackstock: The current regulations are in effect until November 28th of this year. So anything hired up until the effective date of the final regulation would be current. Does that answer your question?

Lisa Davis: Yes. I'm just wondering if they would be hiring feverishly now and knowing they have 5 years versus...

Sheila Blackstock: That isn't possible.

Lisa Davis: ... Okay. Just wondering. Thank you so much.

Hazeline Roulac: Thank you.

Operator: Our next question will come from the line of Kimberly Gimmarro.

Kimberly Gimmarro: Thank you. I'm interested in the use of the OSCAR report to trend areas of concern and how that will be reconciled both for surveyor purposes and for facility purposes going forward with the renumbering of tags.

Evan Shulman: Hi. This is Evan Shulman. Thanks for your question. I think that -- first off, right now, I think you're referring to CASPER reports. I am not sure, OSCAR, I think, has been sunset. I would recommend that you -- if you have a question about specific reporting, that you email the email address on that slide 47, and then we can get back to you. There are different reports that are available for providers, and I'm not sure which one you may be referring to. But if you email us, we can get back to you.

Kimberly Gimmarro: Thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Our next question comes from the line of Terry Raser.

Terry Raser: Hi. Thank you for taking my question. My question's in reference to slide 21, where you were talking about the baseline care plan implemented in Phase 2. It also talked about the possibility of combining the comprehensive care plan with the baseline care plan. Can you talk a little more about that?

Ronisha Blackstone: Hi. So, this is Ronisha Blackstone. So, I'm trying to find the exact reg set. But, in a nutshell, what the reg says is that if you want to avoid actually developing both a baseline care plan and a comprehensive, person-centered care plan, then you would have to meet the requirements for developing the comprehensive care plan within 48 hours of admission because the baseline care plan has to be done within 48 hours of a resident's admission.

So if a facility wanted to go ahead and try to get the comprehensive care plan done at that time, they are open to do that. But, it's not a requirement that they have to. But if they want to avoid having to do two care plans, then they're – it's flexible. They can do so.

Terry Raser: So it would be done prior to the MDS being completed at that point, then?

Ronisha Blackstone: Right. Yes, that's right. So, but it's like, I think, the comprehensive care plan has to be done -- is it, what, 21 days, 14 days?

Sheila Blackstock: Within 21 days from admission, but 7 days from completion, yes.

Ronisha Blackstone: Right. And, then, the MDS has to be done within 14 days. So, there's still a window where you can try to get it done sooner if you want to.

Terry Raser: I just thought that the whole process of having the MDS and the CAHs and the care plan was that the MDS was the starting point and then the CAHs help to determine whether you are going to care plan or not. So, how does that -- does that change all that because you are writing now your care plan prior to your MDS being completed, which is supposed to be driving your care plan?

Sheila Blackstock: We understand that care plans are dynamic documents. So they're not going to stay static necessarily. The 48-hour baseline care plan is to make sure -- one of the things that is recognized is that during transitions of care, people are at an increased level of risk. So there was a need to address that. And because we realized that, for many facilities, the comprehensive care plan would not necessarily be feasible in 48 hours, we established the requirements for the baseline care plan. To the extent that you wait the time that's allowed to complete the comprehensive care plan, that's fine.

But what we didn't want to do is prohibit people from being more -- completing that comprehensive care plan more rapidly. So it was – it's really an effort to offer maximum flexibility as opposed to make you do something different in your comprehensive care plan. Does that make sense?

Terry Raser: It does. I'm just concerned survey-wise that everything won't be covered that needs to be covered if the care plan's written prior to the MDS, that's all. I was just thinking that direction. I mean, I understand what you're saying because some residents don't even stay long enough to have a comprehensive care plan because they're not there 21 days.

Sheila Blackstock: Exactly.

Terry Raser: And most facilities I think anyway have a shorter care plan within the first couple days that the resident's there to begin with.

Sheila Blackstock: And to the extent that new issues would be identified subsequently, they would need to be incorporated into the care plan because if you have a resident who does stay for a very long time and their condition changes or their needs change, you would be updating the care plan for that anyway.

Terry Raser: Right. Great. Okay.

Karen Tritz: So, this is Karen. So, what I hear the concern is is that if you're going to be expanding on the baseline care plan to develop a more comprehensive care plan but are doing it in advance of the formal MDS timelines, that there creates a survey risk in terms of them looking at that comprehensive care plan but not seeing the associated MDS. Is that -- do I have that captured correctly?

Terry Raser: That's right. Yes.

Karen Tritz: And I think that's something that we can address through sub-regulatory guidance, and I very much appreciate you raising this issue. I think, to the extent that facilities want to expand earlier on the care plan beyond what the baseline care plan is to create a more complete picture for that transition period, I think we can take a look at that related to sub-regulatory guidance and appreciate you raising it with us.

Terry Raser: All right. Thank you very much.

Hazeline Roulac: Thank you, Terry. Next question.

Operator: Your next question will come from the line of Bruce Moorehead.

Bruce Moorehead: Hello. I have a question on slide number 41. What is the reasoning behind the purple attire for residents to wear on Sundays? Thank you.

Karen Tritz: So, this is Karen. That is my feeble attempt at humor to lighten it up. It is not a requirement. It is intended for illustration purposes to look at how the

implementation will occur. So you can disregard that. It is not a requirement for facilities.

Operator: All right. Our next question will come from the line of Patti Harrison.

Patti Harrison: Yes. I would like to ask a question regarding, could you please clarify the prohibition on pre-dispute arbitration agreements? Coming from a state that is very litigious, we use arbitration agreements in our admission packet as a means of giving another layer to possible resolve a dispute other than just the grievance process of the facility.

Evan Shulman: Hi. So this is Evan Shulman. So, if you – it's in Section 483.70. Pre-dispute arbitration agreements are no longer allowed. They are no longer allowed to provide at admission as a condition of admission. They are not allowed to be entered into with the residents at any time. However, arbitration is allowed. And arbitration may be offered when a dispute arises. And there are conditions that must be met once the -- when the arbitration agreement is offered, such as it must be -- a resident's continuing right to remain in the facility must not be contingent upon the resident or resident's representative signing a binding pre-arbitration agreement. Must be in a language that they understand. So, arbitration agreements are still allowed, but pre-dispute arbitration agreements are not. And when a dispute arises, a facility may offer arbitration. But there are some conditions around how that must be offered.

Patti Harrison: So, from what I'm understanding, we can continue it in our packet. And even if an individual refuses to acknowledge it or sign it, it's not a reason that we would not admit the resident. But we would need to add that clarification from what you're saying to that arbitration policy.

Evan Shulman: No. I don't -- I mean, I don't have your agreement in front of me, so I'm not sure. But, if your agreement is a pre-dispute arbitration agreement, that is not allowed.

Patti Harrison: Okay. Alright. Thank you very much.

Hazeline Roulac: Thank you, Patti. Next question.

Operator: Our next question will come from the line of Candy Goring.

Candy, your line is open.

And our next question will come from the line of Adina Pelman.

Adina, your line is open.

Okay. Our next question will come from the line of Stephanie Christopher.

Stephanie Christopher: Yes. My question is, under the Resident's Rights portion, it talks about charges that are made -- or changes that are made to charges for other items and services that the facility offers. The resident has to be informed within 60 days of implementation? Does that include room and board charges? And is this effective -- is the 60-day notice effective as of November 28, 2016?

Sheila Blackstock: Hi. That requirement would be effective as of November 28, 2016.

Stephanie Christopher: And it includes room and board charges?

Sheila Blackstock: I am actually looking for that specifically. But if those are charges that the resident would be expected to pay, yes.

Stephanie Christopher: Okay. Thank you.

Hazeline Roulac: Thank you, Stephanie.

Operator: And our next question comes from the line of James Gant.

James Gant: Yes. My question is, with the inclusion of respiratory therapy in the specialized rehab services, would their time now be treated in a similar manner as PT, OT, speech therapy when reporting documenting means?

Karen Tritz: We're having trouble hearing the question. Could you restate that, please?

James Gant: Yes, ma'am. I'm sorry. My question is, with the inclusion of respiratory therapy in the specialized rehab services, would that mean that we would include their time in the same manner as we would PT, OT, or speech therapy when documenting minutes?

Evan Shulman: Are you referring to minutes from a billing perspective or minutes from reporting hours in the payroll-based journal?

James Gant: Correct. It would be in reference to billing. So, physical therapy minutes would add to the therapy time and would affect the RUG rates, for instance.

Evan Shulman: You know, we don't have an answer for you on that on this call. If you want to email us, we can route that to the right area.

James Gant: Okay. Thank you.

Evan Shulman: The email address is on slide 47.

James Gant: Thank you.

Evan Shulman: Sure.

Operator: All right. And our next question will come from the line of Shannon Hall.

Shannon Hall: Thank you for taking my question. In the presentation regarding the QAPI plan on page 31, it was stated that there is a requirement to submit that in Phase 2. And I was interested in your clarification regarding who it is to be submitted to.

Karen Tritz: Thank you for your question. The intent is that the facility would present its QAPI plan to the state survey agency during the survey that happens.

So, it isn't an expectation that it would be separately submitted to any other body. But it would be presented to the state surveyors when they are surveying your facility.

Shannon Hall: Thank you very much.

Hazeline Roulac: Hi, Holley. We'll take one more question.

Operator: Okay. Our final question, then, will come from the line of Mary Rybicki.

Mary Rybicki: Yes. Hello. I was wondering what is the exact number of hours that defines a full-time dietitian. And if there is a full-time dietitian in the facility, does that mean that the Food and Nutrition Services Manager still should meet the new educational requirements and credentialing expectations?

Sheila Blackstock: Hi. This is Sheila Blackstock. Could you go ahead and send us that question?

Mary Rybicki: Oh, sure.

Sheila Blackstock: We just want to be sure...

Mary Rybicki: What do you want me to do…email it?

Sheila Blackstock: Yes. There is an email in the slide presentation. If you would send it to that email inbox, we will take a look at it. We want to make sure we respond accurately when you -- when we give you an answer to the question.

Mary Rybicki: Okay. Thank you. Thank you.

Hazeline Roulac: Thank you.

Additional Information

Unfortunately, that's all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 47 of the presentation. If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN Connects Calls website. We will place an announcement in the MLN Connects Provider eNews, and you will receive an email when these resources are available.

On slide 50 of the presentation, you will find information in a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Hazeline Roulac. I would like to thank our presenters. And thank you, our participants, for joining us today for this presentation on the Long-Term Care Facilities Reform of Requirements. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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