Michigan Homecare and Hospice Association Annual Conference

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Home Health Agencies

Preparing for Federal Surveys –
5 Top Deficiencies

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The Bureau of Survey & Certification

- BSC was established in 2022 to provide sole oversight of the federal survey and certification process for over 20 healthcare provider types. Functions of BSC include federal complaint investigations, routine annual surveys, and monitoring and enforcement of federal regulations which serve to protect the health, safety, and quality of care received by Michigan residents.

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BSC Mission, Vision, Values

- **Mission**
  Ensuring Michiganders receive quality healthcare with federal regulations as our guide using a collaborative and respectful approach
- **Vision**
  Achieving national recognition through innovative collaboration with health care providers to improve the quality of life for Michigan residents
- **Values**
  collaboration, reliability, fairness, authenticity, and knowledge

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BSC Regulatory Oversight

- Federal Certification of Providers and Suppliers on behalf of the Centers for Medicare and Medicare Services (CMS)
- Long Term Care Division
- Acute & Continuing Care Division

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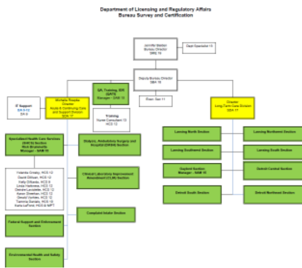
BSC Organizational Chart



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What's New in BSC

- Quarterly LTC and ACC Stakeholder Meetings (Quarterly MHHA, et al)
- User-friendly external website development
- Development and implementation of standard operating procedures
- Development and implementation of communication expectations
- Creation of quality assurance division

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General Overview

- **State Licensure**
  - Not required for HHAs
- **Federal Certification**
  - Initial Certification
    - Visit: https://www.michigan.gov/lara/bureau-list/bsc/accs-division/hha
    - Accreditation Organizations (AO): CHAP, JC, ACHC
    - Routine recertification surveys: Conducted by the State Agency (SA) or AO
    - Complaints: SA –CMS authorizes SA (State Agency) to conduct investigations of deemed providers
    - OASIS testing is no longer required for initial certification.
    - The SA no longer issues a state facility ID.

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Medicare Administrative Contractor (MAC)

- Private health care insurer that has been awarded jurisdiction to process Medicare medical claims
- Michigan is in Region J6-
  - National Government Services (NGS)

https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs

- CMS-855A
- Provider Enrollment, Chain, and Ownership System (PECOS)

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CMS – Tier Workload FY 2024

Tier 1 Non-Deemed Providers	Tier 2	Tier 3	Tier 4
36.9 Month Maximum Interval	Complaint Investigations Triaged Non-IJ High (within 45 days)	Complaint Investigations Triaged Non-IJ Medium (next survey)	24.9 Month Maximum Interval
Complaint Investigations Triaged as High or Immediate Jeopardy/IJ (within 48 hours)			Complaint Investigations Triaged as Non-IJ Low (next survey)
			Branch location application review
Deemed Providers			
Validation Surveys (8)	Complaint Investigations Triaged Non-IJ High with RO approval (w/i 45 days)		Branch location application review
Complaint Investigations Triaged as Immediate Jeopardy/IJ with RO approval (w/i 48 hours)			

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Actions Requiring Federal Approval

- Initial certification (by an Accrediting Organization)
- Re-certification
- Change of Ownership (CHOW)
- Change of Information (address, name, etc.)
- Change of Administrator
  - Email; LARA-BSCSupport@michigan.gov
  - Provide: facility name, address, email address, provider #, new administrator full name, effective start date
- Branch site questionnaires have been updated (approvals/relocations) the newest versions are on our website;
  - https://www.michigan.gov/lara/bureau-list/bsc

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HHA Informal Dispute Resolution

- IDR protocol will be included in the cover letter sent with the 2567 (survey report).
- Only applies to Condition level citations.
- State specifically what tag is disputed and submit documentation supporting your contention.
- Submission of supporting documents will be through Egress secure workspace. Directions for its use will be included with the survey report’s cover letter.
- IDR review is an informal process and is not an evidentiary hearing.

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Allowed Practitioners

- During the pandemic CMS made flexibility allowances for Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists to order and manage the care of patients of Home Health Agencies.
- The revised State Operations Manual Appendix B has made that flexibility permanent. Ref: **QSO-24-07-HHA**

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Standard Survey Changes

- CMS has identified a select number of standard regulations most closely related to the agency's ability to deliver quality patient care and services.
- The most recent revision of the regulations have added EP standards.
- Addition of 3 level 1 Emergency Preparedness (EP) tags to a Standard survey: Appendix Z's E-0004, E-0013, and E-0036.
- E-0004 EP Plan must be reviewed and updated annually.
- E-0013 EP Policy & Procedures with emphasis on Hazard Risk Assessment and Communication Plan.
- E-0036 Testing & Training: Facility AND Community based full-scale exercises.

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Survey Process Overview

- Entrance Conference
- Request for Documents (Egress secure workspace)
- Record Review
- Home Visits
- Policy and Procedure Reviews
- Interviews
- Exit Conference

**Non-cooperation could end the survey process and require SA to recommend termination to CMS

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Most Frequently Cited Tags in 2023

- G-0574: Plan of care must include…..
- G-0536: Review of all current medications.
- G-1022: Discharge and Transfer Summaries.
- G-528: The comprehensive assessment must accurately reflect the patient's current health, psychosocial, functional, and cognitive status……
- G-710: (The skilled service) provides services in the plan of care…….

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G-0574: Plan of care must include….

- §484.60(a)(2) The individualized plan of care must include the following:
- (i) All pertinent diagnoses;
- (ii) The patient's mental, psychosocial, and cognitive status;
- (iii) The types of services, supplies, and equipment required;
- (iv) The frequency and duration of visits to be made;
- (v) Prognosis;
- (vi) Rehabilitation potential;
- (vii) Functional limitations;
- (viii) Activities permitted;
- (ix) Nutritional requirements;
- (x) All medications and treatments;
- (xi) Safety measures to protect against injury;
- (xii) A description of the patient's risk for emergency department visits and
- hospital re-admission, and all necessary interventions to address the
- underlying risk factors.
- (xiii) Patient and caregiver education and training to facilitate timely
- discharge;
- (xiv) Patient-specific interventions and education; measurable outcomes and
- goals identified by the HHA and the patient;
- (xv) Information related to any advanced directives; and
- (xvi) Any additional items the HHA or physician may choose to include.

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G-0536: Review of all current medications.

§484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

- Identify all medications that the patient is taking (both prescription and non-prescription) as well as times of administration and route.
- The skilled professional performing the comprehensive assessment may perform the Medication review or collaborate with other disciplines to perform the med review.
- HHA should have policies that guide staff in the event there is a concern identified with a patient's medication that should be reported to the physician or allowed practitioner.

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G-1022: Discharge and Transfer Summaries

- §484.110(a)(6)
- (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or
- (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
- (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

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G-1022: Discharge and Transfer Summaries

- Content of a Discharge Summary typically contain:

- Admission and discharge dates.
- Physician (or allowed Practitioner) responsible for the HHA plan of care
- Reason for admission to the HHA.
- Type of services provided and frequency of services.
- Laboratory data.
- Current Medications.
- Discharge condition.
- Outcomes in meeting the goals in the plan of care.
- Patient and caregiver post discharge instructions.

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G-528: The comprehensive assessment must accurately reflect the patient's current health, psychosocial, functional, and cognitive status…..

- §484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status;
- Completion of the comp assessment should provide the HHA with a complete picture of the patient's status to be used in developing the plan of care.
- Assesses the pt's ability to participate in care, ability to function independently in the home, and ability to implement the plan of care.

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Condition of Participation: Skilled Professional Services (G-700)

- Skilled professionals who provide services directly or under arrangement must participate in the coordination of care.
- G-706 Participate in ongoing interdisciplinary assessment of the pt.
- G-708 Participate in the development and evaluation of the plan of care.
- G-710 Provide services ordered by the physician or allowed practitioner.
- G-712 & 714 Participate in pt, representative & caregiver counseling and education

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G-710: The skilled professional provides services that are ordered in the plan of care……

- §484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;
- Disciplines failed to promptly initiate services.
- Failed to conduct the ordered visit frequency.
- Failed to implement measures ordered in the plan of care.

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Bonus tags: Extended Survey tasks (Condition level findings)

- If Level 1 standards are cited, then all tags within the COP umbrella will be reviewed.
- If 3 or more standards are found to be deficient, it may rise to a Condition level deficiency.
- When a Condition is cited then all Conditions are reviewed.
- The following are often the Conditions that are found out of compliance during extended tasks: QAPI, EP, and Professional Services

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Bonus Slide: Condition of Participation: Quality Assessment & Performance Improvement (QAPI, G-640)

- The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHH-wide, data driven QAPI program.
- G-642 The program must at least be able to show measurable improvement that will improve quality of care.
  - Must measure analyze and track indicators including adverse pt events.
- G-646 QAPI activities must focus on high risk, high volume, or problem prone area.
- G-656 Must take actions aimed at performance improvement.

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After the Survey….

- CMS-2567 is sent to HHA apx. 10 business days after exit
  - Deemed HHAs receive report from CMS
  - Non-Deemed HHAs receive report from SA (state agency) via email
- Plan of Correction (POC) is due back to SA no later than 10 days
  - LARA-BSCSupport@michigan.gov
  - Email is preferable – hard copies are **NOT** required
  - Compliance Dates-
    - SA **MUST** be able to verify compliance no later than 45 days after exit, therefore correction dates must be before the 45th day.
    - The administrator **MUST** sign and date page 1
    - Each tag **MUST** have a completion date
    - Each tag **MUST** have a corrective action that:
      - Address's systemic issues
      - Measures to implement that assures no recurrence.
      - Monitoring- who will do it? How will they do it? And how often?
- Final Letter recommending compliance to CMS.

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Quality, Safety, & Education Portal Training Catalog

- Check out CMS's new "Quality in Focus" interactive video series at QSEP – Driving Healthcare Quality (cms.gov)
- The series of 10-15 minute videos are tailored to specific provider types and are intended to reduce the deficiencies most commonly cited during the CMS survey process.
- Reducing these common deficiencies increases quality of care for people.
- After watching the videos, you will learn to:
  - -Understand surveyor evaluation criteria
  - -Recognize deficiencies
  - -Incorporate solutions into your facility's standards of care

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Q & A

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Where to Find us....

- Contact Info-
  - On the web:
  - Michigan.gov/bsc
  - Via email:
    - LARA-BSCSupport@michigan.gov
  - Phone- 517-284-0193
  - Fax- 517-763-0214

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