I. Consent Items
   A. Determination of quorum
   B. Approval of Meeting Minutes – October 24, 2017
   C. Financial Report – October Financials (Jones)
   D. Board Member Replacements

II. President’s Report (Schueller)

III. Roundtable Discussion with DHS Secretary Linda Seemeyer

IV. Old Business
   A. Legislative update (Vander Meer, White, Stoa)
      1. WHCA/WiCAL PAC Report
      2. Nurse Assistant Training legislation (AB-432/SB-341)
      3. Certified Dementia Training Specialist (AB-630)
   B. SNF Margins Study (Dickson)
   C. Family Care MCO reimbursement issues (Vander Meer, Dickson)
      1. Denial of retroactive payments
      2. Inclusa rate cuts
      3. State-Family Care MCO contract
   D. Congressional Tax Package (Vander Meer)

V. New Business
   A. RoP Implementation (Vander Meer, Strader, Purtell)
      1. AHCA Response to implementation
      2. Delay of RoP enforcement penalties
   B. Survey and Certification (Strader and Purtell)
      1. New Survey process forms
      2. WHCA/WiCAL New Survey Process Webinar – January 10
      3. CMS Region V Meeting preview
      4. CMS S&C Memos
         1. 11/24/17 Temporary enforcement delays and freeze on 5-Star Health Inspection Rating
         2. 11/24/17 Prep for Launch of New LTC Survey Process
         3. 10/27/17 Clarification regarding NA Training Waiver and Appeal Requirement
         4. 10/27/17 Revised policy regarding immediate Imp of Fed Remedies – draft seeking feedback by Dec 1, 2017
   C. Season Ticket – www.whcawical.org/seasonticket

VI. Reports
   A. WiCAL Council Report (Kelm and Purtell)
   B. WHCA Committee Reports
   C. DON Council Report (Strader)
   D. AHCA Reports (Vander Meer)
   E. WHCA District Presidents’ Reports

VIII. Adjournment

NEXT SCHEDULED MEETING: January Board Meeting – 9 a.m., January 23, 2018
M3 Insurance – 828 John Nolen Dr, Madison, WI 53713

WHCA/WiCAL thanks the following sponsors for their generous support:
WHCA/WiCAL Service Corporation and M3 Insurance
WHCA BOARD OF DIRECTORS
MEETING MINUTES

9 a.m., Tuesday, October 24, 2017
Teleconference

Board Members Present: Tim Dietzen, Laura Holmstrom, Mike Jones, Dale Kelm, Deb Klatkiewicz, Kevin Larson, Pat Lemire, David Mills, Jeff Schueller, Mark Scoles, Kris Sprtel, Stacy Suchla, Barb Walters, Angela Willms, Cliff Woolever

Board Members Absent: Spencer Beard, Dave Egan, Paul Fiscus, Tom Graves, Wanda Hose, Janel Konkel, Dave Kruchten, Donna Kruchten, Steve Kuranz, Peggy Rahkonen, Rebecca Rouse, Josh Theis, Leslie Thompson.

Staff Members Present: Kate Dickson, Brian Purtell, Jim Stoa, Jackie Strader, John Vander Meer

I. Consent Items

A. Determination of quorum

It was determined quorum was present and the meeting was called to order at 9:04 a.m.

B. Approval of Meeting Minutes – September 26, 2017

Cliff Woolever moved to approve the August 22 minutes. Kevin Larson seconded and the motion was adopted unanimously.

C. Financial Report – September Financials (Jones)

Treasurer Mike Jones reviewed the highlights of the financial statements through September with the Board. Financial statements are on file at the Association's office.

II. President’s Report (Schueller)

Board President Jeff Schueller reminded members that Wednesday, November 1 begins the 2017 Fall Convention. Schueller encouraged members to attend Fall Convention. Schueller discussed the Shining Star Awards and urged members to attend the event in order to thank and reward staff.

III. Old Business

A. State Legislative update (Vander Meer, Stoa)

1. WHCA/WiCAL PAC Report

Public Affairs Director Jim Stoa discussed the PAC fundraising goal and progress toward that goal. Executive Director Vander Meer discussed the development of a corporate fundraising event tentatively to be held at Spring Conference.

2. Nurse Assistant Training legislation (AB-432/SB-342)

Vander Meer and Stoa discussed progress on AB-432. The bill passed out of the Assembly Committee on Aging and Long-Term Care on a bipartisan 5-2 vote. The bill may come to the Assembly floor by early November. Opposition to the bill has ramped up, as now AARP, unions, and others are actively opposing it.

WHCA/WiCAL thanks the following sponsors for their generous support:
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3. Certified Dementia Training Specialists Legislation (LRB-3913)

Vander Meer discussed the draft proposal of a bill WHCA/WiCAL has opposed in the past. Vander Meer said the association plans to continue opposition to it. Deb Klatkiewicz underscored the need to continue opposing it. Vander Meer said that he had a meeting scheduled with other provider associations to discuss an organized opposition effort.

B. RoP Letter (Vander Meer)

Vander Meer noted that of 122 Congressmen who signed on to the RoP letter, three were from Wisconsin – Congressmen Grothman, Duffy, and Gallagher. Senator Johnson also signed on to a senate version of the letter. WHCA/WiCAL staff and members had advocated for Congressmen to sign on for the past month.

C. WisCaregiver Career Program (Vander Meer)

Vander Meer said the final deadline for sign ups was Friday, October 20. About 70% of member facilities signed up.

D. ACA Repeal and Replace (Vander Meer)

Vander Meer said the provider community is currently in a holding pattern. We have been successful in stopping previous iterations of Obamacare repeal, but President Trump continues to indicate that efforts will be revived.

E. PearsonVue Credentia (Vander Meer)

Vander Meer said there continue to be reports of testing regularities, canceled sites, and problematic testers and proctors. Vander Meer wrote a letter to Shari Klessig regarding our Association’s concerns and requesting the Department address these issues.

Vander Meer encouraged members to also reach out to Klessig with their own personal concerns. Schueller asked if it would be worthwhile to set up a call with Klessig and providers. Vander Meer said he would set it up.

F. Emergency Preparedness Resources (Purtell, Strader)

Legal Services Director/WiCAL Executive Director Brian Purtell discussed resources available through AHCA and through WHCA.

G. Family Care State-MCO Provider Contract (Vander Meer, Dickson)

Vander Meer said the association has voiced concerns with DHS that the increased Family Care funding included in the state budget is actually passed through to providers. Legislators and the governor have been clear that they want that money to go to providers.
WHCA BOARD OF DIRECTORS
MEETING MINUTES

9 a.m., Tuesday, October 24, 2017
Teleconference

Director of Reimbursement Policy Kate Dickson discussed recent conversations she has had with DHS staff as we pursue a response regarding the contract.

Members discussed recent issues they have had with MCOs.

H. Shining Star Awards (Stoa)

Stoa said the Association received an unprecedented 48 nominations. The event this year will be a marquis banquet and will include exciting entertainment. Stoa said that video profiles of all winners will be available shortly after the awards banquet on the association’s YouTube page.

Vander Meer thanked the Shining Star selection committee for its work selecting this year’s winners: Jeff Schueller, WHCA/WiCAL Board President; Theresa Lang of Specialized Medical Services; Rochelle Kruchten of Sun Prairie HealthCare Center; and Shelly Sievert of Direct Supply.

I. AHCA/NCAL Convention (Vander Meer, Schueller, Stoa)

Vander Meer discussed the valuable interactions he and Stoa had at AHCA Convention. Stoa said he had many productive discussions with vendors, along with state affiliate and AHCA staff. Schueller discussed the need to increase the WHCA/WiCAL PAC to fundraise at the level of other state affiliates.

J. Fall Convention (Vander Meer)

Vander Meer discussed current registration. Vander Meer discussed the many valuable events and programs available and encouraged Board Members to attend.

IV. New Business

A. DHS Rate Setting Division Proposal to Property Workgroup (Vander Meer and Dickson)

Dickson discussed the first Property Workgroup meeting held by DHS, intended to be first of three meetings. DHS proposed a new property cost center rate setting process. The intention is to simplify the process and provide more transparency and predictability for providers. However, the Department’s proposed plan is not funded so there would be new winners and losers. The Association preference is to not move forward with these changes in the coming year and to push for funding through the next biennial budget.

B. Survey and Certification (Vander Meer, Purtell, Strader)

1. DQA Survey Data

Quality Advancement and Regulatory Affairs Director Jackie Strader said DQA released their survey data that encompasses the first 3 quarters of 2017. A new deficiency added to the top 10 is F-157, physician notification. The top three are unchanged. Strader said that one thing which jumped out to her was the number of F-314 tags received at the harm or IJ level – 46 so far in 2017. In all of 2016, there were a total of 48.

This will be the last quarter of data before the release of newly renumbered F-tags.

WHCA/WiCAL thanks the following sponsors for their generous support:

WHCA/WiCAL Service Corporation and M3 Insurance
2. New Survey Process Implementation

Purtell discussed the recent Survey workshops. The Nov. 28 Phase II implementation is just about a month away. Purtell said he would develop a feedback loop to discuss what members are experiencing with survey during the early phase-in of Phase II.

3. WHCA Member SNF Survey Workgroup

Purtell and Schueller discussed creating a survey workgroup. Jeff Schueller, Angela Willms, Barb Walters, Deb Klatkiewicz, Dale Kelm, and David Mills all volunteered to participate. Purtell said he would send out a notice to volunteers to set up a call.

C. Service Corporation member replacements.

   1. Schueller discussed the need to appoint three members to the Service Corporation. Stacy Suchla, Laura Holmstrom, and Angela Willms volunteered.

V. Reports

A. WiCAL Council Report (Kelm and Purtell)

   Purteil said the WiCAL Council will be scheduling a call in the near future related to PEAL and WCCEAL.

B. WHCA Committee Reports (Education, Quality, Payment)

   Quality Advancement Committee – Strader said that the Association is including CareConnection articles each week related to guidance about the survey procedure.

   Payment Council – Dickson said Payment Council meeting subjects have already been covered during discussion from the Board meeting.

C. DON Council Report

   Strader said the DON Council canceled its New DON conference.

D. AHCA Reports (Vander Meer)

   Vander Meer referenced staff experience at the AHCA/NCAL Convention and congratulated Wisconsin’s Bronze and Silver Quality Award winners.

E. WHCA District Presidents’ Reports

IV. Adjournment

   Kris Sprtel moved to adjourn. Barb Walters seconded and the motion passed unanimously.

NEXT SCHEDULED MEETING: December Board Meeting – 9 a.m., December 5, 2017

M3 Insurance

WHCA/WiCAL thanks the following sponsors for their generous support:

WHCA/WiCAL Service Corporation and M3 Insurance
**WHCA/WiCAL**

**Comparative Balance Sheet**

**As of October 31, 2017**

<table>
<thead>
<tr>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Assets**

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking/Savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Operating-Town</td>
<td>247,364.31</td>
<td>171,584.08</td>
<td>44.17%</td>
</tr>
<tr>
<td>Operating Reserve</td>
<td>450,348.50</td>
<td>536,092.91</td>
<td>-15.99%</td>
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<tr>
<td>Petty cash</td>
<td>100.00</td>
<td>100.00</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total Checking/Savings</strong></td>
<td>697,812.81</td>
<td>707,776.99</td>
<td>-1.41%</td>
</tr>
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</table>

Accounts Receivable

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues Receivable-Bus Partners</td>
<td>700.00</td>
<td>4,550.00</td>
<td>-84.62%</td>
</tr>
<tr>
<td>Dues Receivable-Members</td>
<td>91,082.03</td>
<td>21,998.81</td>
<td>314.03%</td>
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<tr>
<td>Dues Receivable AHCA</td>
<td>73,157.65</td>
<td>41,068.50</td>
<td>78.14%</td>
</tr>
<tr>
<td>Dues Receivables WiCAL</td>
<td>1,715.00</td>
<td>1,481.00</td>
<td>15.8%</td>
</tr>
<tr>
<td>Non-Dues Receivables</td>
<td>61,177.36</td>
<td>27,499.15</td>
<td>122.47%</td>
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<tr>
<td><strong>Total Accounts Receivable</strong></td>
<td>227,832.04</td>
<td>96,597.46</td>
<td>135.86%</td>
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</table>

Other Current Assets

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants Receivable</td>
<td>7,340.00</td>
<td>0.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Prepaid-Other</td>
<td>1,282.72</td>
<td>4,187.59</td>
<td>-69.37%</td>
</tr>
<tr>
<td>Prepaid Insurance</td>
<td>2,407.06</td>
<td>-1,430.58</td>
<td>268.26%</td>
</tr>
<tr>
<td>Undeposited Funds</td>
<td>6,573.35</td>
<td>5,403.70</td>
<td>21.65%</td>
</tr>
<tr>
<td><strong>Total Other Current Assets</strong></td>
<td>17,603.13</td>
<td>8,160.71</td>
<td>115.71%</td>
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</table>

**Total Current Assets**

<table>
<thead>
<tr>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>943,247.98</td>
<td>812,535.16</td>
<td>16.09%</td>
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**Fixed Assets**

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<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Equipment</td>
<td>21,638.88</td>
<td>21,611.18</td>
<td>0.13%</td>
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<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>21,638.88</td>
<td>21,611.18</td>
<td>0.13%</td>
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</tbody>
</table>

**Other Assets**

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacKenzie/Lynn Scholarship Fund</td>
<td>62,829.25</td>
<td>70,229.34</td>
<td>-10.54%</td>
</tr>
<tr>
<td><strong>Total Other Assets</strong></td>
<td>62,829.25</td>
<td>70,229.34</td>
<td>-10.54%</td>
</tr>
</tbody>
</table>

**TOTAL ASSETS**

<table>
<thead>
<tr>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,027,716.11</td>
<td>904,375.68</td>
<td>13.64%</td>
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</tbody>
</table>

**LIABILITIES & EQUITY**

**Liabilities**

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>0.00</td>
<td>2,596.97</td>
<td>-100.0%</td>
</tr>
<tr>
<td><strong>Total Accounts Payable</strong></td>
<td>0.00</td>
<td>2,596.97</td>
<td>-100.0%</td>
</tr>
</tbody>
</table>

Other Current Liabilities

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued Pension/Other</td>
<td>25,975.95</td>
<td>19,552.96</td>
<td>32.85%</td>
</tr>
<tr>
<td>AHCA Dues Payable</td>
<td>120,083.93</td>
<td>116,275.25</td>
<td>3.28%</td>
</tr>
<tr>
<td>Deferred Revenue-Bus Part Memb</td>
<td>7,247.28</td>
<td>8,064.50</td>
<td>-10.13%</td>
</tr>
<tr>
<td>Deferred Revenue-Conv Asses</td>
<td>2,111.25</td>
<td>2,262.50</td>
<td>-6.69%</td>
</tr>
<tr>
<td>Deferred Revenue-WHCA</td>
<td>74,915.83</td>
<td>93,547.38</td>
<td>-19.92%</td>
</tr>
<tr>
<td>Deferred Revenue-WiCAL</td>
<td>1,956.88</td>
<td>3,505.95</td>
<td>-44.18%</td>
</tr>
<tr>
<td>NCAL Dues Payable</td>
<td>3,024.88</td>
<td>-2,097.54</td>
<td>244.21%</td>
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<tr>
<td>Sales Tax Payable</td>
<td>291.47</td>
<td>300.09</td>
<td>-2.87%</td>
</tr>
<tr>
<td><strong>Total Other Current Liabilities</strong></td>
<td>235,607.47</td>
<td>241,411.09</td>
<td>-2.4%</td>
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</table>

**Total Current Liabilities**

<table>
<thead>
<tr>
<th>Oct 31, 17</th>
<th>Oct 31, 16</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>235,607.47</td>
<td>244,008.06</td>
<td>-3.44%</td>
</tr>
<tr>
<td></td>
<td>Oct 31, 17</td>
<td>Oct 31, 16</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Long Term Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MacKenzie/Lynn Scholarship Trst</td>
<td>62,829.25</td>
<td>70,229.34</td>
</tr>
<tr>
<td><strong>Total Long Term Liabilities</strong></td>
<td>62,829.25</td>
<td>70,229.34</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>298,436.72</td>
<td>314,237.40</td>
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<tr>
<td><strong>Equity</strong></td>
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</tr>
<tr>
<td>Net Assets</td>
<td>593,984.34</td>
<td>426,655.26</td>
</tr>
<tr>
<td>Net Income</td>
<td>135,295.05</td>
<td>163,483.02</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td>729,279.39</td>
<td>590,138.26</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
<td>1,027,716.11</td>
<td>904,375.68</td>
</tr>
</tbody>
</table>
### Comparative Income Statement
January through October 2017

<table>
<thead>
<tr>
<th></th>
<th>Jan - Oct 17</th>
<th>Jan - Oct 16</th>
<th>$ Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Partners</td>
<td>36,511.05</td>
<td>39,037.50</td>
<td>-2,526.45</td>
<td>-6.47%</td>
</tr>
<tr>
<td>Convention Assessment</td>
<td>11,313.75</td>
<td>11,987.50</td>
<td>-673.75</td>
<td>-5.62%</td>
</tr>
<tr>
<td>Directory &amp; Other Advertising</td>
<td>41,333.34</td>
<td>16,450.00</td>
<td>24,883.44</td>
<td>151.27%</td>
</tr>
<tr>
<td>Educational Seminars</td>
<td>82,539.82</td>
<td>54,259.99</td>
<td>28,279.83</td>
<td>52.12%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>142,077.00</td>
<td>147,525.00</td>
<td>-5,448.00</td>
<td>-3.69%</td>
</tr>
<tr>
<td>GFM Scholarship Fund Income</td>
<td>26,531.00</td>
<td>24,487.50</td>
<td>2,043.50</td>
<td>8.35%</td>
</tr>
<tr>
<td>Grant Income</td>
<td>18,350.00</td>
<td>1,400.00</td>
<td>16,950.00</td>
<td>1,210.71%</td>
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<tr>
<td>Interest Income</td>
<td>1,367.72</td>
<td>2,453.97</td>
<td>-1,086.25</td>
<td>-44.27%</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>0.00</td>
<td>10.00</td>
<td>-10.00</td>
<td>-100.0%</td>
</tr>
<tr>
<td>Service Corp. Dividend</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Special Service Income</td>
<td>11,438.00</td>
<td>10,962.00</td>
<td>476.00</td>
<td>4.34%</td>
</tr>
<tr>
<td>Spring Conference</td>
<td>122,872.00</td>
<td>157,517.50</td>
<td>-34,645.50</td>
<td>-22.0%</td>
</tr>
<tr>
<td>WHCA Dues</td>
<td>437,528.79</td>
<td>455,259.25</td>
<td>-17,730.46</td>
<td>-3.9%</td>
</tr>
<tr>
<td>WiCAL Income</td>
<td>13,047.68</td>
<td>12,247.60</td>
<td>800.08</td>
<td>6.53%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>944,910.15</td>
<td>933,597.81</td>
<td>11,312.34</td>
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<tr>
<td><strong>Gross Profit</strong></td>
<td>944,910.15</td>
<td>933,597.81</td>
<td>11,312.34</td>
<td>1.21%</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ed. Seminars</td>
<td>16,917.08</td>
<td>14,123.42</td>
<td>2,793.66</td>
<td>19.78%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>7,017.99</td>
<td>6,589.41</td>
<td>428.58</td>
<td>6.5%</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>97,850.92</td>
<td>92,810.59</td>
<td>5,040.33</td>
<td>5.43%</td>
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<tr>
<td>General</td>
<td>116,229.97</td>
<td>127,187.98</td>
<td>-10,958.01</td>
<td>-8.62%</td>
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<tr>
<td>GFM Scholarship Fund Expenses</td>
<td>26,531.00</td>
<td>28,454.90</td>
<td>-1,923.90</td>
<td>-6.76%</td>
</tr>
<tr>
<td>Office</td>
<td>94,858.12</td>
<td>90,123.21</td>
<td>4,734.91</td>
<td>5.25%</td>
</tr>
<tr>
<td>Reconciliation Discrepancies</td>
<td>0.00</td>
<td>-125.00</td>
<td>125.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Salaries</td>
<td>397,495.45</td>
<td>368,197.92</td>
<td>29,297.53</td>
<td>7.96%</td>
</tr>
<tr>
<td>Special Service Expenses</td>
<td>8,208.97</td>
<td>0.00</td>
<td>8,208.97</td>
<td>100.0%</td>
</tr>
<tr>
<td>Spring Conference</td>
<td>28,556.79</td>
<td>25,869.48</td>
<td>2,687.31</td>
<td>10.39%</td>
</tr>
<tr>
<td>Travel</td>
<td>14,531.13</td>
<td>14,327.20</td>
<td>203.93</td>
<td>1.42%</td>
</tr>
<tr>
<td>WiCAL</td>
<td>1,417.68</td>
<td>2,555.68</td>
<td>-1,138.00</td>
<td>-44.53%</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>809,615.10</td>
<td>770,114.79</td>
<td>39,500.31</td>
<td>5.13%</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>135,295.05</td>
<td>163,483.02</td>
<td>-28,187.97</td>
<td>-17.24%</td>
</tr>
</tbody>
</table>
## Comparative Income Statement

**October 2017**

### Income

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 17</th>
<th>Oct 16</th>
<th>$ Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Partners</td>
<td>3,695.83</td>
<td>3,356.25</td>
<td>339.58</td>
<td>10.12%</td>
</tr>
<tr>
<td>Convention Assessment</td>
<td>1,162.50</td>
<td>1,243.75</td>
<td>-81.25</td>
<td>-6.53%</td>
</tr>
<tr>
<td>Directory &amp; Other Advertising</td>
<td>750.00</td>
<td>0.00</td>
<td>750.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Educational Seminars</td>
<td>714.00</td>
<td>8,143.00</td>
<td>-7,429.00</td>
<td>-91.23%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>48,209.00</td>
<td>14,338.00</td>
<td>33,871.00</td>
<td>236.23%</td>
</tr>
<tr>
<td>Grant Income</td>
<td>1,835.00</td>
<td>0.00</td>
<td>1,835.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Interest Income</td>
<td>99.79</td>
<td>253.57</td>
<td>-153.78</td>
<td>-60.65%</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Service Corp. Dividend</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Special Service Income</td>
<td>1,284.15</td>
<td>3,480.00</td>
<td>-2,195.85</td>
<td>-63.1%</td>
</tr>
<tr>
<td>WHCA Dues</td>
<td>45,126.85</td>
<td>45,577.50</td>
<td>-450.65</td>
<td>-0.99%</td>
</tr>
<tr>
<td>WiCAL Income</td>
<td>1,204.58</td>
<td>1,077.43</td>
<td>127.15</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

**Total Income**

|          | 104,081.70 | 77,469.50 | 26,612.20 | 34.35% |

### Gross Profit

|          | 104,081.70 | 77,469.50 | 26,612.20 | 34.35% |

### Expense

<table>
<thead>
<tr>
<th>Category</th>
<th>Oct 17</th>
<th>Oct 16</th>
<th>$ Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ed. Seminars</td>
<td>5,199.51</td>
<td>510.00</td>
<td>4,689.51</td>
<td>919.51%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>4,175.00</td>
<td>4,760.78</td>
<td>-585.78</td>
<td>-12.3%</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>11,067.68</td>
<td>7,788.60</td>
<td>3,279.08</td>
<td>42.1%</td>
</tr>
<tr>
<td>General</td>
<td>12,682.07</td>
<td>11,368.31</td>
<td>1,313.76</td>
<td>11.56%</td>
</tr>
<tr>
<td>GFM Scholarship Fund Expenses</td>
<td>4,250.31</td>
<td>8,500.89</td>
<td>-4,250.58</td>
<td>-50.0%</td>
</tr>
<tr>
<td>Office</td>
<td>8,790.94</td>
<td>7,469.57</td>
<td>1,321.37</td>
<td>17.69%</td>
</tr>
<tr>
<td>Salaries</td>
<td>41,475.16</td>
<td>33,364.00</td>
<td>8,111.16</td>
<td>24.31%</td>
</tr>
<tr>
<td>Travel</td>
<td>1,239.56</td>
<td>0.00</td>
<td>1,239.56</td>
<td>100.0%</td>
</tr>
<tr>
<td>WiCAL</td>
<td>0.00</td>
<td>2,306.49</td>
<td>-2,306.49</td>
<td>-100.0%</td>
</tr>
</tbody>
</table>

**Total Expense**

|          | 88,880.23  | 76,068.64  | 12,811.59 | 16.84%  |

### Net Income

|          | 15,201.47   | 1,400.86   | 13,800.61 | 985.15% |
## WHCA/WiCAL
### Income Statement
January through October 2017

<table>
<thead>
<tr>
<th>Income</th>
<th>Jan - Oct 17</th>
<th>Annual Budget</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Partners</td>
<td>36,511.05</td>
<td>45,174.96</td>
<td>80.82%</td>
</tr>
<tr>
<td>Convention Assessment</td>
<td>11,313.75</td>
<td>13,500.00</td>
<td>83.81%</td>
</tr>
<tr>
<td>Directory &amp; Other Advertising</td>
<td>41,333.34</td>
<td>24,999.96</td>
<td>165.33%</td>
</tr>
<tr>
<td>Educational Seminars</td>
<td>82,539.82</td>
<td>51,999.96</td>
<td>158.73%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>142,077.00</td>
<td>157,915.08</td>
<td>89.97%</td>
</tr>
<tr>
<td>GFM Scholarship Fund Income</td>
<td>26,531.00</td>
<td>0.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Grant Income</td>
<td>18,350.00</td>
<td>21,999.96</td>
<td>83.41%</td>
</tr>
<tr>
<td>Interest Income</td>
<td>1,367.72</td>
<td>2,100.00</td>
<td>65.13%</td>
</tr>
<tr>
<td>Special Service Income</td>
<td>11,438.00</td>
<td>11,021.04</td>
<td>103.78%</td>
</tr>
<tr>
<td>Spring Conference</td>
<td>122,872.00</td>
<td>158,141.04</td>
<td>77.7%</td>
</tr>
<tr>
<td>WHCA Dues</td>
<td>437,528.79</td>
<td>549,920.04</td>
<td>79.56%</td>
</tr>
<tr>
<td>WiCAL Income</td>
<td>13,047.68</td>
<td>13,041.00</td>
<td>100.05%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>944,910.15</td>
<td>1,049,813.04</td>
<td>90.01%</td>
</tr>
<tr>
<td><strong>Gross Profit</strong></td>
<td>944,910.15</td>
<td>1,049,813.04</td>
<td>90.01%</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ed. Seminars</td>
<td>16,917.08</td>
<td>16,550.88</td>
<td>102.21%</td>
</tr>
<tr>
<td>Fall Convention</td>
<td>7,017.99</td>
<td>36,216.12</td>
<td>19.38%</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>97,850.92</td>
<td>129,136.08</td>
<td>75.77%</td>
</tr>
<tr>
<td>General</td>
<td>116,229.97</td>
<td>196,791.12</td>
<td>59.06%</td>
</tr>
<tr>
<td>GFM Scholarship Fund Expenses</td>
<td>26,531.00</td>
<td>0.00</td>
<td>100.0%</td>
</tr>
<tr>
<td>Office</td>
<td>94,858.12</td>
<td>117,055.80</td>
<td>81.04%</td>
</tr>
<tr>
<td>Salaries</td>
<td>397,495.45</td>
<td>496,144.96</td>
<td>79.8%</td>
</tr>
<tr>
<td>Special Service Expenses</td>
<td>8,208.97</td>
<td>12,933.96</td>
<td>63.47%</td>
</tr>
<tr>
<td>Spring Conference</td>
<td>28,556.79</td>
<td>28,556.52</td>
<td>100.0%</td>
</tr>
<tr>
<td>Travel</td>
<td>14,531.13</td>
<td>10,199.16</td>
<td>142.47%</td>
</tr>
<tr>
<td>WiCAL</td>
<td>1,417.68</td>
<td>3,999.96</td>
<td>35.44%</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>809,615.10</td>
<td>1,049,584.56</td>
<td>77.14%</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>135,295.05</td>
<td>228.48</td>
<td>59,215.27%</td>
</tr>
</tbody>
</table>
→ As of 12/1/17: $17,873 total raised.
→ 71% toward our $25,000 goal.

→ 100% Board Member Goal:
  
  o 15 of 27 board members have contributed.
  o 56%
  
  ▪ 0 Board members have given since the last Board meeting.

December Fundraising Activity:

- End-of-year marketing campaign
- Revised goal of $25,000
- See attachment for more details.

Recent/Upcoming PAC activity

→ October 25: Risser SSDC Event
→ December 5: RACC Bowling Event
ONE MONTH TO REACH OUR ANNUAL FUNDRAISING GOAL!

The WHCA/WiCAL Political Action Committee is on pace to break fundraising records.

But we need your help to reach our 2017 goal.

**PLEASE DONATE TODAY TO HELP THE WHCA/WiCAL PAC END THE YEAR STRONG!**

Earlier this year, we set a lofty fundraising goal of $20,000. We nearly reached that goal through our first campaign push earlier this year. We want to continue the momentum by setting a new goal - **$25,000**.

WHCA/WiCAL and our members have seen many successes through the current legislative session, including:

- 2% SNF Medicaid Reimbursement increase in each year of the 2017-19 biennium
- $60.7 million increase in Family Care funding
- Governor's veto of a budget provision to transfer nursing home beds free of cost
- Assembly passage of the CNA Training Bill with momentum growing in the State Senate.
A Representative of EVERY MEMBER FACILITY is being asked for $2/bed. WHCA/WiCAL needs your help to ensure that we get our message out.

Please write your personal check to WHCA/WiCAL PAC and send it to:
131 W. Wilson St. #1001
Madison, WI 53703

-OR-

2. GO HERE to donate using your personal credit card!

You can make a single payment or set up recurring contributions.

THANK YOU to all who have already given to the PAC. Your contribution directly helps to advance the best interests of the long-term care provider community!

WHCA/WiCAL PAC, Tom Graves, Treasurer.
ACTION NEEDED: Ask Your State Senator to Advance the CNA Training Bill

CONTACT YOUR STATE SENATOR:
ASK THEM TO HOLD A HEARING AND PASS CNA TRAINING BILL

Last week, the Wisconsin State Assembly passed the CNA Training Bill, which ensures that the State of Wisconsin could not require more than federal training standard for Certified Nursing Assistants.

Please help keep the momentum up for this legislation!

- As soon as possible, take a moment to look up your State Senator: legis.wi.gov/waml. Fill in your address in the upper right-hand corner.
- Find your Senator’s email address, which is in the format of Sen.NAME@legis.wi.gov, copy the message below into an email, fill in the blanks, and send to your State Senator:

Dear Sen. XXXX:

Last week, the Wisconsin State Assembly on a bipartisan basis passed the CNA Training Bill (AB-432). This legislation would help the Wisconsin long-term care provider community recruit more critically needed frontline caregivers. Wisconsin currently faces a serious caregiver workforce shortage and we need your help. Please encourage your colleagues to hold a public hearing on the CNA training bill (AB-432/SB-341) and pass this important legislation.

Thank you for your help on this important matter!

NAME

FACILITY

3. If you need more information, here are some resources:

- Workforce Report
- WHCA/WiCAL Testimony on AB-432
- WHCA/WiCAL Press Release on AB-432 Passage

Email or CC Jim Stoa, WHCA/WiCAL’s Director of Public Affairs at jstoa@whcawical.org to let him know that you contacted your State Senator.

Please reach out to your State Senator today!

Posted in Legislation & Advocacy, Workforce
AN ACT to create 146.43 of the statutes; relating to: dementia specialist certification.

Analysis by the Legislative Reference Bureau

This bill creates a dementia specialist certification. The bill prohibits any person from using the title “dementia specialist” or “certified dementia specialist” without the certification. If a person successfully completes an instructional program that provides the instruction specified in the bill, the instructional program administrator must certify that person as a dementia specialist.

For further information see the state fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 146.43 of the statutes is created to read:

146.43 Dementia specialist certification. (1) INSTRUCTIONAL PROGRAM;

certification. (a) If an instructional program provides instruction on all of the following, the program may offer a dementia specialist certification:
1. Understanding the signs and symptoms of the various forms of dementia and the possible variations in care needs among individuals affected by the various forms of dementia.

2. How to approach, observe, listen to, and communicate with an individual with dementia.

3. Recognizing pain in an individual with dementia.

4. Skills and techniques for encouraging purposeful activities to provide holistic care intended to promote optimal life experiences for persons with dementia.

5. Understanding the needs of an individual with dementia, how to develop a trusting relationship within the challenges of the effects of dementia, and how to avoid and manage behaviors that may be harmful to the individual or others.

6. Communication skills necessary to communicate with coworkers, professionals, and families regarding individuals with dementia.

7. Skills necessary to effectively advocate for the needs and interests of persons with dementia.

8. Developing and using care plans to assist individuals with dementia in experiencing the highest possible quality of life.


(b) An instructional program administrator who is offering a dementia specialist certification under par. (a) shall certify as a dementia specialist any person who successfully completes, under criteria established by the instructional program administrator, the instructional program described under par. (a).
(2) Prohibitions on use of title. No person may use the title “dementia specialist” or “certified dementia specialist” unless he or she is certified under sub. (1).
November 28, 2017

Please Participate in AHCA/NCAL SNF Margin Study

New payment models, the expansion of managed care, and regulatory changes have all had a significant impact on our profession. More change is coming, and our job is to help you prepare for that change.

To help us build new and stronger advocacy tools to fight for nursing facilities and skilled nursing facility (SNF) resources, we need to learn more about your facilities. We already know that state Medicaid programs pay less than it costs to provide care. We also know that both Medicare and Medicaid managed care is expanding and the federal Centers for Medicare and Medicaid Services is exploring a new Medicare Prospective Payment System for SNFs. To help us all be stronger advocates for adequate funding, please participate in the study below.

The new information collected will be extremely important in advocacy in the near future and we want to ensure that Wisconsin has data included.
A few important reminders about the study:

- AHCA and BDO have focused on making completion of the survey as easy as possible and assure members that all information will be confidential and only blinded summary level data will be shared publicly. The survey is web-based.

- If your building is part of a regional chain or larger company, check with your corporate office to determine whether your home office is completing the survey.

- Click here to visit the webpage and view a video on how to complete the survey. Please complete the survey no later than December 8, 2017.

QMB & Coinsurance Issue

On October 2, CMS made a number of problematic changes to billing programming, remittance advise and related guidance associated with QMBs.

Today, CMS issued corrective guidance to providers, states and plans. To view the guidance, click here.

Beginning December 8, 2017, CMS systems will revert back to the previous display of patient responsibility for QMBs on RAs. Providers may want to hold QMB claims and submit them after December 8.

WHCA/WiCAL: The Wisconsin Health Care Association/Wisconsin Center for Assisted Living is a non-profit organization dedicated to representing, protecting and advancing the interests of Wisconsin’s long-term care provider community and the residents they serve. WHCA is Wisconsin’s most representative nursing home association, as it does not restrict membership to any particular segment of the industry. In addition to its advocacy on behalf of its members, staff and residents, WHCA strives to provide its membership with the benefits of affiliation through the development and dissemination of information, training, and quality improvement assistance. WiCAL advocates for assisted living facilities by helping members provide the highest quality services to the elderly and disabled citizens of Wisconsin. WHCA/WiCAL represents more than 200 facilities, their 28,000 employees and the 27,000 residents they serve.
November 29, 2017

Curtis,

We can make any of the times you suggested work. Thank you for the opportunity to meet with you about this important issue.

WHCA/WiCAL believes that the subsequent interpretation of the additional language to the State-Family Care MCO contract that you proposed is circumnavigating legislative intent. Skilled nursing facilities received a 2 percent rate increase in the 2017-19 Budget. By indicating that it is up for negotiation between providers and MCOs as to whether providers – who are the ones that are actually providing the care – receive retroactive payments in your subsequent contract interpretations DHS places the thumb on the scales in favor of the MCOs, in effect, giving them license to deny retroactive payments. We are opposed to any subsequent DHS interpretation of this language that indicates MCOs are able to deny of retroactive payments.

Just this past week yet another facility closed its doors due to financial problems. By my understanding that makes 13 in the last year and a half. I hear from facilities all the time about the significant financial difficulties that they are experiencing. I have serious concerns about whether Department officials have adequate appreciation for the significant financial concerns that facilities are experiencing. Decisions like this could lead to further facility closures – affecting people’s lives, forcing residents to move to different facilities, requiring their families to travel further distances to visit their loves ones, and costing hard-working caregivers their jobs. That’s the bottom line here: by denying payments to facilities, the Department is undermining the financial integrity of the skilled nursing profession in Wisconsin, and limiting their ability to provide care to residents who need it.

During our meeting on Nov. 13, you and other DHS officials clearly indicated that the Family Care MCOs have adequate funds to pay these rates. While My Choice Family Care disputes that they have the funds to pay the increases included in the 2017-19 Budget – the legislative intent of the budget is crystal clear. Consistently, Department officials have indicated that Family Care MCOs, like My Choice Family Care are required to pay the Medicaid rate. The reality is that there is no negotiation between Family Care MCOs and providers – there is take it or leave it. By offering this subsequent interpretive language you are telling Family Care MCOs that they have the license to deny payment of retroactive Medicaid rates.

It is also important to note in this particular situation involving Cameo Care Center, it was caused by the delay in the setting of rates, and due to no fault of the provider. I have heard consistently that this is the result of being short-staffed in the Rate-Setting Division. Skilled nursing facilities know about being short-staffed, and I have significant concerns that decisions like this that will make this problem worse in settings where care is being provided because we are not able to offer competitive wages. Facilities should be held responsible for delays in the setting of rates, and denied already inadequate Medicaid rates through selective interpretations of Family Care MCO contracts.

I look forward to discussing this with you and Krista today.
The contract is for an effective date of 1/1/18. I can do 8:30, 9, or 2. I will have Krista join if available. We need to see this off.

Curtis J. Cunningham
Assistant Administrator for Long Term Care Programs and Benefits
Division of Medicaid Services
Wisconsin Department of Health Services
curtis.cunningham@wisconsin.gov
(608) 261-7810
All,
Based on what I received, there is a desire to add the requirement to pay the 2%. Therefore, we will be adding the following underlined language to the contract:

Medicaid Rates
a. Negotiated Rates
   If the MCO can negotiate such agreements with providers, the MCO may pay providers less than Medicaid fee-for-service rates.

b. The Medicaid Rate for Nursing Home Services
   i. In determining the “Medicaid fee-for-service rate” in Article VIII.N.8.a. and c. for the purchase of nursing home services, the MCO must employ the Medicaid fee-for-service nursing home rate methodology applied solely to the MCO’s residents in that nursing facility.
   ii. Nursing home rates must reflect the annual 2% rate increase that was included in the State’s 17-19 biennial budget.

We will now be notifying the MCOs of this change and it is likely that there will be inquiries in regards to how they can ensure compliance. While I hope there are not disputes around this language, if there are disputes the interpretation of compliance will be to have the MCO to provide evidence that they included the 2% rate increase effective January 1, 2018. While the easiest way to demonstrate compliance would be to pay the FFS rate based on the current contract language, this would not be required. The paid rate would only need to reflect the a calculation including a 2% increase starting January 1, 2018.

I appreciate every one's feedback on this issue and look forward to continuing this discussion over the next year.

Regards,
Curtis J. Cunningham
Assistant Administrator for Long Term Care Programs and Benefits
Division of Medicaid Services
Wisconsin Department of Health Services
curtis.cunningham@wisconsin.gov
(608) 261-7810
 REMINDER: Let us Know if Inclusa has Notified Your Facility of Significant Rate Changes

In response to ongoing concerns related to Family Care MCO rate cuts that have been reported by some residential providers who have residents that are enrollees in the MCO Inclusa, representatives of the provider associations met with Wisconsin Department of Health Services officials to voice concerns related to the inadequacy of rates and reported rate cuts by Inclusa. During the meeting, DHS officials indicated that they do not get involved in rate negotiations between providers and MCOs, and that such negotiations are between the provider and the particular MCO organization.

The associations have met with Inclusa on a number of occasions. According to Inclusa representatives, approximately 1,000 assisted living communities, serving 5,900 residents, are under contract with Inclusa. Inclusa has indicated approximately one-half of the residents will receive a rate cut; the other 50% will either see no rate change or an increase. We have requested additional rate details from Inclusa.

In order to ensure a sense of the scope of this issue within their respective memberships, the provider associations have sent out a survey related to rate cuts earlier this week. Click HERE to view/participate in the survey.

WHCA/WiCAL, in cooperation with the state’s other long-term care provider associations, would like to ensure that we give the long-term care provider community a good sense of their options related to contracting with Family Care MCOs moving forward. If your facility
If these efforts to contest rate cuts sought by the MCO do not produce results, providers have options, including but not limited to:

- Accept the rate that is provided.
- Notify the Family Care MCO that your facility will no longer be able to accept future residents.
- To the extent consistent with your facility's contractual obligations and other legal requirements, tell the MCO that your facility will review rates on an individual resident (current or prospective) basis and determine your facility's ability to serve the resident based on the resident's care and services needs and the rate offered. In certain circumstances, this may mean initiating discharge notices to residents for which the MCO refuses to provide an adequate rate. Note: The associations have heard from some members that Inclusa is only willing to deal with providers on an “all or nothing basis.” This policy is stated in the Discharge Clause section of the Inclusa rate-letter. However, depending on your facility’s importance to Inclusa, this approach could prove effective.
- Terminate, following the proper contractual notice requirements, the contract with the MCO, and indicate that your facility cannot continue to serve as participating provider.

Other pertinent issues from the Association’s meeting with Inclusa include:

- Inclusa stated that all providers may set up one-on-one meetings with MCO representatives and go over rates on a member-by-member basis
- The rate-setting methodology employed now by Inclusa is “member-focused” and directly related to the acuity of the member. There are no longer tiers with caps, the higher the acuity, the higher the rate.
- As the MCO combines what was previously three organizations, the GSRs newer to this methodology will see the most dramatic rate cuts (GSR 2 is the newest). GSRs 4 and 7 have been in the system several years and should see rates stabilizing.
- Rate-setting includes analyzing current rates then comparing to new methodology. If current rate is within 10% of new rate, it stays the same. If the new rate is 10–60% off, there will be a 10% cut or increase. If the new rate is >60% off, there will be a 12% cut or increase.
- Inclusa representatives indicated they intend to make all $60 million in Governor’s Budget go directly to providers. The mechanism to do this isn’t known yet but they would like to see it go into the base.
- They also indicate that it is their understanding that because they use a regression analysis to set rates, once the new funding is introduced, it should be in the base going forward and be included in the cost to continue for the next biennium.

Members with concerns regarding the adequacy of Family Care rates are encouraged to contact their legislators.

To find out who are your legislators and their contact information, go HERE and type in your address in the upper right-hand corner.

Should you have any questions or comments regarding the above information, please do not hesitate to contact WHCA/WiCAL at (608) 257-0125.
We have heard from several members who have been notified by Inclusa, an MCO serving 51 Wisconsin counties, of a January 1, 2018 reduction in the daily rate paid to assisted living providers. We are attempting to gather more information about this situation through a survey of members located in Inclusa’s service area.

You do not need to complete the survey if your organization does not contract with Inclusa to serve Family Care clients.

Because this situation is quickly evolving, please complete the survey by Tuesday, November 21, 2017. Access the survey at the following link:


Please direct questions to WHCA/WiCAL Director of Reimbursement Policy, Kate Dickson.

As always, we appreciate your participation in these crucial efforts.

Posted in Family Care, Managed Care, Member News
House Passes Tax Reform; Senate Version Keeps Medical Deduction

The House passed sweeping tax overhaul legislation Thursday, shifting efforts to the Senate. The Senate’s tax bill differs significantly from the House version in numerous ways, including the medical expenses deduction, which remains intact in the Senate version.

The House passed the bill with 227 votes. Thirteen Republicans and all Democrats voted against the legislation. On the same day, the U.S. Senate Committee on Finance voted along party lines to advance a markedly different version of tax reform that includes a partial repeal of the individual mandate included in the 2010 health care law but does not touch the medical expense deduction.

AHCA/NCAL issued a press release last week opposing the elimination of the medical expense deduction, which many long term care patients use to offset the financial burden of receiving uncompensated long term or post-acute care.

The Senate version differs primarily because of procedural rules surrounding the budget reconciliation process. In order to avoid a Democratic filibuster, Senate Republicans are using the reconciliation process to pass legislation with a simple 50-vote majority. The process, however, ties lawmakers’ hands on issues of deficit spending, meaning the Senate bill necessarily must have more offsets or fewer revenue cuts than the House version in order for it to come to the floor.

In addition to procedural hurdles, the Congressional Budget Office (CBO) issued a report indicating that the Office of Management and Budget (OMB) would be forced to cut Medicare if tax legislation creates too much deficit spending. OMB would be forced to cut Medicare spending by $25 billion, or four percent of total spending. The House version of tax legislation is projected to increase the deficit by $1.5 trillion, according to the CBO.

AHCA/NCAL will continue to monitor the tax reform effort insofar as it affects its members and the patients they serve.

From: AHCAPressOffice [mailto:ahcapressoffice@AHCA.org]
Sent: Wednesday, November 8, 2017 10:16 AM
To: Carly Sfregola <csfregola@ahca.org>
Subject: AHCA/NCAL Press Statement - Long Term Care Profession Opposes Elimination of Private Activity Bonds in Tax Proposal

For Immediate Release
November 8, 2017

Contact: AHCAPressOffice@ahca.org
(202) 898-2814

Long Term Care Profession Opposes Elimination of Private Activity Bonds in Tax Proposal

Washington, D.C. — The American Health Care Association/National Center for Assisted Living (AHCA/NCAL) President and CEO Mark Parkinson today issued the following statement regarding the tax proposal under consideration in the House of Representatives:

“AHCA/NCAL opposes the elimination of private activity bonds, a provision included in H.R. 1, “Tax Cuts and Jobs Act.” Private activity bonds are a critical form of tax-exempt financing which long term care providers utilize to fund new
construction, make infrastructure improvements, develop affordable housing and other projects. Should this provision become law, it would severely threaten the ability of providers to make these investments in the future, and would seriously damage operations for long term care providers who deliver critical care for more than one million seniors and people with disabilities.”

-30-

ABOUT AHCA/NCAL
The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,500 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day. For more information, please visit www.ahca.org or www.ncal.org.
Work Continues on Improving Requirements of Participation Rules

11/28/2017

Patrick Connole

Long term and post-acute care (LT/PAC) providers won partial relief in their attempt to delay and change the Phase 2 Requirements of Participation (RoP) that went into effect on Nov. 28 when the Centers for Medicare & Medicaid Services (CMS) last week delayed some types of enforcement of the new requirements for 18 months.

The headline action taken by CMS will provide an 18-month moratorium on the use of certain enforcement remedies (Civil Monetary Penalties, Denial of Payment for New Admissions, and discretionary termination) for specific Phase 2 requirements. Despite the delay, CMS said it may use “directed plans of correction or directed in-services” for these specific Phase 2 requirements. The 18-month delay time frame will be used to educate facilities about specific new Phase 2 standards, the agency said.

Clif Porter, senior vice president, government relations for the American Health Care Association (AHCA), says much work remains on getting to the goal of the LT/PAC profession when it comes to changing the way the new requirements both read and will be implemented.

“We are appreciative from an enforcement standpoint, but also disappointed that many of the issues we raised remain unaddressed,” he says. “While the financial penalties are not hanging over the heads of providers, there remains the burden for operators to comply, which causes a separate financial burden across the industry.”

Some of the specific requirements under Phase 2 are unnecessary, providers say, like for instance their concerns about displaying competencies in the behavioral health area even if a facility does not offer such services and other matters related to the survey process.

Porter says AHCA continues to discuss possible changes to the overall rule and hopes CMS will address industry concerns in the near term. “While many of the new regulations actually are helpful and we support them there are several that still need to be addressed and need to be changed,” he says.

Ahead of the Nov. 28 implementation date, AHCA had worked with congressional allies in the House and Senate to push the Department of Health and Human Services (HHS) and CMS to issue a one-year delay in the implementation of the updated RoP for skilled nursing facilities.

As part of the effort, a letter signed by 24 senators was sent to the heads of HHS and CMS on Oct. 26 urging such a delay, joining a similar campaign in the House which saw 122 lawmakers sign on for giving providers more time to comply with the new RoP.

CMS estimates that the cost of compliance during the first year of the updated RoP could be as much as $62,900 per facility and $55,000 in subsequent years. Across the nation, this would total $831 million in the first year and on-going annual costs of $736 million.

In addition to the challenge presented by higher costs, some of the updated requirements appear to be duplicative since, in many cases, providers have already developed effective procedures and guidelines to protect patients and ensure the provision of quality care.

CMS made its announcement of the enforcement delay in part in two memos, titled Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare and Preparation for Launch of New Long-Term Care Survey Process.

Also included in the first memo were the following key items:

- A freeze on health inspection star ratings: Following the implementation of the new survey process on Nov. 28, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare website
for any surveys occurring for the next 12 months to between Nov. 28, 2018. CMS said there is no change to
the staffing or quality measure component and the overall rating can still change based on your staffing and
quality measure component.

- Availability of Survey Findings: The survey findings of facilities surveyed under the new survey process
will be published on Nursing Home Compare, but will not be incorporated into calculations for the Five-Star
Quality Rating System for 12 months. CMS will add indicators to Nursing Home Compare that summarize
survey findings.

- Methodological Changes and Changes in Nursing Home Compare: In early 2018, Nursing Home Compare
health inspection star ratings will be based on the two most recent cycles of findings for standard health
inspection surveys and the two most recent years of complaint inspection, the agency said.

- Five-Star Rating System Changes: These changes, CMS said, would only be frozen for any surveys or
Informal Dispute Resolutions (IDRs) that are initiated after Nov. 28, 2017. Any survey or IDR that was initiated
before that date will continue to impact facility Five-Star Ratings.

In the second memo, CMS confirmed that it will begin the new survey process on Nov. 28, 2017, and in doing
so offers guidance to state surveyors as they implement the new survey.
It's clear that the Centers for Medicare & Medicaid Services (CMS) has heard our concerns about the Phase 2 Requirements of Participation. Late today, the Survey and Certification Group (S&C) at CMS issued two memos that further delay enforcement of provisions of the new requirements but falls short of the complete delay that we had sought. These memos indicate that CMS is delaying some enforcement provisions of the Phase 2 requirements, but CMS will proceed with implementing the new survey process beginning on November 28.

We are disappointed that CMS did not take additional steps to delay the new survey process and the full implementation of the new requirements. Today's memos indicate that CMS has taken several of our concerns into consideration but we must continue to push for additional change as the requirements and survey process are implemented.

The first memo, titled *Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare*, is available online [here](#). The second memo, titled *Preparation for Launch of New Long-Term Care Survey Process (LTCSP)*, is available online [here](#).

In summary, the first memo states that CMS is proceeding with implementing Phase 2 of the Requirements of Participation with the following changes:

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements**: CMS will provide an 18-month moratorium on the use of certain enforcement remedies (CMP, DPNA and discretionary termination) for specific Phase 2 requirements (see below). However, CMS may use directed plans of correction or directed inservices for these specific Phase 2 requirements. This 18-month period will be used to educate facilities about specific new Phase 2 standards.

- **Freeze Health Inspection Star Ratings**: Following the implementation of the new survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare website for any surveys occurring between November 28, 2017 and November 27, 2018. There is no change to the staffing or quality measure component and the overall rating can still change based on your staffing and quality measure component.

- **Availability of Survey Findings**: The survey findings of facilities surveyed under the new survey process will be published on Nursing Home Compare, but will not be incorporated into calculations for the Five-Star Quality Rating System for 12 months. CMS will add indicators to Nursing Home Compare that summarize survey findings.

- **Methodological Changes and Changes in Nursing Home Compare**: In early 2018, Nursing Home Compare health inspection star ratings will be based on the two most recent cycles of
findings for standard health inspection surveys and the two most recent years of complaint inspection.

**Phase 2 Requirements Impacted by the Temporary Enforcement Moratorium**

CMS has provided the following list of F-Tags included in the 18-month moratorium on use of CMPs:

- F655 (Baseline Care Plan); §483.21(a)(1)-(a)(3)
- F740 (Behavioral Health Services); §483.40F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); §483.40(a)(1)-(a)(2)
- F758 (Psychotropic Medications) related to PRN Limitations §483.45(e)(3)-(e)(5)
- F838 (Facility Assessment); §483.70(e)
- F881 (Antibiotic Stewardship Program); §483.80(a)(3)
- F865 (QAPI Program and Plan) related to the development of the QAPI Plan; §483.75(a)(2) and,
- F926 (Smoking Policies). §483.90(i)(5)

**Five-Star Rating System Changes**

Five-Star Rating changes will only be frozen for any surveys or IDRs that are initiated after November 28, 2017. Any survey or IDR that was initiated before November 28, 2017 will continue to impact facility Five-Star Ratings. Survey results, including the number, type and severity of deficiencies, will continue to be posted on Nursing Home Compare. The memo also states that in early 2018, CMS intends to recalculate all Five-Star Ratings, excluding the third oldest survey from every rating. After that time, only the past two surveys will be included in the rating system.

CMS recommends that providers impacted by this freeze that are involved with ACOs or managed care provide a copy of this memo to the ACO or hospital.

**New Survey Process**

The second memo, *Preparation for Launch of New Long-Term Care Survey Process*, confirms that CMS will begin the new survey process on November 28, 2017. The memo provides guidance to state surveyors as they implement the new survey.

As facilities are preparing for the new survey process to begin this week, AHCA has developed a free three-part series on ahcancaLED to understand what an owner or CEO needs to know about the new regulations that go into effect on November 28. Presented by Dr. David Gifford, AHCA Senior Vice President of Quality & Regulatory Affairs, and designed specifically for owners and CEOs, this new series will provide an overview of what to expect.

- Part 1: Overview and key themes
- Part 2: Overview of the new survey process
- Part 3: Key questions to ask your management team to make sure your organization is ready

To access this exclusive member benefit, visit ahcancaLED and register using your AHCA username and password. If you need additional assistance or have any questions, please contact the ahcancaLED team at educate@ahca.org.

**Conclusion**

AHCA has had ongoing discussions with CMS officials and Administrator Seema Verma about the content and implementation of the Phase 2 Requirements of Participation and the new survey process. We know that there are many concerns with the new requirements, even with the changes we have successfully fought for up to this point. CMS has indicated a willingness to continue to work with us as the requirements go into effect. AHCA will continue our efforts to find solutions that help you provide quality care.
Sincerely,

Mark Parkinson
President & CEO

This message contains confidential information and is intended only for AHCA/NCAL membership. Dissemination, distribution or copying the contents of this email beyond this group is strictly prohibited.
1. **Past noncompliance:** The revised Chapter 7 released late October indicates “This guidance does not apply to past noncompliance deficiencies as described in §7510.1 of this chapter. The determination to impose federal remedies for past noncompliance is at the discretion of the CMS Regional Office (RO).”
   a. Can CMS provide as much clarity to PNC, including instruction on determining such for both the SSAs and the provider community. Of particular note would be situations that are quite different, yet fall within a broad Ftag. Using (prior) F314 and F323 as common examples: Event occurred several months ago, i.e. fall, facility identified, corrected, monitored, yet during survey an observation unrelated, to the prior event, such as smoking is noted, thus precluding PNC. Similarly, facility failure to provide appropriate wound care treatment identified and corrected, yet single observation of resident not having heels floated, negates PNC.
   b. Can CMS clarify the “level” of correction necessary to have been undertaken to have PNC be recognized? Example: Facility’s RCA identified knowledge/skills gap for single or limited number of personnel, with corrective action taken towards this identified issue, yet the expectation seems to be applied is that “all staff must receive the corrective action” to qualify for PNC.
   c. If 75101.1 does not apply, what criteria/thought process with RO apply in determining whether and what remedies will be applied.

2. **Immediate imposition of remedies:** If s/s G is going to be applied and treated as SQC under this new policy, will CMS explicitly allow for the severity level to be challenged at IDR/IIDR? Currently, severity can only be challenged if SQC or IJ.

3. **CO Review of Large CMPs:** First version of immediate imposition of remedies indicates that CMPs in excess of $250,000 are to be referred to CO for review. S&C 18-01, which states it replaces S&C 16-31, make no reference to CO referral. Will large CMPs still be referred and reviewed at CO level?

4. **S&C 18-01-7400.3** “The purpose of federal remedies is to encourage the provider to achieve and sustain substantial compliance. In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly. While a facility is always responsible for all violations of the Medicare and Medicaid requirements, when making remedy choices, the CMS RO should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.
   a. How can this be reconciled with the mandated use of the CMP analytic tool?
   b. In current reimbursement climate, how can the application of massive CMPs be considered consistent with the purpose to “achieve and sustain” substantial compliance?

5. **Transfer Notice:** CMS clarification that provision of monthly notice to ombudsman is an appropriate means to meet requirement is a pointless exercise and waste of facility and ombudsman resources. This provides no benefit to residents, and presumably will either be simply filed by Ombudsman office, or worse, will take time and attention away from those few instances in which the ombudsman office might actually seek involvement. Will CMS provide further clarification that eliminates the notice requirement for “routine”
transfers to hospitals, particularly given that there are existing safeguards and pressures to prevent/reduce unnecessary hospital admissions and readmissions?

6. **Enforcement remedies for Phase 2 requirements:** How will CMS expect to differentiate within a deficiency if enforcement is to be applied or not, particularly if allegations of noncompliance/Ftag contain elements of both Phase 2 or non-Phase 2? Alternatively, has CMS identified which Ftags are truly only Phase 2 requirements, thus not subject to enforcement?

7. **The Health Inspection Score** is currently going to be frozen for a year. Has there been any updates to this? If the score remains frozen for one year what is the methodology being used when it becomes live again?

8. What is the expectation/goal for a **policy for food brought in from visitors**? It appears to be a focus considering it is on the entrance conference worksheet.

9. Residents with “dehydration” are to be identified on the Matrix. The definition is somewhat misleading in that the examples given could include several residents that have no hydration issues. Is there any further clarification on what “actual” hydration concerns mean? This matrix definition leaves room for many interpretations.

10. **F661 Discharge Summary** refers to the residents most recent comprehensive MDS assessment as being a part of the information that must be given to the resident/resident representative. Some are interpreting this to mean a copy of the comprehensive MDS must be given. Could you provide clarification if this is the expectation? If not, what is the expectation that would be sufficient for compliance?

11. **F743 No Pattern of Behavioral Difficulties Unless Unavoidable:** Examples given in the guidance refer to depression and withdrawal, etc. Many residents that come to a SNF have not been properly diagnosed and treated for these conditions until they enter the SNF. Many times these undiagnosed and untreated conditions prior to being admitted to a SNF has caused the need for the SNF admission. When reading this cite and examples it is concerning that this could be any number or residents within a SNF facility.
DATE: November 24, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare

Memorandum Summary

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements:** CMS will provide an 18 month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18 month period will be used to educate facilities about specific new Phase 2 standards.

- **Freeze Health Inspection Star Ratings:** Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018.

- **Availability of Survey Findings:** The survey findings of facilities surveyed under the new LTC survey process will be published on NHC, but will not be incorporated into calculations for the Five-Star Quality Rating System for 12 months. CMS will add indicators to NHC that summarize survey findings.

- **Methodological Changes and Changes in Nursing Home Compare:** In early 2018, NHC health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspections.

Background

On September 28, 2016, CMS revised the SNF and NF Requirements for Participation, which became effective on November 28, 2016, and have a three-part phase-in of implementation dates over three years. Phase 1 became effective on November 28, 2016. Implementation of the new regulations for nursing homes under Phase 2 will become effective on November 28, 2017 (see S&C memo: 17-36-NH, dated June 30, 2017).
We also published revised interpretive guidance for Appendix PP of the SOM with the June 30, 2017 memo reflecting the new regulatory changes, which includes renumbering the nursing home F-Tags to correspond with the new regulatory sections. Implementation of Phase 2 reforms is scheduled to occur simultaneously with a new, computer-based LTC survey process in which we are incorporating the new regulatory requirements as well as combining the Traditional and Quality Indicator Survey processes.

To address concerns about the implementation of the new requirements and new LTC survey process, CMS will be making specific policy and process adjustments to the enforcement system and results posted on Nursing Home Compare. These changes are described in more detail below.

**Temporary Moratorium on Imposition of Certain Enforcement Remedies**

To address concerns regarding the scope and timing of the revised requirements (42 CFR part 483, subpart B), there will be a 18-month moratorium on the imposition of civil money penalties (CMPs), discretionary denials of payment for new admissions (DPNAs) and discretionary termination where the remedy is based on a deficiency finding of one of the specified Phase 2 F-tags noted below. CMS is not extending the moratorium to F608 which addresses reporting reasonable suspicion of a crime due to the concerns about significant resident abuse going unreported. CMS will use this 18-month moratorium period to educate surveyors and the providers to ensure they understand the health and safety expectations that will be evaluated through the survey process since these Phase 2 requirements are associated with unique and separate tags where specialized efforts and technical assistance may be needed. Previous communication indicated that the moratorium would be in effect for 12 months; that has been extended to 18 months to ensure provider understanding and readiness. Deficiency findings for all other F-tags will follow the standard enforcement process which includes all available enforcement remedies. Please note, facilities cited for any noncompliance with Phase 1 or Phase 2 requirements (beginning November 28, 2017), or both, will continue to be subject to statutorily-required provisions (mandatory DPNA and termination for failure to achieve substantial compliance within the required timeframes). Further note that this 18 month moratorium on the imposition of remedies does not change the implementation date for the Phase 2 provisions and state survey agencies should cite these tags as appropriate and continue to forward their findings to the RO as normal.

The following F-Tags included in this moratorium are:

- F655 (Baseline Care Plan); §483.21(a)(1)-(a)(3)
- F740 (Behavioral Health Services); §483.40
- F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); §483.40(a)(1)-(a)(2)
- F758 (Psychotropic Medications) related to PRN Limitations §483.45(e)(3)-(e)(5)
- F838 (Facility Assessment); §483.70(e)
- F881 (Antibiotic Stewardship Program); §483.80(a)(3)
- F865 (QAPI Program and Plan) related to the development of the QAPI Plan; §483.75(a)(2) and,
- F926 (Smoking Policies). §483.90(i)(5)
For surveys identifying noncompliance of both Phase 1 and the Phase 2 tags specified above, the CMS Regional Office (RO) will follow standard enforcement procedures related to the Phase 1 tag if the Phase 1 tag(s) necessitates the imposition of remedies. For example, if a survey conducted during the moratorium period cites deficiencies both for infection control practices at tag F880 and antibiotic stewardship at tag F881 and the RO determines enforcement remedies are warranted, the RO may impose appropriate remedies as it relates to F880; however, only a Directed Plan of Correction (DPOC) and/or Directed In-Service training (DIST) remedy could be imposed for the findings related to tag F881. Once the temporary moratorium period is over, enforcement for all cited tags will return to the normal enforcement policies. The following chart explains how the enforcement remedies will be applied during the 18-month moratorium time period.

**Application of Discretionary Enforcement Remedies During 18 Month Moratorium**

<table>
<thead>
<tr>
<th>Discretionary Enforcement Remedies</th>
<th>Phase 1 Tags Only</th>
<th>Both Phase 1 and Phase 2 Tags</th>
<th>Phase 2 Tags Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Enforcement Policies Apply Or 18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)</td>
<td>Normal Enforcement Policies Apply</td>
<td>Normal Enforcement Policies Apply for the Phase 1 tag(s); and DPOC/DIST only may be imposed for Phase 2 tag(s)</td>
<td>18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)</td>
</tr>
</tbody>
</table>

**Directed Plan of Correction**

A Directed Plan of Correction (as defined in 42 CFR §488.424) is an enforcement remedy developed by CMS, the State Survey Agency (or a temporary manager if applicable) requiring a facility to take action within specified timeframes to correct cited non-compliance. For these Phase 2 F-Tags identified above, we expect that the Directed Plan of Correction would address the structures, policies and processes needed by the facility to demonstrate and maintain substantial compliance.

A Directed Plan of Correction is completed when the facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that can be verified by CMS without an on-site visit. Surveyors are expected to go back on-site to review compliance when there is a credible allegation of compliance by the facility if any of the F-tags cited are Substandard Quality of Care (SQC), or when tags are at the actual harm or immediate jeopardy levels. See § 7317.2 of the CMS State Operations Manual (SOM) for information concerning on-site revisits and § 7500 for information concerning Directed Plans of Correction.
**Directed In-Service Training**

Directed In-Service Training is an enforcement remedy that may be used when CMS or the State, (or the temporary manager if applicable) believes that education is likely to correct the deficiencies and help the facility achieve and sustain substantial compliance. For this remedy to be used effectively and appropriately, the deficiency finding should demonstrate that a knowledge deficit significantly contributed to the deficiency. This remedy requires the relevant staff of the facility to attend an in-service training program that will address a demonstrated knowledge deficit. The purpose of directed in-service training is to provide the information necessary for the facility to achieve and maintain substantial compliance. Facilities should use programs developed by well-established centers of geriatric health services education such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or CMS RO may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize their state’s ombudsman program to provide training about residents’ rights and quality of life issues.

After the directed in-service training has been completed, CMS RO or the State will assess whether substantial compliance has been achieved either through an on-site visit or by examining credible written evidence that it can be verified without an on-site visit. See § 7317.2 of the SOM for information concerning on-site revisits and § 7502 for information concerning Directed In-Service Training.

**Statutorily Mandated Remedies not affected by Temporary Moratorium**

The temporary moratorium described above does not include remedies that are required by federal law such as the Denial of Payment for New Admissions (DPNA) if the facility has not achieved compliance within 3 months of the finding under sections 1819(h)(2)(D) and 1919(h)(3)(C) of the Social Security Act (Act) and Termination after 23 days for immediate jeopardy under sections 1819(h)(4) and 1919(h)(5) of the Act or termination after 6 months for non-immediate jeopardy noncompliance under sections 1819(h)(2)(C) and 1919(h)(2)(D) of the Act.

CMS expects that the non-compliance for covered Phase 2 requirements would be corrected in advance of the statutorily-mandated timeframes as occurs with most cited deficiencies.

**Temporary Freeze of Health Inspection Five-Star Ratings**

Most facilities will be surveyed for compliance with Phase 2 requirements using the LTC revised survey process within one year after the November 28, 2017 Phase 2 implementation date. Due to the differing standards and process between those facilities surveyed under the new survey process compared to prior surveys, CMS will be holding constant, or “freezing,” the health inspection star rating for health inspection surveys and complaint investigations conducted on or after November 28, 2017. We expect this freeze to begin in early 2018, and last approximately one year. Note that recent health surveys and complaint investigations conducted before November 28, 2017, will continue to be calculated in a facility’s star rating, including any revisit
or changes based on informal dispute resolutions (IDR) or independent IDR. *Examples of when ratings can change include:*

1) A standard health inspection survey and revisit is conducted within the month of October 2017, and is closed after November 28, 2017. The survey results will be used in the nursing home’s star rating as a survey conducted before the ratings freeze. Similar actions will take place for complaint investigations conducted prior to the ratings freeze.

2) A request for an IDR is received prior to the freeze and completed after November 28, 2017 with a change in scope/severity for at least one citation. The change will be reflected in the nursing home’s star rating as a change prior to the ratings freeze.

Additionally, the health inspection star rating will no longer use information of the third (oldest) cycle of health inspection survey and complaint investigation data that is part of a nursing home’s health inspection score. The weighted health inspection score and star rating for all nursing homes will then be based on the two most recent cycles of survey data. This change is to account for the fact that the data would have been dropped from the health inspection score because of its age, as part of the normal update process. This change will also occur in early 2018 for all facilities. At that time, the most recent cycle of data will be weighted at 60 percent and the prior cycle of data will receive a 40 percent weighting. We will be updating the *Five Star Quality Rating System* Technical User’s Guide to reflect these changes.

CMS will continually monitor survey activity during the one year period to determine if any changes to the freezing methodology need to be made.

**Other Changes to Nursing Home Compare**

In addition to the items listed above, CMS is implementing other adjustments to ensure transparency. In addition to freezing the health inspection star rating on *Nursing Home Compare*, CMS plans to provide summaries of a facility’s most recent survey findings, such as the total number of deficiencies cited, and the highest scope and severity level cited. This also includes identifying nursing homes with deficiency-free surveys. We also will post the full report of each survey (Form CMS-2567), which provides more details about the survey findings. We expect to implement these changes in early 2018, concurrent with the changes to the *Five Star Quality Rating System*.

CMS is aware that multiple programs (e.g., accountable care organizations (ACOs), bundled payment models, Medicare Advantage plans) use the *Five-Star Quality Rating System* as a component of their program. We have communicated information about changes to the rating system noted in this memorandum to these programs so they can evaluate any potential impact, and make any changes they feel warranted. The *Nursing Home Compare* website will also display information about the changes to the ratings system. For questions about how the *Five-Star Quality Rating System* is used or may impact one of these or other programs, we encourage individuals to communicate directly with the program’s specific organizational or primary contact.

The changes explained in the memorandum serve a temporary need to accommodate the implementation of the first major regulatory change to the LTC requirements in over 25 years.
These types of changes are rare, and the *Five Star Quality Rating System* and *Nursing Home Compare* website remain an excellent source for information about nursing homes. In addition to survey findings, consumers can find information about quality measures and staffing to help support their decision making. We’re also looking forward to future improvements, such as the inclusion of new staffing data from the Payroll-Based Journal program. That said, we believe the website and ratings system is one source of information about nursing homes, but consumers should seek other sources as well. For example, we encourage families to visit the facility and speak to the administrator, other staff, current residents, or the family or resident council. Also, speak with their physician or friends who have had similar situations.

**Contact:** For questions or concerns, please contact NHSurveyDevelopment@cms.hhs.gov

**Effective Date:** November 28, 2017. This policy should be immediately communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators.

/s/

David R. Wright

cc: Survey and Certification Regional Office Management
DATE: October 27, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification regarding Nurse Aide Training and Competency Evaluation Program (NATCEP/CEP) Waiver and Appeal Requirements

Memorandum Summary

- **Existing Waiver and Appeal Authorities:** The Centers for Medicare & Medicaid Services (CMS) is providing clarification regarding existing statutory and regulatory authority regarding waivers and appeals of NATCEP/CEP prohibition or loss.

Background

The NATCEP/CEP is a statutory requirement and is the standardized training program that all nurse aides must meet to work in a Skilled Nursing Facility (SNF), Nursing Facility (NF) or a dually participating SNF/NF. States operate the approval process for the NATCEP/CEP programs.

Sections 1819(f)(2)(B)(iii)(I) and 1919(f)(2)(B)(iii)(I) of the Social Security Act (the Act) prohibit the approval, in certain cases, to operate a NATCEP/CEP program for two years based on survey findings or waivers of minimum requirements for licensed nurse coverage.

Specifically, a facility may not operate a NATCEP/CEP program for two years if:

1. It is operating under a waiver for coverage by licensed nurses;
2. It has been subject to an extended survey or partial extended survey;
3. It has been assessed a Civil Money Penalty (CMP) of at least $10,483 as adjusted by 45 CFR 102*; or,
4. Has been subject to imposition of a denial of payment, temporary manager, or termination.

* The assessed amount is the final CMP amount determined to be owed, e.g., after waiver of right to a hearing, administrative appeals, settlement, dispute resolutions.
Note: Per the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, adjustments to the civil money penalties are expected to be published annually. These adjustments will be published in the Federal Register and located at 45 CFR Part 102.

If a facility loses the authority to operate a NATCEP/CEP program, in some cases, they may regain the ability to operate their program prior to end of the 2-year ban through the following authorities or waivers:

1. State Authority to Waive NATCEP/CEP Disapproval

Sections 1819(f)(2)(C) and 1919(f)(2)(C) of the Social Security Act (the Act) provide waiver authority for NATCEP/CEP if the State—

   (i) determines that there is no other such program offered within a reasonable distance of the facility,
   (ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and,
   (iii) provides notice of such determination and assurances to the State long-term care ombudsman.

The State is responsible for development of policies and procedures to implement this waiver authority. For example, the state may require that the facility submit a specific waiver request to the State. The State will make the final determination after considering the recommendations and facts of the case as provided by the facility and in accordance with each of the above requirements, as operationalized by the State.

The State’s authority to waive the NATCEP/CEP loss can be granted under any of the reasons described above, provided that the statutory requirements and any additional programmatic requirements established by the State are met.

2. CMS Regional Office authority to waive disapproval of NATCEP/CEP Due to Civil Money Penalties (CMPs) - 1819(f)(2)(B)(iii)(c), (D) and 42 CFR §483.151

Facilities may also request a waiver of NATCEP/CEP loss based on a CMP if the amount imposed is at least $10,483 as adjusted by 45 CFR 102 and the CMP was not related to the quality of care furnished to residents. “Quality of care furnished to residents” means the direct hands-on care and treatment that a health care professional or direct care staff furnished to a resident. This definition is not limited exclusively to Substandard Quality of Care (SQC) deficiencies.

A waiver based on NATCEP/CEP loss due to a CMP must be submitted to the State Survey Agency. The State will refer this request to the CMS Regional Office (RO). While the waivers should be submitted to the State, CMS will make the final determination on a case by case basis after considering the recommendation and facts of the case as provided by the State.
3. Appeal Rights in Cases for NATCEP/CEP Disapproved Due to Extended/Partial Extended Survey - 42 CFR §§498.3(b)(14)(ii) and 498.3(b)(16)

When NATCEP/CEP is lost due to an extended or partial extended survey as a result of Substandard Quality of Care (SQC) findings, the facility has the right to request an appeal of these findings to the HHS Departmental Appeals Board (for SNFs and SNF/NFs) or the state (for NFs).

The loss of NATCEP occurs after the time frame for requesting a hearing has expired, after receipt of a written waiver of appeal, or after the civil money penalty is upheld on administrative appeal.

Other Considerations

In addition to a formal appeal process, facilities are offered dispute resolution processes, which may affect the outcome of the disapproval or loss of the NATCEP/CEP program:

- Regulations at 42 CFR §488.331 require that facilities are offered an informal opportunity to dispute cited deficiencies through an Informal Dispute Resolution (IDR) process.
- In addition, sections 1819(h)(2)(B)(ii)(IV) and 1919(h)(2)(B)(ii)(IV) of the Act and regulations at 42 CFR §488.331 facilities are provided the opportunity to request and participate in an Independent IDR process (IIDR) if CMS imposes CMPs and these penalties are subject to being collected and placed in an escrow account pending a final administrative decision.

An IDR or an IIDR that removes or reduces the findings that required the loss of NATCEP/CEP will result in a restoration of that facility’s program.

Contact: If the State has questions above the NATCEP/CEP program, please contact the CMS Regional Office. For other questions, please feel free to send these to the dnh_triageteam@cms.hhs.gov.

Effective Date: Immediately. This reminder of current policy should be communicated with all survey, certification and enforcement staff, their managers, State/Regional Office training coordinators and the State Nurse Aide registry staff within 30 days of this memorandum.

/s/
David R. Wright

Attachment: Waiver and Appeals Authority Chart

cc: Survey and Certification Regional Office Management
    State Medicaid Agencies
Attachment 1

WAIVER AND APPEAL AUTHORITIES FOR DISAPPROVAL or LOSS OF NATCEP/CEP PROGRAMS

Facilities may seek any of the following in pursuing review of their disapproval or loss of their NATCEP/CEP program.

<table>
<thead>
<tr>
<th>Reason for Disapproval</th>
<th>Extended/Partial Extended Survey, CMP, Denial of Payment, Temporary Manager, Waiver of Licensed Nurse</th>
<th>CMP of no less than $10,483 – due and payable</th>
<th>Extended/Partial Extended Survey Finding of SQC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waivers Allowable</td>
<td>NATCEP program, may be offered in (but not by) a SNF or NF if the State—</td>
<td>If the deficiency is not related to Quality of Care for residents – meaning direct hands-on care and treatment that a health care professional or direct care staff furnished to a resident</td>
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<td></td>
<td>(i) determines that there is no other such program offered within a reasonable distance of the facility,</td>
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<td></td>
<td>(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and</td>
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<td>(iii) provides notice of such determination and assurances to the State long-term care ombudsman.</td>
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<tr>
<td>Appeal Rights</td>
<td></td>
<td>Appeal of Level of Non-compliance - 42 CFR §§498.3(b)(14)(i)(ii), (b)(16)</td>
<td></td>
</tr>
<tr>
<td>Who Determines</td>
<td>State determines, does not require CMS approval.</td>
<td>State Recommends/CMS Regional Office Determines</td>
<td>SNF only and SNF/NF - Departmental Appeals Board (DAB) determines. NF only – State determines</td>
</tr>
</tbody>
</table>
DATE: November 24, 2017
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Preparation for Launch of New Long-Term Care Survey Process (LTCSP)

Memorandum Summary

- **The new computer-based LTCSP will be effective November 28, 2017.**
- **Appendix P will no longer be available:** Beginning with surveys occurring on November 28, 2017, Appendix P will no longer be accessible. The LTCSP procedure guide will replace Appendix P as the procedural and technical guide for conducting LTC standard surveys. Chapter 7 of the State Operations Manual (SOM) will be revised to include survey policy.
- **Survey Resources:** A link to resources surveyors will need to conduct LTC surveys will be made available on November 17, 2017. Surveyors must download items included on this link to their survey laptops by November 28, 2017.

Background

Beginning November 28, 2017, the Centers for Medicare & Medicaid Services (CMS) is launching the new LTCSP. The LTCSP will be implemented by each state for all LTC standard surveys and reflects CMS efforts to create an effective and efficient survey process that combines the best of both the Traditional and Quality Indicator Survey processes into a single nationwide survey process.

CMS began weekly training sessions in July, in an effort to ensure that all States and Regions have been fully trained in the new LTCSP.

Appendix P No Longer Available

Appendix P of the SOM has historically been the survey protocol, containing high-level policy as well as step-by step procedures for conducting the LTC standard survey. During development and testing of the new survey process, a LTCSP procedure guide was created. This procedure guide has undergone revisions based on test results, is now finalized, and will replace Appendix P as the procedural and technical guide for conducting LTC standard surveys. The LTCSP procedure guide will be made available to all surveyors via a Survey Resources link (see below).
Policies not included in the LTCSP procedure guide will be added to Chapter 7 of the SOM.

**Survey Resources**

CMS has identified survey policy-related information which surveyors will need to conduct surveys, and has either incorporated it into the survey software, the LTCSP procedure guide, or created a separate document that is available on the Survey Resources link at the following website: [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html).

Surveyors must download items included on this link to their survey laptop computers prior to conducting surveys on November 28th. CMS recommends creating a folder on the desktop entitled “Survey Resources” and saving each document to this folder.

**Contact:** For questions or concerns, please contact NHSurveyDevelopment@cms.hhs.gov.

**Effective Date:** Immediately. This information should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 10 days of this memorandum.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management
DATE: October 27, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revised Policies regarding the Immediate Imposition of Federal Remedies- FOR ACTION

Memorandum Summary

- This policy memo replaces S&C: 16-31-NH released July 22, 2016 and the revision on July 29, 2016.

- Revisions to Chapter 7 of the State Operations Manual (SOM) (Attachment): The Centers for Medicare & Medicaid Services (CMS) has revised guidance relating to the Immediate Imposition of Federal Remedies. Other sections of Chapter 7 have been revised to ensure consistency with these revisions. Major revisions include:
  - We specify that when the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regions may determine the most appropriate remedy;
  - We clarified that Past Noncompliance deficiencies as described in §7510.1 of this chapter, are not included in the criteria for Immediate Imposition of Remedies;
  - For Special Focus Facilities (SFFs), we now exclude any S/S level “F” citations under tags F812, F813 or F814 from the tags that require immediate imposition of remedies.

- This memo is being released in draft. We seek comment on this policy by December 1, 2017.

Background

Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and dually participating facilities (SNF/NFs) are required to be in substantial compliance with Medicare and Medicaid requirements at all times and are always responsible for the health and safety of its residents.

The purpose of federal remedies is to promote the initiative and responsibility of facilities to continuously monitor their performance and promptly achieve, sustain and maintain compliance with all federal requirements. To support this purpose, we are directing the immediate imposition of federal remedies in certain situations.
Page 2 – State Survey Agency Directors

In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly and to maintain continued compliance. Noncompliance may occur for a variety of reasons and can result in various levels of harm or likely harm to residents. The CMS Regional Offices (ROs) should consider the extent to which the noncompliance is a one-time mistake or accident, the result of larger systemic concerns, or a more intentional action or disregard for resident health and safety.

CMS is in the process of updating the SOM to reflect this revised guidance. The final version of this document when published in the on-line SOM may differ slightly from this interim advanced copy which is attached.

Contact: Please contact the CMS Regional Office or the dnh_triangeteam@cms.hhs.gov to provide feedback on this draft by December 1, 2017.

Effective Date: CMS is seeking input on this draft and requests comments. CMS will review these comments before issuing a final version.

/s/
David R. Wright

Attachment: Advanced Guidance Revisions to SOM Chapter 7

cc: Survey and Certification Regional Office Management
State Medicaid Agencies
SUBJECT: Revisions to the State Operations manual (SOM 100-07) Chapter 7

I. SUMMARY OF CHANGES: Revisions to the State Operations manual (SOM 100-07) Chapter 7 – To provide revisions in sections 7304 through 7304.3, 7306, 7308.3, 7313.2, 7400.5, and 7400.5.1 regarding policies related to Immediate Imposition of Federal Remedies (previously referred to as Opportunity or No Opportunity to Correct). Sections 7304.2.1 and 7304.2.2 have been deleted and incorporated into other sections noted above.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.) (R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER/SECTION/SUBSECTION/TITLE</th>
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<tbody>
<tr>
<td>R</td>
<td>Chapter 7/7304/ Mandatory Immediate Imposition of Federal Remedies</td>
</tr>
<tr>
<td>R</td>
<td>Chapter 7/7304.1/ Criteria for Mandatory Immediate Imposition of Federal Remedies</td>
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<tr>
<td>R</td>
<td>Chapter 7/7304.2/ Effective Dates for Immediate Imposition of Federal Remedies</td>
</tr>
<tr>
<td>D</td>
<td>Chapter 7/7304.2.1/ Mandatory Criteria for Having No Opportunity to Correct</td>
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<td>D</td>
<td>Chapter 7/7304.2.2/ Additional State Discretion</td>
</tr>
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<td>R</td>
<td>Chapter 7/7304.3/ Responsibilities of the State Survey Agency and the CMS Regional Office when there is an Immediate Imposition of Federal Remedies</td>
</tr>
<tr>
<td>R</td>
<td>Chapter 7/7306/ Timing of Civil Money Penalties (CMPs) for Immediate Imposition</td>
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<td>D</td>
<td>Chapter 7/7306.1/ Imposition of a Civil Money Penalty when a Facility is not allowed an Opportunity to</td>
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<tr>
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<td>Chapter 7/7306.3 When State Recommends a Civil Money Penalty for Past Noncompliance</td>
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<td>D</td>
<td>Chapter 7/7306.4/ Amount</td>
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<td>Chapter 7/7308/ Enforcement Actions When Immediate Jeopardy (IJ)</td>
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<td>D Chapter 7/7308.1/ Action That Must Be Taken</td>
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<td>D Chapter 7/7308.2/ Enforcement Action That Must Be Taken</td>
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<tr>
<td>D Chapter 7/7308.3/ Action That Must Be Taken</td>
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<tr>
<td>R Chapter 7/7309/ Key Dates When Immediate Jeopardy (IJ) Exists</td>
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<td>R Chapter 7/7309.1/ 2nd Business Day</td>
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<td>R Chapter 7/7309.2/ 5th Business Day</td>
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<td>R Chapter 7/7309.4/ No Later Than 10th Calendar Day</td>
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<td>R Chapter 7/7309.5/ By 23rd Calendar Day</td>
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<td>R Chapter 7/7313/ Procedures for Recommending Enforcement Remedies When Immediate Jeopardy Does Not Exist</td>
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<td>R Chapter 7/7313.1/ Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies</td>
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<tr>
<td>D Chapter 7/7313.2/ Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies</td>
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<tr>
<td>R Chapter 7/7400/ Enforcement Remedies for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and Dually Participating Facilities (SNFs/NFs)</td>
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<td>R Chapter 7/7400.1/ Available Federal Enforcement Remedies</td>
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<td>R Chapter 7/7400.2/ Enforcement Remedies for the State Medicaid Agency</td>
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<tr>
<td>R Chapter 7/7400.3/ Selection of Remedies</td>
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<tr>
<td>R Chapter 7/7400.3.1/ Availability of State Medicaid Agency Remedies to the Regional Office in Dually Participating Facilities</td>
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<tr>
<td>R Chapter 7/7400.5/ Factors That Must Be Considered When Selecting Remedies</td>
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<tr>
<td>D Chapter 7/7400.5.1/ Matrix for Scope &amp; Severity</td>
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</tbody>
</table>

III. FUNDING: No additional funding will be provided by CMS.

IV. ATTACHMENTS:

<table>
<thead>
<tr>
<th>Business Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Manual Instruction</td>
</tr>
<tr>
<td>Confidential Requirements</td>
</tr>
<tr>
<td>One-Time Notification</td>
</tr>
<tr>
<td>Recurring Update Notification</td>
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</tbody>
</table>

*Unless otherwise specified, the effective date is the date of service.*
7304 - Mandatory Immediate Imposition of Federal Remedies
(Rev.)

Noncompliance may occur for a variety of reasons and can result in harm to residents or put residents at risk for harm. When facilities do not maintain substantial compliance, CMS may use various enforcement remedies to encourage prompt compliance. The purpose of federal remedies is to promote the initiative and responsibility of facilities to continuously monitor their performance and promptly achieve, sustain and maintain compliance with all federal requirements. To support this purpose, we are directing the immediate imposition of federal remedies in certain situations outlined in §7304.1 below, and we recommend using the type of remedy that best achieves the purpose based on the circumstances of each case.

This guidance does not apply to past noncompliance deficiencies as described in §7510.1 of this chapter. The determination to impose federal remedies for past noncompliance is at the discretion of the CMS Regional Office (RO).

7304.1 - Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies
(Rev.)

A facility shall not be offered an opportunity to correct deficiencies before federal remedies are imposed if the situation meets any one or more of the following criteria:

- Immediate Jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Any deficiency from the current survey at levels “G, H or I”, that falls into any of the Substandard Quality of Care (SQC) regulatory sections that are not IJ but did result in injury, harm, or impairment; OR
- Any deficiency at “G” or above on the current survey AND if there were any deficiencies at “G” or above on the previous standard health or LSC survey or if there was any deficiency at “G” or above on any type of survey between the current survey and the last standard health or LSC survey. These surveys (standard health or LSC, complaint, revisit) must be separated by a certification of compliance, i.e., be from different noncompliance cycles. In other words, level G or above deficiencies from multiple surveys within the same noncompliance cycle must not be combined to make this “double G or higher” determination; OR
- A facility classified as a Special Focus Facility (SFF) AND has a deficiency citation at level “F,” (excluding any level “F” citations under tags F812, F813 or F814) or higher for the current health survey or “G” or higher for the current Life Safety Code (LSC) survey.

The remedies to be imposed by statute do not change, (e.g., 3-month automatic Denial of Payment for new admissions (DPNA), 23-day termination when IJ is present and 6-month termination). In addition to these statutory remedies, the CMS RO must also immediately impose one or more additional remedies for any situation that meets the criteria identified above. The State Survey and/or Medicaid Agencies shall not permit changes to this policy.
NOTE: “Current” survey is whatever Health and/or LSC survey is currently being performed, e.g., standard, revisit, or complaint. “Standard” survey (which does not include complaint or revisit surveys) is a periodic, resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation.

While States are not required to recommend the types of remedies to be imposed, they are encouraged to do so, since States may be more familiar with a facility’s history and the specific circumstances in the case at hand. The CMS RO may or may not accept these recommendations.

Regardless of a State’s recommendation, the CMS RO must take the necessary actions to impose a remedy or multiple remedies, based on the seriousness of the deficiencies following the criteria set forth in 42 C.F.R. §488.404. Also refer to §§7400.5.1 and 7400.5.2 of this chapter. In addition to any statutorily imposed remedy, additional remedies should be selected that will bring about compliance quickly and achieve and maintain compliance. When making remedy choices, the CMS RO considers the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.

The State Survey Agency is authorized to both recommend and impose one or more Category 1 remedies, in accordance with §7314 of this Chapter. CATEGORY 1 remedies include:
- Directed plan of correction,
- State monitoring, and
- Directed in-service training.

Use of Federal Remedies in Immediate Jeopardy (IJ) Citations - When IJ is identified on the current survey that resulted in serious injury, harm, impairment or death a CMP must be imposed.

For IJ citations where there is no resultant serious injury, harm, impairment or death but the likelihood is present, the CMS RO must impose a remedy or remedies that will best achieve the purpose of attaining and sustaining compliance. CMPs may be imposed, but they are not required.

Types of Remedies - The choice of remedy is made that best achieves the purpose of attaining and sustaining compliance based on the circumstances of each case and recommendations from the State. Federal remedies are summarized below. Refer to §§7500 – 7556 of this chapter for more detail on these remedies.

Civil Money Penalties (CMPs) - Federal CMPs are only imposed by the CMS RO. If a CMP is imposed, it must be done in accordance with instructions in the CMP Analytic Tool and §§7510 through 7536 of this chapter.

If a per instance CMP is imposed, the facility shall not be given an opportunity to correct any deficiency for which this CMP is imposed prior to the imposition of this remedy.
**Directed In-Service Training** – Refer to §7502 of this chapter. Consider this remedy in cases where the facility has deficiencies where there are knowledge gaps in standards of practice, staff competencies or the minimum requirements of participation and where education is likely to correct the noncompliance. Depending on the topic(s) that need to be addressed and the level of training needed, facilities should consider using programs developed by well-established centers of geriatric health services such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or regional office may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize the ombudsman program to provide training about residents’ rights and quality of life issues.

**Directed Plan of Correction** Refer to §7500 of this chapter. This remedy provides for directed action(s) from either the State or CMS RO that the facility must take to address the noncompliance or a directed process for the facility to more fully address the root cause(s) of the noncompliance. Achieving compliance is ultimately the facility’s responsibility, whether or not a directed plan of correction is followed.

**Temporary Management** - Refer to §7550 of this chapter. This is the temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation. A temporary manager may be imposed anytime a facility is not in substantial compliance, but must be imposed when a facility’s deficiencies constitute IJ or widespread actual harm and a decision is made to impose an alternative remedy to termination. It is the temporary manager’s responsibility to oversee correction of the deficiencies and assure the health and safety of the facility’s residents while the corrections are being made. A temporary manager remedy may also be imposed to oversee orderly closure of a facility. The State will select the temporary manager when the State Medicaid Agency is imposing the remedy and will recommend a temporary manager to the regional office when CMS is imposing the remedy. Each State should compile a list of individuals who are eligible to serve as temporary managers. These individuals do not have to be located in the State where the facility is located.

**Denial of Payment for all New Medicare and Medicaid Admissions (DPNA)** – See §7506 of this chapter. This remedy may be imposed alone or in combination with other remedies to encourage quick compliance. Regardless of any other remedies that may be imposed, a mandatory denial of payment for new admissions must be imposed when the facility is not in substantial compliance three months after the last day of the survey identifying deficiencies, or when a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys (see 42 CFR 488.414).

**Denial of all Payment for all Medicare and Medicaid Residents (DPAA) (Discretionary).** See §7508 of this chapter. Only CMS has the authority to deny all payment for Medicare and/or Medicaid residents. This is in addition to the authority to deny payment for all new admissions
(discretionary) noted above. This is a severe remedy. Factors to be considered in selecting this remedy include but are not limited to:

1. Seriousness of current survey findings;
2. Noncompliance history of the facility; and
3. Use of other remedies that have failed to achieve or sustain compliance.

**State Monitoring** - Refer to §7504 of this chapter. A State monitor oversees the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. Consider imposing this remedy when, for example, there are concerns that the situation in the facility has the potential to worsen or the facility seems unable or unwilling to take corrective action. A State monitor must be used when a facility has been cited with substandard quality of care (SQC) deficiencies on the last three consecutive standard health surveys.

**Termination of Provider Agreement** - See §7556 of this chapter. While this remedy may be imposed at any time the circumstances warrant regardless of whether IJ is present; regardless of any other remedies that may be imposed, termination of a facility’s provider agreement must be imposed when the facility is not in substantial compliance six months after the last day of the survey identifying deficiencies or within no more than 23 days if IJ is identified and not removed.

**7304.2 - Effective Dates for Immediate Imposition of Federal Remedies (Rev.)**

The State Survey Agency must immediately inform its CMS RO when immediate imposition of remedies must be made so that the notice letter, from the State Survey Agency or the CMS RO, to the facility can promptly be sent out and meet the timelines for notice as outlined in §7305 of this chapter. This will ensure that remedies are imposed as soon as possible. Once a remedy is imposed, it becomes effective as of the date in the notice letter. All remedies remain in effect and continue until the facility is determined to be in substantial compliance (which may occur before the revisit date). Substantial compliance must be verified in accordance with §7317 of this chapter.

**For Immediate Jeopardy (IJ) Situations:** A facility’s removal of the conditions that caused the IJ may, at CMS’s discretion, result in the rescission of the 23-day termination. A per day CMP must be lowered when the survey agency has verified that the IJ has been removed but deficiencies at a lower level continue. Refer to the CMP Analytic Tool instructions for determining the dates of a per day CMP. However, CMS shall not rescind any other remedies imposed until the facility achieves substantial compliance or is terminated. Remedies imposed must remain in effect, irrespective of when the IJ is removed, unless otherwise rescinded or revised as a result of legal proceedings. Remedies will be immediately imposed and effectuated whether or not the IJ was:

- removed during the survey, or,
- removed in a subsequent IJ removal revisit before the 23rd day.

**7304.3 - Responsibilities of the State Survey Agency and the CMS Regional Office (RO) when there is an Immediate Imposition of Federal Remedies**
When federal remedies are to be immediately imposed as outlined in §7304.1, within five (5) business days from when the initial notice was sent to the facility by the survey agency, the State Survey Agency MUST:

- Copy the CMS RO on its initial notice to the facility. The State Survey Agency does not need prior approval from the CMS RO before sending this notice to the facility; and
- Assure all of these cases are referred to the CMS RO for their review and action.

The survey agency (State or Federal) must enter all of these cases as a NO opportunity to correct into the Automated System Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM) system within five (5) business days of sending the initial notice to the facility. The State Survey Agency and the CMS RO must have systems in place to routinely check and monitor the ASPEN-AEM database to identify cases that may require enforcement action or additional follow-up, as needed.

**7306 - Timing of Civil Money Penalties (CMPs)**

**7306.1 - Immediate Imposition of a Civil Money Penalty (CMP)**

If a per instance CMP is imposed, the facility shall not be given an opportunity to correct any deficiency for which this CMP is imposed prior to the imposition of this remedy.

While the State Survey Agency is not required to recommend that a CMP (or the amount of a CMP) be imposed as a result of the noncompliance referenced in §7304.1, they may do so. This recommendation must be sent to the CMS regional office (RO) and the State Medicaid Agency.

The CMS RO and the State Medicaid Agency must respond to the State survey agency’s recommendation and, if accepted, the CMS RO sends out the formal notice of the immediate imposition of a CMP to the facility in accordance with the requirements in §§7305, 7309 and 7520.

**7308 - Enforcement Actions When Immediate Jeopardy (IJ) Exists**

When the State Survey Agency identifies IJ, no later than two business days following the survey date which identified the IJ, it must notify:

- The CMS Regional Office (RO) and the State Medicaid Agency of its survey findings by telephone, e-mail, or other means acceptable to the CMS RO and the State Medicaid agency; and,
- The facility of the IJ findings in writing. A written notice or letter to the facility in lieu of a Form CMS 2567 would be acceptable.

Waiting for the complete statement of deficiencies (Form CMS-2567) and the facility’s plan...
of correction for the non-IJ deficiencies can result in undue delay in determining removal of IJ. Therefore, a Statement of Deficiencies (Form CMS-2567) and a facility’s plan of correction for the non-IJ deficiencies may be deferred until the survey agency verifies the IJ is removed.

In addition to the imposition of enforcement remedies, the CMS RO terminates the Medicare provider agreement within 23 calendar days of the last date of the survey, and/or appoints a temporary manager who must remove the IJ within no more than 23 calendar days of the last date of the survey. When the CMS RO imposes termination of a Medicare provider agreement, it must notify the State Medicaid Agency.

In order to prevent termination from occurring within 23 days, the IJ must be removed, even if the underlying deficiencies have not been fully corrected. When IJ is identified, the facility must submit an allegation that the IJ has been removed, including a specific plan detailing how and when the IJ was removed.

Documentation must be completed indicating whether the IJ was removed and deficiencies corrected (Form CMS-2567B), or that the IJ was removed but compliance had not been achieved (Form CMS-2567).

If the facility alleges that the IJ is removed and the survey agency verifies this but the facility is still not in substantial compliance, then complete a full Statement of Deficiencies (CMS Form 2567), which requires a plan of correction for all remaining deficiencies.

In addition, whenever a facility has deficiencies that constitute both IJ and substandard quality of care (SQC) (as defined in 42 CFR §488.301), the survey agency must notify the attending physician of each resident found to have received SQC as well as the State board responsible for licensing the facility’s administrator. Notify physicians and the administrator licensing board in accordance with §7320.

7309 - Key Dates When Immediate Jeopardy (IJ) Exists (Rev.)

NOTE: These timelines apply whether the survey was conducted by a State Survey Agency, CMS Regional Office (RO) or a CMS contractor.

7309.1 - 2nd Business Day (Rev.)

When the State Survey Agency identifies IJ, no later than two business days following the survey date which identified the IJ, it must notify;

- The CMS Regional Office (RO) and the State Medicaid Agency of its survey findings by telephone, e-mail, or other means acceptable to the CMS RO and the State Medicaid agency: and,

- The facility of the IJ findings in writing that the State is recommending to the CMS RO (for skilled nursing facilities and dually participating facilities) or to the State
Medicaid Agency (for nursing facilities) that the provider agreement be terminated and that a Civil Money Penalty (CMP) or other remedies may be imposed, refer to §§7304 and 7304.1. A temporary manager may be imposed in lieu of or in addition to termination. Procedures pertaining to the imposition of CMPs and temporary management can be found in §§7510-7536 and §7550, respectively.

This letter may also serve as the formal notice from the State Survey Agency for imposition of any category 1 remedy or denial of payment for new admissions remedy when authorized by the CMS RO and/or the State Medicaid Agency. This notice must also include the facility’s right to informal dispute resolution (IDR) or an independent informal dispute resolution (IIDR) and to a formal appeal of the noncompliance.

7309.2 - 5th Business Day

Within five business days from when the initial notice was sent to the facility by the State Survey Agency, they must assure these IJ cases are forwarded and referred to the CMS RO for their review and action, including all documentation (e.g., notice letter, contact reports, Forms CMS-1539 and CMS-2567, if completed). This information may be transmitted and referred to the CMS RO via the Automated System Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM) system.

7309.3 - 5th - 21st Calendar Day

Except when formal notice of remedies is provided by the State Survey Agency, as authorized by CMS and/or the State Medicaid Agency, the CMS RO and/or the State Medicaid Agency issues a formal notification of remedies to the facility (see §7305). In addition, the notice should include the facility’s right to a formal appeal of the noncompliance which led to the temporary management remedy, termination, or any other enforcement actions (except State monitoring). For the temporary management remedy, the notice will advise the facility of the conditions of temporary management as specified in §7550, and that failure to relinquish control to the temporary manager will result in termination. The general public is also given notice of the impending termination.

7309.4 - No Later Than 10th Calendar Day

If the survey entity verifies that the IJ has been removed, then the survey agency must send the Statement of Deficiencies (Form CMS-2567) to the facility, the CMS RO, and, if the facility participates in Medicaid, the State Medicaid Agency.

NOTE: The facility is not required to submit a PoC in order to verify the removal of the IJ. The facility should submit a written allegation of removal of the IJ with sufficient detailed information to demonstrate how and when the IJ was removed. If a PoC is to be submitted, it
must be received no later than 10 calendar days after the facility receives their Statement of Deficiencies (Form CMS-CMS-2567) from the survey agency.

The CMS RO must impose a Civil Money Penalty (CMP) if the IJ resulted in serious injury, harm, impairment or death on the current survey.

For IJ citations where there is no resultant serious injury, harm, impairment or death but the likelihood is present, a remedy must be imposed; however, the CMS RO may select whichever type of remedy best achieves the purpose of achieving and sustaining compliance and address various levels of noncompliance.

7309.5 - By 23rd Calendar Day
(Rev.)

Termination takes effect unless the IJ has been removed. If the IJ has been removed and verified by the survey agency however additional deficiencies remain and substantial compliance has not been achieved, the facility may be given up to 6 months from the last day of survey during which to achieve substantial compliance. (See §7316 for key dates when immediate jeopardy does not exist.)

7313 - Procedures for Recommending Enforcement Remedies When Immediate Jeopardy Does Not Exist
(Rev.)

Once noncompliance is identified, the surveying entity must first determine whether to immediately impose remedies in accordance with the criteria in §7304.1 or give the facility an opportunity to correct its deficiencies before remedies are imposed.

7313.1 - Facilities Given an Opportunity to Correct Deficiencies prior to the Immediate Imposition of Federal Remedies
(Rev.)

A facility may be permitted to correct its deficiencies and delay the imposition of remedies only when the criteria outlined in §7304.1 of this chapter are not met. Facilities must submit an acceptable plan of correction for its deficiencies.

The State Survey Agency, or the CMS regional office (RO) for federal surveys, provides the initial notice to the facility that failure to correct cited deficiencies may result in the recommendation or imposition of remedies. The State Survey Agency may provide formal notice in its initial notice to the facility or in its notice letter related to the first revisit survey of the imposition of Category 1 remedies and the denial of payment for new admissions if authorized by its CMS RO.

If at the time of the first revisit the facility has not achieved substantial compliance, remedies may be imposed and will be effective once formal notice has been provided to the facility. In these circumstances, the State Survey Agency recommends to the CMS RO and the State
Medicaid Agency that remedies be imposed and/or become effective. The CMS RO and the State Medicaid Agency should establish procedures with the State Survey Agency as to when and how the documentation of noncompliance is to be communicated and how and when responses regarding these recommendations will be made.

7400 - Enforcement Remedies for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and Dually Participating Facilities (SNFs/NFs) (Rev.)

Sections 1819(h) and 1919(h) of the Act, as well as 42 CFR §§488.404, 488.406, and 488.408, provide that CMS or the State may impose one or more remedies in addition to, or instead of, termination of the provider agreement when the State or CMS finds that a facility is out of compliance with federal requirements. Enforcement protocols/procedures are based on the premise that all requirements must be met and take on greater or lesser significance depending on the specific circumstances and resident outcomes in each facility.

7400.1 - Available Federal Enforcement Remedies (Rev.)

In accordance with 42 CFR §488.406, the following remedies are available:

- Termination of the provider agreement;
- Temporary management;
- Denial of payment for all Medicare and/or Medicaid residents by CMS;
- Denial of payment for all new Medicare and/or Medicaid admissions;
- Civil money penalties;
- State monitoring;
- Transfer of residents;
- Transfer of residents with closure of facility;
- Directed plan of correction;
- Directed in-service training; and
- Alternative or additional State remedies approved by CMS.

7400.2 - Enforcement Remedies for the State Medicaid Agency (Rev.)

Regardless of what other remedies the State Medicaid Agency may want to establish in addition to the remedy of termination of the provider agreement, it must establish, at a minimum, the following statutorily-specified remedies or an approved alternative to these specified remedies:

- Temporary management;
- Denial of payment for all new admissions;
- Civil money penalties;
- Transfer of residents;
- Transfer of residents with closure of facility; and
- State monitoring.
The State Medicaid Agency may establish additional or alternative remedies as long as the State has been authorized by CMS to do so under its State plan. Guidance on the review and approval (or disapproval) of State Plan amendment requests for alternative or additional remedies can be found in §7805.

Whenever a State Medicaid Agency’s remedy is unique to its State plan and has been approved by CMS, then that remedy may also be imposed by the regional office against the Medicare provider agreement of a dually participating facility in that State. For example, where CMS has approved a State’s ban on admissions remedy as an alternative remedy under the State plan, CMS may impose this remedy but only against Medicare and Medicaid residents; only the State can ban the admission of private pay residents.

7400.3 - Selection of Remedies
(Rev.)

In order to select the appropriate remedy(ies) for a facility’s noncompliance, the seriousness, scope and severity of the deficiencies must first be assessed. The purpose of federal remedies is to encourage the provider to achieve and sustain substantial compliance. In addition to the required enforcement action(s), remedies should be selected that will bring about compliance quickly. While a facility is always responsible for all violations of the Medicare and Medicaid requirements, when making remedy choices, the CMS RO should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety.

7400.3.1 – Matrix for Scope & Severity
(Rev.)

| Immediate jeopardy to resident health or safety | J | K | L |
| Actual harm that is not immediate | G | H | I |
| No actual harm with potential for more than minimal harm that is not immediate jeopardy | D | E | F |
| No actual harm with potential for minimal harm | A | No PoC | B | C |

Substandard Quality of Care (SQC) is defined in 42 C.F.R. §488.301 as one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to certain participation requirements.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements (42 C.F.R. §488.301).
Registration Form (Please Print)

Facility __________________________________________________________
Address __________________________________________________________
City_________________________________________ State ____________ Zip________
Phone _____________________________
Contact Name _____________________________
Name ___________________________________________ Email Address _____________________________
Name ___________________________________________ Email Address _____________________________
Registration Fees:
(25% Discount) First registrant from member facility: $359
(30% Discount) Each additional registrant from member facility:
Amount $ ________ Price $ ________
First registrant from member facility: $359
Each additional registrant from member facility: $ ________
Total Amount $ ________
Payment Options:
□ Invoice Facility □ Payment Enclosed □ Charge My Credit Card
Charge to:
□ VISA □ Master Card □ American Express
Name on Credit Card _____________________________________________
Credit Card # ____________ CSV# ____________
Expiration Date _____________________________
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□ Eau Claire □ Appleton □ Brookfield

Register online at www.whcawical.org/seasonticket
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- Appleton Radisson Paper Valley Hotel 321 West College Avenue Appleton, WI 54911 920-533-8000
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