Topics for today

ABN

QRP

POC
The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. The use of the renewed form with the expiration date of 06/30/2023 will be mandatory on 8/31/2020. Due to COVID-19 concerns, CMS is going to expand the deadline for use of the mandatory for use on 1/1/2021. The renewed form may be implemented prior to the mandatory deadline.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

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CMS is ending the current waiver of PBJ staffing data submission beginning with the 2020 quarter 2 data.

Quarter 2 (April 1 to June 30) staffing data must be submitted by August 14, 2020.

Current Five-Star Reports will remain frozen with the December 31, 2019, staffing data.

Quarter 1 (January 1 to March 31) data won’t be used to calculate staffing star ratings.

Providers with the automatic downgrade penalty to one star for staffing will have staffing data suppressed. Staffing data won’t be reported for those providers and won’t be downgraded to one star.

The October 2020 Five-Star Report staffing measure will be updated with quarter 2 data submitted by August 14, 2020.
SNF QRP

- CMS has issued notification to providers who were determined to be out of compliance with the Skilled Nursing Facility Quality Reporting Program (SNF QRP) requirements for 2019. Reporting noncompliance affects the fiscal year 2021 annual payment update (APU), resulting in a two-percentage point reduction in the SNF’s APU.

- If applicable, CMS posted this notification to the provider’s Certification and Survey Provider Enhanced Reports inbox folder in the Quality Improvement and Evaluation System on July 13, 2020. Medicare Administrative Contractors also are notifying noncompliant providers.

- Requests for reconsideration must be submitted to CMS by email no later than August 18, 2020.

SNF QRP Reconsideration Process
Help Desk email is SNFQRPRecoconsiderations@cms.hhs.gov

QRP informational page for Reconsiderations

COVID-19 Public Health Emergency (PHE) Tip Sheet
Which MDS records should you submit?

• The MDS should be submitted for all new admission records and discharge records that occur on or after July 1, 2020. The submission deadline for Q3 data (July 2020–September 2020) is February 15, 2021. The submission deadline for Q4 measure data (October 2020–December 2020) is May 15, 2021.

• Timely submission and acceptance requirements of MDS data to meet the 80-percent threshold are unchanged. SNFs are required to submit at least 80 percent of the necessary data to calculate the SNF QRP quality measures.

• The compliance threshold calculation is based on the number of MDS assessments submitted with complete data on each MDS assessment used for the SNF QRP.

CARES ACT RELIEF FUND


• Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? (Modified 7/30/2020)

  – As explained in the notice of reporting requirements on the Provider Relief Fund website, reports on the use of Provider Relief Fund money must be submitted no later than July 31, 2021, and accordingly HHS expects that providers will fully expend their payments by that date. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for increased healthcare related expenses or lost revenue attributable to coronavirus.
CARES Act & Provider Relief Fund

- On July 20, 2020, the Department of Health & Human Services (HHS) posted a notice for post-payment reporting requirements for the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and Provider Relief Fund (PRF).
- The HHS notice informed recipients who received one or more payments exceeding $10,000 in the aggregate from the PRF of the timing and future reporting requirements. HHS will issue detailed instructions regarding these reports by August 17, 2020, and the reporting system will be available for reporting on October 1, 2020.
- Each provider that received a payment from the PRF and used any part of the payment agreed to a set of terms and conditions that, among other obligations, requires each recipient to submit reports to HHS in its requested format.

The reporting instructions will provide directions on reporting obligations applicable to any provider that received a payment. The intent of the reports is to allow providers to demonstrate compliance with the terms and conditions related to the allowable use of each PRF payment received.

Notice on Timing of Reports

- The reporting system will become available to recipients for reporting on October 1, 2020.
- All recipients must report within 45 days of the end of calendar-year 2020 on their expenditures through the period ending December 31, 2020.
- Recipients who have expended funds in full prior to December 31, 2020, may submit a single final report at any time during the window that begins October 1, 2020, but no later than February 15, 2021.
- Detailed PRF reporting instructions and a data collection template with the necessary data elements will be available on the HRSA website by August 17, 2020.

Distribute of POC Antigen COVID-19 Testing Devices

- POC is Point-of-Care
- These test devices are being shipped based on prioritization of hot spot areas, cases of COVID-19 among staff and residents.
- Lack of access to testing.
- Providers must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver to receive a testing device.
• POLLING QUESTIONS

• Have you completed any facility wide testing?
• Have you done more or less than three rounds of testing?
• Are you in Phase II at this time?
• Have any residents in your home installed Granny Cams?

Testing and headed to Phase II

DHSS guidance can be found at: https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/professionals.php#collapseSix

• Facility Wide test must be within 14 days of your reopening. All negative tests including residents & staff.
• You cannot reopen until 28 days after your last positive COVID tests – resident & staff.
• Staffing levels good
• Consider what is going on in the community
• County has to be in a downward trajectory.
• If there were no positive test results in the entire facility, additional, ongoing, bi-monthly (twice a month or approximately every two weeks), testing of a minimum of ten percent (10%) of staff. (randomize sampling of staff)
Remember the Reopening is voluntary

Get consultation with local and State public health agencies regarding all decisions on widespread testing and retesting in the facility. Discuss with DHSS Regional Office as to when to begin the repeat.

Positive Test (Resident or Staff) – Facility wide testing is required.

Repeat 3-4 days later a re-test all residents and staff...

Then one week later

This continues and is repeated weekly until two rounds of all negative results.

Only the people that test negative do the repeat testing. Positive people test or symptom-based strategy.

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GUIDELINES


• ALL long-term care facilities: SNF, NF, ALF & RCF

QUESTIONS
COMMUNICATION

• Stay in contact with us.

• Stay in contact with your County Health Department

• “Love Thy Neighbor - just do it six foot apart”

LET US KNOW HOW WE CAN HELP

EVALUATIONS

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Nursing Home Help
We can do virtual visits via zoom!