August 9, 2016 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

CMS Announces Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes

The federal Centers for Medicare and Medicaid Services (CMS) announced in a recent Survey and Certification Letter (click here), that they are:

- Revising Chapter 7 of the State Operations Manual (SOM) regarding policies on the immediate imposition of federal remedies;
- Requiring the immediate imposition of Civil Monetary Penalties (CMP) if an Immediate Jeopardy is cited; and
- Irrespective of a state recommendation to impose or not impose a remedy, the CMS Regional Office must immediately impose, without permitting a facility an opportunity to correct deficiencies, one or more federal remedies based on the seriousness of the deficiencies or when actual harm or Substantial Quality of Care (SQC) is identified.

Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) and dually participating facilities (SNF/NFs) are required to be in compliance with Medicare and Medicaid requirements. To avoid enforcement actions, including termination of their provider agreements, facilities have a responsibility to correct any deficiencies cited as a result of a federal survey. CMS and the State Survey Agencies (SAs) have no statutory or regulatory obligation to provide noncompliant facilities an opportunity to correct their deficiencies prior to immediately imposing federal enforcement remedies (e.g. CMP, directed plan of correction, temporary management, etc.).

CMS is implementing a national policy that requires the use of federal enforcement remedies when one or more residents suffer significant harm. CMS’ policy about when facilities with deficiencies are given an opportunity to correct them before remedies are imposed can be found in Chapter 7 of the SOM. Chapter 7 is revised to define new mandatory criteria for the immediate imposition of federal remedies prior to affording a facility an opportunity to correct deficiencies. The effective dates for these remedies are clarified and now require that any deficiency cited at a Scope and Severity (S/S) level of J or higher (IJ level) will require the immediate imposition of a CMP against that facility, in addition to any other remedy or remedies imposed.

CMS is specifying the responsibilities of the SAs and the ROs when there is an immediate imposition of federal remedies. When a facility is NOT allowed an opportunity to correct deficiencies prior to the immediate imposition of federal remedies as defined in §7304.1:

- The survey agency (state or federal) must enter all of these cases into the Automated Survey Processing Environment (ASPEN)/ASPEN Enforcement Manager (AEM) system as a “No Opportunity to Correct” case within five business days from when the initial notice was sent to the facility;
- The state must transfer these cases to the RO for their review and imposition of federal remedies; and,
The RO must take action to impose remedies as described in policy, regardless of a state’s recommendation and must consider the seriousness of the deficiencies following the criteria set forth in 42 C.F.R. §488.404 -Factors to be considered in selecting remedies.

Furthermore, section 7400.5.1, Factors That Must Be Considered When Selecting Remedies, and the Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix has been revised. Specifically:

- S/S citations at levels A, B and C now all indicate no remedies are required;
- They deleted the notation, * “This is required only when a decision is made to impose alternative remedies instead of or in addition to termination” for Required Category 2 remedies, and for S/S levels at G, H or I -Actual harm that is not immediate jeopardy; and,
- They added Termination and Temporary Management as possible remedies under Category 2 remedies.

CMS is in the process of updating the SOM to reflect this revised guidance. The final version of this document, when published in the online SOM may differ slightly from this interim advanced copy.

The effective date for this update is for all surveys completed on or after September 1, 2016.

4 Reasons You Should Consider a SNFist Program

It might take a little time to get familiar with all of the new health care acronyms, but SNFist is one that should be moved to the top of your list. The SNFist/Post-Hospitalist is a new genre of primary care specialist—one who works specifically within the four walls of a post-acute care facility and specializes in geriatric care within the context of that facility. The SNFist/Post-Hospitalist specialization is still young, having emerged in response to the projected “boom” of post-acute care residents and the general dissatisfaction with the system of care within the current model. There are only a few thousand SNFist specialists in the United States, and there are even far less SNFist/Post-Hospitalist programs. So if you are interested in improving patient care and saving money on hospital readmissions, I advise that you get your organization on the SNFist wagon soon.

Although there are tremendous benefits to employing General Medicine’s SNFist program in particular, this article is meant to be an introduction to the benefits of implementing the SNFist/Post-Hospitalist model in general.

1. SNFists provide higher quality patient care

A SNFist program provides post-acute patients with higher quality patient care than conventional post-acute care models because they were formed to meet the special needs of patients in post-acute facilities. This means that the physicians can gain a more detailed understanding of the nuanced functions and procedures not only specific to post-acute care, but those that are specific to your post-acute care facility. Intimate relationships are also formed between resident patients and medical caretakers, making way for more informed illness management. Further, a SNFist/Post-Hospitalist program upholds the values of patient-centered care, helping resident patients develop high levels of personal agency so they can participate in their recovery and stabilization.

2. SNFist Programs make continuity of care a breeze

Simply put, having a SNFist program just makes communication more convenient. Physicians and clinicians are on site, so there is no need to coordinate communication with external parties. SNFist/Post-Hospitalist programs significantly reduce the issue of patient transportation—both by taking appointments on site and by seeing patients more frequently to prevent unnecessary hospitalizations. Without a SNFist program in place, resident patients may only be seen by their physician on a monthly basis, or if medically stable, every 60 days. Tasks such as scheduling and coordinating appointments are reduced from volatile communication hubs to accessible on-site services. Since the SNFist/Post-Hospitalist is familiar with the limitations of the facility, they can suggest ways that resident patients can participate in the management of their health care using the resources that are available to them.

3. SNFist/Post-Hospitalist Programs are proven to reduce hospital readmissions

The Medicare Payment Advisory Commission reports that 25 percent of hospital readmissions for post-acute patients are avoidable and caused by negligent care in a post-acute care facility. Because SNFist physicians and clinicians are on site, they are more apt to catch illnesses and unforeseen problems earlier in their development before they require
emergency treatment. While some experts suggest that geriatric care is best given inside the patients’ homes, the post-acute care industry should pride itself on providing high-quality professional care, and bringing in a SNFist/Post-Hospitalist program is a proven method for showing impact based on hospital readmission data. For instance, in a recent case study by General Medicine, the 30-day hospital readmission rate was reduced by 56 percent when compared to the national average for dual-eligibles.

4. SNFists can help improve the public’s perception of long term care

In spite of all its difficulties, working in long term care is a labor of love. This is true for everyone involved, from volunteers to SNFists, all the way up to directors of large organizations. Unfortunately, our compassion and life’s work has a less-than-desirable stereotype. Each of us wants to do whatever we can to improve the public’s perception of long term care facilities—particularly nursing homes—to alleviate fears and negative feelings that may happen to develop in potential patients and their families, not to mention medical students who are considering geriatric medicine or long term care as an area of specialty. SNFist/Post-Hospitalist programs allow physicians to have the time to truly care for their patients and understand all of the nuances and particularities of working in post-acute care. By incorporating a SNFist program into the structure of your post-acute care organization, both the staff and the residents will do their best, and the public will see that.

AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 7 of 13

This is part of a series featuring one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of Clinical Foundation: “First of All, Do No Harm” Thinking Built into Practice

Key Takeaways: “First of All, Do No Harm” Thinking Built into Practice

- Before doing something, we consciously consider potential unintended and undesirable consequences of a proposed action or intervention.
- As we do something, we consciously consider whether we are doing it correctly, and how we know that it is the right way.
- The ability to choose the right interventions and avoid problematic ones lies at the heart of all clinical practice and is essential to “person-centered care.”

Visit the AHCA Clinical Practice website to learn more about the element of “Clinical Foundation: “First of All, Do No Harm” Thinking Built Into Practice” and answers to these key questions:
What does this mean? Why is this important? What are some examples? What is my part (as an individual employee, manager or practitioner)? What can my organization do?

Start somewhere, pick one element and work through it with your team.

Enjoy the journey through the framework!

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**Hospitals Use of Electronic Health Records – Integration of Medication Information**

Poor communication between providers and between providers and patients, within and across care settings, has been identified as a source of medication error. Improving communication is a key aspect of decreasing medication errors and improving patient safety (Kitson, et al., 2013).

Disparities in access to health information, services, and technology can result in:
- Less use of preventive services.
- Poorer chronic disease management.
- Higher hospitalization rates.
- Poorer reported health status (Berkman, et al., 2004).

Patients need to understand their medication (indications, administration, adverse effects) to safely and effectively use it. But important medication information is given to patients in a haphazard way (Persell, 2013).

Integration of medication information measures include:
- People under age 65 with a usual source of care whose health provider usually asks about prescription medications and treatments from other doctors.
- Hospitals with electronic exchange of patient medication history with hospitals outside their system.
- Hospitals with electronic exchange of patient medication history with ambulatory providers outside their system.

**People Whose Provider Usually Asks About Medications and Treatments From Other Doctors**

*People under age 65 with a usual source of care whose health provider usually asks about prescription medications and treatments from other doctors, by education and chronic conditions, 2002-2013*
**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2013.

**Importance:** Different providers may prescribe medications for the same patient. Patients must track all their medications, but medication information can be confusing, especially for patients on multiple medications. When care is not well coordinated and some providers do not know about all of a patient's medications, patients are at greater risk for adverse events related to drug interactions, overdosing, or underdosing. Medication information generated in different settings might not be sent to a patient's primary care provider, so the patient is the primary source of medication information. Actively gathering and managing all of a patient’s medical information is an important part of care coordination.

**Trends:** From 2002 to 2013, the percentage of people with a usual source of care whose health provider usually asked about prescription medications and treatments from other doctors improved from 75.1 percent to 79.9 percent. The percentage of people with a usual source of care whose health provider usually asked about prescription medications and treatments from other doctors showed improvement for patients of all educational levels and all groups with chronic conditions.

**Groups With Disparities:** In 8 of 12 years, people with less than a high school education were less likely than people with any college to be asked about prescription medications and treatments from other doctors. In 7 of 12 years, high school graduates were less likely than people with any college to be asked about prescription medications and treatments from other doctors.

**Hospitals With Electronic Exchange of Patient’s Medication History With Other Hospitals**

*Hospitals with electronic exchange of patient's medication history with hospitals outside their system, by region and geographic location, 2009-2013*

**Key:** MSA = metropolitan statistical area.

**Source:** American Hospital Association, Information Technology Supplement, 2009-2013.

**Importance:** Health information exchange enables patients' health information to follow them between delivery settings in order to support care coordination and avoid duplication of services. There is broad consensus that such connectivity is critical to improving care and reducing health care costs.
Trends: From 2009 to 2013, the percentage of hospitals with electronic exchange of patient’s medication history with hospitals outside their system increased from 13.4 percent to 49.6 percent.
From 2009 to 2013, the percentage of hospitals with electronic exchange of patient’s medication history with hospitals outside their system more than tripled for residents of all regions.
From 2009 to 2013, the percentage of metropolitan hospitals that electronically exchanged patient medication history with hospitals outside their system significantly increased from 13.3 percent to 51.7 percent. The percentage of nonmetropolitan hospitals that electronically exchanged medication history increased from 13.5 percent to 47.0 percent.
Differences: In 2013, hospitals in the Midwest were most likely to have electronic exchange with hospitals outside their system, followed by the South, West, and Northeast (50.7 percent, 50.4 percent, 49.0 percent, and 45.6 percent, respectively).

Hospitals With Electronic Exchange of Patient’s Medication History With Other Hospitals

Hospitals with electronic exchange of patient’s medication history with hospitals outside their system, by ownership and bed size, 2009-2013

Importance: Health information exchange enables patients’ health information to follow them between delivery settings in order to support care coordination and avoid duplication of services. There is broad consensus that such connectivity is critical to improving care and reducing health care costs.

Trends: From 2009 to 2013, the percentage of hospitals that electronically exchanged patient medication history with hospitals outside their system increased:
   - From 9.4 percent to 37.2 percent for for-profit hospitals.
   - From 13.6 percent to 56.8 percent for not-for-profit hospitals.
   - From 12.0 percent to 41.8 percent for non-Federal hospitals.
   - For Federal hospitals, the percentage decreased from 27.7 percent to 22.0 percent.

From 2009 to 2013, the percentage of hospitals that electronically exchanged patient medication history with hospitals outside their system increased:
   - From 14.8 percent to 42.6 percent for hospitals with fewer than 100 beds.
   - From 12.1 percent to 53.5 percent for hospitals with 100-399 beds.
   - From 13.9 percent to 62.7 percent for hospitals with 400 or more beds.

Differences: In 4 of 5 years, hospitals with fewer than 100 beds were less likely than large hospitals (400+ beds) to exchange information with hospitals outside their system.
In 3 of 5 years, hospitals with 100-399 beds were less likely than large hospitals (400+ beds) to exchange information with hospitals outside their system.

Hospitals With Electronic Exchange of Patient’s Medication History With Ambulatory Providers

Hospitals with electronic exchange of patient’s medication history with ambulatory providers outside their system, by region and geographic location, 2009-2013
Key: MSA = metropolitan statistical area.

Source: American Hospital Association (AHA), Information Technology Supplement, 2009-2013.

Importance: Health information exchange enables patients’ health information to follow them between delivery settings in order to support care coordination and avoid duplication of services. There is broad consensus that such connectivity is critical to improving care and reducing health care costs.

Trends: From 2009 to 2013, the percentage of hospitals with electronic exchange of patient medication history with ambulatory providers outside their system increased from 28.2 percent to 51.8 percent.

From 2009 to 2013, the percentage of hospitals that electronically exchanged patient medication history with ambulatory providers outside their system increased:
   From 29.2 percent to 52.8 percent in the Northeast.
   From 32.2 percent to 52.0 percent in the Midwest.
   From 25.4 percent to 52.3 percent in the South.
   From 24.9 percent to 49.4 percent in the West.

From 2009 to 2013, the percentage of metropolitan hospitals that electronically exchanged patient medication history with ambulatory providers outside their system significantly increased from 29.6 percent to 56.4 percent. The percentage of nonmetropolitan hospitals that electronically exchanged patient medication history increased from 26.2 percent to 45.9 percent.

Differences: In 2013, hospitals in metropolitan areas (56.4 percent) were more likely to exchange information with ambulatory providers outside their system than hospitals in nonmetropolitan areas (45.9 percent).

Hospitals With Electronic Exchange of Patient’s Medication History With Ambulatory Providers
Hospitals with electronic exchange of patient’s medication history information with ambulatory providers outside their system, by ownership and bed size, 2009-2013


Note: Non-Federal hospitals refer to government hospitals.
Importance: Health information exchange enables patients’ health information to follow them between delivery settings in order to support care coordination and avoid duplication of services. There is broad consensus that such connectivity is critical to improving care and reducing health care costs.

Trends: From 2009 to 2013, the percentage of hospitals that electronically exchanged medication history with ambulatory providers outside their system increased:

- From 19.6 percent to 43.7 percent for for-profit hospitals.
- From 32.0 percent to 59.4 percent for not-for-profit hospitals.
- From 13.2 percent to 22 percent for Federal hospitals.
- From 23.0 percent to 39.8 percent for non-Federal hospitals.

From 2009 to 2013, the percentage of hospitals that electronically exchanged patient medication history with hospitals outside their system increased:

- From 23.7 percent to 42.1 percent for hospitals with fewer than 100 beds.
- From 30.4 percent to 57.8 percent for hospitals with 100-399 beds.
- From 32.9 percent to 67.3 percent for hospitals with 400 or more beds.

Differences: In all years, not-for-profit hospitals were more likely to have electronic exchange with ambulatory providers outside their system than for-profit and Federal hospitals.
In all years, hospitals with fewer than 100 beds were less likely than hospitals with 400 or more beds to electronically exchange medication history with ambulatory providers outside their system.

**Important Regulations, Notices & News Items of Interest**

1) The following federal Survey and Certification (S&C) Letters were released since the last issue of *Regulatory Beat*:

- **S&C 16-31 – NH** - Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes — *See Lead Article*. REVISED 07.29.16 to add temporary management under remedies for termination and correct the effective date. *Revisions to Chapter 7 of the State Operations Manual (SOM)*: This policy memorandum provides advanced guidance relating to revisions in SOM sections §7304 through 7304.3, 7306.1, 7308.3, 7400.5.1, 7400.6.2 and 7313.2 regarding policies on the Immediate Imposition of Federal Remedies (previously referred to as Opportunity to Correct or No Opportunity to Correct). Sections 7304.2.1 and 7304.2.2 are being deleted and incorporated into the revised sections noted above. *Civil Money Penalties (CMPs) for Immediate Jeopardy (IJ)*: CMS Regional Office (RO) must now immediately impose a CMP any time Immediate Jeopardy (IJ) is cited. *Immediate Imposition of Remedies Required*: Irrespective of a state recommendation to impose or not impose a remedy, the CMS RO must immediately impose, without permitting a facility an opportunity to correct deficiencies, one or more federal remedies based on the seriousness of the deficiencies or when actual harm or Substandard Quality of Care (SQC) is identified as outlined in §7304.1.

- **S&C 16-32 – ESRD** - Preconfigured Hemodialysis Systems- NxStage System One with Pureflow SL. The NxStage System One with PureFlow SL is a preconfigured hemodialysis system that is Food and Drug Administration (FDA) approved to meet the Association for the Advancement of Medical Instrumentation (AAMI) standards for water quality and dialysate. Preconfigured hemodialysis systems differ from traditional hemodialysis water systems and therefore all the requirements of 42 CFR 494.40 Water and Dialysate Quality will not be applicable to the function of a preconfigured hemodialysis system. Consistent with 42 CFR 494.40 (e) surveyors must evaluate water and dialysate quality for preconfigured hemodialysis machines by ensuring that the FDA and manufacturer’s labeling for the machine are followed by the facility.

2) Federal HHS/CMS released the following notices/announcements since the last issue of *Regulatory Beat*:

- On July 25, 2016, CMS issued a lengthy proposed rule aimed at expanding bundled payments in the Medicare program. The new rule, which is over 900 pages long, proposes to do the following:
○ Implement a new, mandatory bundled payment model for heart attack and bypass surgery episodes that will be tested in 98 randomly-selected Metropolitan Statistical Areas (MSAs) across the country (yet to be selected);
○ Expand the current Comprehensive Care for Joint Replacement (CJR) program by adding a hip and femur fracture episode in the 67 MSAs that already have begun testing the model (click here to review AHCA’s summary of the CJR final rule);
○ Implement a new incentive payment model around cardiac rehabilitation to be tested in 90 MSAs (45 of which were also selected for the aforementioned cardiac episode model and 45 of which were not); and
○ Establish a pathway for physicians with significant participation in bundled payment models to qualify for payment incentives under the recently proposed Quality Payment Program by adding a new voluntary bundled payment model to the Bundled Payments for Care Improvement (BPCI) initiative, which will be available in 2018.

Click here for the full proposed rule.
Click here for the CMS press release on the rule.
Click here for the CMS fact sheet on the rule.

• SNF Readmission Measure: Top 10 Things You Should Know. A new fact sheet is available for the Skilled Nursing Facilities (SNFs) Readmission Measure (SNFRM). The SNF Value-Based Purchasing (VBP) program ties portions of SNF payments to performance on this measure, which is calculated by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior proximal hospitalization. Visit the SNF VBP webpage for more information on the program.

• IMPACT Act Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the July 7 call on Quality Measures and the IMPACT Act. CMS experts discuss key quality measures related to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and how they will affect you.

• SNFs: Final FY 2017 Payment and Policy Changes. On July 29, CMS issued a final rule (CMS-1645-F) outlining FY 2017 Medicare payment policies and rates for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS), the SNF Quality Reporting Program (QRP), and the SNF Value-Based Purchasing (VBP) Program. CMS projects that aggregate payments to SNFs will increase in FY 2017 by $920 million, or 2.4 percent, from payments in FY 2016. This estimated increase is attributable to a 2.7 percent market basket increase reduced by 0.3 percentage points, in accordance with the multifactor productivity adjustment required by law.

  Changes to the SNF QRP:
  ○ Adopts three measures to meet the resource use and other measure domains and one measure to satisfy the domain of medication reconciliation
  ○ SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the annual market basket percentage update factor for fiscal years beginning with FY 2018
  ○ Policies and procedures associated with public reporting are being finalized, including the reporting timelines, preview period, review and correction of assessment-based and claims-based quality measure data, and the provision of confidential feedback reports to SNFs

  SNF VBP Program:
  ○ Specifies the SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure as required by law
  ○ Finalized additional policies, including establishing performance standards, establishing baseline and performance periods, adopting a performance scoring methodology, and providing confidential feedback reports to SNFs

For More Information:
○ Final Rule will become effective on October 1, 2016
○ SNF PPS website
○ SNF QRP webpage
○ IMPACT Act Downloads and Videos webpage
○ SNF VBP webpage
Hospice Benefit: Final FY 2017 Payment and Policy Changes. On July 29, CMS issued a final rule (CMS-1652-F) outlining FY 2017 Medicare payment rates and wage index and the Hospice Quality Reporting Program (QRP) for hospices serving Medicare beneficiaries. As finalized, hospices would see a 2.1 percent ($350 million) increase in their payments for FY 2017 (reflecting an estimated 2.7 percent inpatient hospital market basket update, reduced by a 0.3 percentage point productivity adjustment and a 0.3 percentage point adjustment required by law).

Changes to the Hospice QRP:
- Provides a description of the Hospice CAHPS® Survey and outlines participation requirements for the FY 2019 and FY 2020 annual payment updates
- Finalizes two new quality measures for FY 2017
- CMS expects to begin public reporting hospice quality measures via a Compare site in CY 2017

Enhanced Data Collection:
- CMS is considering enhancing the current Hospice Item Set (HIS) data collection instrument to be more in line with other post-acute care settings
- This revised data collection instrument would be a comprehensive patient assessment instrument, rather than the current chart abstraction tool

For More Information:
- Final Rule will become effective on October 1, 2016
- Hospice Center website

First Release of the Overall Hospital Quality Star Rating on Hospital Compare. On July 27, CMS updated the star ratings on the Hospital Compare website. The new Overall Hospital Quality Star Rating summarizes data from existing quality measures publicly reported on Hospital Compare into a single star rating for each hospital, making it easier for consumers to compare hospitals and interpret complex quality information. It will include 64 of the more than 100 measures displayed on Hospital Compare.

For More Information:
- Overall Hospital Quality Star Rating Methodology Report, including a complete list of measures
- Blog: Helping Consumers Make Care Choices through Hospital Compare

Home Health Agencies: New PEPPER Available. A new Program for Evaluating Payment Patterns Electronic Report (PEPPER) for Home Health Agencies (HHAs) is available through the PEPPER Resources Portal. CMS contracts with TMF to produce and distribute these free reports that summarize HHA claims data statistics for areas that may be at risk for improper Medicare payments. HHAs can use the data to support internal auditing and monitoring activities. Compare your Medicare billing practices with other HHAs in the nation, Medicare Administrative Contractor jurisdiction, and state. The report includes:
- Average case mix
- Average number of episodes
- Episodes with 5 or 6 visits
- Non-Low-Utilization Payment Adjustment (LUPA) payments
- High therapy utilization episodes
- Outlier payments

For More Information:
- PEPPERresources.org, including a sample HHA PEPPER
- Distribution Schedule: How to Get Your PEPPER webpage
- HHA User Guide
- Submit questions to the Help Desk
ICD-10 Coding Resources. The ICD-10 website features official coding resources that can help you maintain your ICD-10 progress, including:

- 2017 ICD-10-CM diagnosis and ICD-10-PCS inpatient procedure code sets and guidelines
- Specialty Resources Guide
- Quick Start Guide
- Clinical Concepts Series: Family Practice, Internal Medicine, Cardiology, OB/GYN, Orthopedics, and Pediatrics
- MLN Connects® Videos: ICD-10 Coding Basics, Coding for ICD-10-CM: More of the Basics, ICD-10 Post-Implementation: Coding Basics Revisited

Visit the ICD-10 website and Roadto10.org for the latest news and official resources, including the Next Steps Toolkit and a contact list for provider Medicare and Medicaid questions.

SNF Quarterly Reports Available through Nursing Home Compare. CMS released July quarterly reports for Skilled Nursing Facilities (SNFs) through the Nursing Home Compare reporting system, including information on the SNF Value-Based Purchasing (VBP) Program. Beginning on October 1, 2016, SNFs will also receive quarterly confidential feedback reports on the SNF VBP Program through the Certification and Survey Provider Enhanced Reporting (CASPER) system. For more information, visit the SNF VBP Program webpage, or contact us at SNFVBPinquiries@cms.hhs.gov.

SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available. A fact sheet is available with information on requirements for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) FY 2018 reporting year (data collection period October 1 through December 31, 2016). Visit the SNF QRP (IMPACT Act of 2014) webpage for more information.

SNF Quality Reporting Program Provider Training — August 24. CMS is hosting a 1-day, in-person training event on August 24 for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) in Chicago, IL. Find out about assessment-based data collection instructions and updates associated with the changes in the October 1, 2016, release of the Minimum Data Set (MDS) 3.0 and other reporting requirements for the SNF QRP. Visit the SNF QRP Training webpage for more information and to register.

IMPACT Act: Data Elements and Measure Development Call — August 31. Wednesday, August 31 from 1:30 to 3:00 p.m. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. During this call, CMS experts discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long term care hospitals.

**Agenda:**
- Overview of National Quality Strategy and CMS Quality Strategy
- Why do we have quality measures?
- How do data elements fit within measure development?
- How is provider data used in the development process?
- Example: pressure ulcer measure
- Question and answer/discussion session

**Target Audience:** PAC providers, health care industry professionals, clinicians, researchers, health IT vendors and other interested stakeholders.
• Protecting Patient Personal Health Information MLN Matters Article — New. An MLN Matters Special Edition Article on Protecting Patient Personal Health Information is available. Learn about the Health Insurance Portability and Accountability Act requirement to protect the confidentiality of Medicare patients’ personal health information.

• National Partnership to Improve Dementia Care and QAPI Call — September 15. Thursday, September 15 from 1:30 to 3:00 p.m. ET. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. This call focuses on effective care transitions between long-term and acute care settings, highlighting transitions that involve residents with dementia. This is critical for residents with dementia, as care transitions can cause heightened anxiety and aggression. Communication should be optimized, as care transitions are high-risk periods for nursing home residents. Additionally, CMS subject matter experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations.

  Speakers:
  o Dr. Kevin Biese, University of North Carolina (UNC), Department of Emergency Medicine
  o Tammie Stanton, UNC Health Care System
  o Kathryn Weigel, Rex Rehabilitation & Nursing Care Center of Apex
  o Scott Bartlett, Pikes Peak Area Council of Governments – Area Agency on Aging
  o Michele Laughman and Debbie Lyons, CMS

  Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

3) The HHS Office of Civil Rights (HHS OCR) has published guidance to assist long term care facilities in complying with their civil rights responsibilities and obligations under regulations by the HHS Centers for Medicare and Medicaid Services that require facilities which are Medicare and/or Medicaid-certified to ensure their residents receive services in the most integrated setting appropriate to their needs.

4) The federal Food and Drug Administration (FDA) updates warnings for fluoroquinolone antibiotics. Limits use for acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis and uncomplicated urinary tract infections. The U.S. Food and Drug Administration approved safety labeling changes for a class of antibiotics, called fluoroquinolones, to enhance warnings about their association with disabling and potentially permanent side effects and to limit their use in patients with less serious bacterial infections.

5) The Agency for Healthcare Research and Quality (AHRQ) recently published a document regarding Strategies To De-Escalate Aggressive Behavior In Psychiatric Patients. The information in this report is intended to help health care decision makers—patients and clinicians, health system leaders and policymakers, among others—make well-informed decisions and thereby improve the quality of health care services. This report is not intended to be a substitute for the application of clinical judgment. Anyone who makes decisions concerning the provision of clinical care should consider this report in the same way as any medical reference and in conjunction with all other pertinent information (i.e., in the context of available resources and circumstances presented by individual patients).

6) The Illinois Department of Healthcare and Family Services (HFS) posted the following notices:

  • HFS has posted a new provider notice regarding Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures. You may view the new provider notice here.

  • HFS has posted a new provider notice. The notice addresses Clarification Regarding Initial 60-Day Higher Rate for Routine Home Care (RHC) and End of Life Service Intensity Add-On (SIA) Payment Split Between Two Calendar Months. You may view the new notice here.

  • HFS has posted a new Medicaid Preferred Drug List. You may view the new list here.
HFS has posted a document regarding Medicare and Third Party Liability (TPL) billing requirements to the HFS LTSS Long Term Care Direct Billing web page. In addition a series of nursing facility claim examples, both in X12 and UB04 formats, have been posted. You may view the documents [here](#).

7) The Illinois Department of Public Health (IDPH) recently released its annual *Long Term Care Report to the General Assembly* – [click here](#). Also, the remaining IDPH Town Hall regional meetings dates are below. They are very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words “Town Hall Reservation” in the subject line.

8/11 – Hamilton Memorial Rehab – McLeansboro – 1-3pm
8/31 – Memorial Education Building – O’Fallon – 1-3pm
9/14 – Alden Estates of Shorewood – Shorewood – 1-3pm
10/19 – Brookens Building – Champaign – 1-3pm
11/15 – Friendship Village – Schaumburg – 10-12noon

8) The American Health Care Association (AHCA) offers the following information:

- With the mandatory Payroll-Based Journal (PBJ) requirement (aka electronic staffing data collection) having been implemented, providers should take note of the latest resources available [here](#) to help them with any questions or issues they are having. A quick search using “PBJ” will yield resources on legal answers, vendors with a PBJ solution and various videos featuring common questions and answers.

- The following resources are now available on the Five-Star achancalED website [here](#):
  - CMS Updated Technical User’ Guide (also [here](#))
  - A member toolkit containing the following items:
    - Suggested talking points
    - Template media statement
    - Template letter to families
    - Sample letter to payors
  - Recorded July 28 Five-Star Webinar
  - The Q&As from the webinar will also be available on the website.

If you have any questions, please contact me at dgifford@ahca.org.

- AHCA sent an email noting that CMS released initial guidance related to the use of new or increased pass-through payments in Medicaid managed care. This guidance applies to states with Medicaid managed care delivery systems in place, or those that are in the process of implementing managed care. States without Medicaid managed care will not be impacted by this guidance, though we do expect CMS to release a proposed rule related to supplemental payment made in the fee-for-service environment.

As you may recall, the final Medicaid managed care rule released this spring restricts the authority of states to direct how Medicaid managed care plans pay providers, which includes pass-through payments, for contracts on or after July 1, 2017, except to:

1. advance value-based purchasing models;
2. participate in delivery system reform or performance improvement initiatives (including multi-payer or community-wide initiatives); or
3. adopt a minimum fee schedule, a uniform dollar or percentage increase or maximum fee schedule for classes of network providers.

9) The latest Telligen events/announcements can be found at [https://www.telligeninqio.com/](https://www.telligeninqio.com/).

10) The New York Times reports on a checklist proposed by “a group of neuropsychiatrists and other experts” to help “identify people at greater risk for Alzheimer’s.”
11) The Hill reports 31 House Democrats, led by Jan Schakowsky (D-Ill.), are urging the CMS to strengthen proposed standards for nursing homes to better protect seniors. The proposed standards are expected to be finalized this September and would require all facilities “to implement written policies and procedures that prohibit and prevent abuse, neglect, mistreatment or misappropriation of property, and consider competence and skill based on the number of residents and range of care when determining sufficient staffing levels.” The lawmakers said the proposal should also require nursing homes to keep “a registered nurse on staff 24 hours a day, seven days a week and mandate staff-to-resident ratios for direct care nurses.”

12) Articles from HealthDay:

- HealthDay reports, “Some people with Alzheimer’s disease and related dementias may often land in the hospital simply because of poor management of other health problems they have,” researchers concluded after conducting an analysis of Medicare data. In fact, “one in 10 people with Alzheimer’s disease or dementia had at least one hospital stay in 2013 that may have been preventable,” the study found. The findings were scheduled for presentation July 25 at the Alzheimer’s Association International Conference.

- HealthDay reports on a recent study that suggests that managing “difficult patients” with dementia “instead of medicating them, could” yield better results. The study focuses on a 156-patient program that trained “nursing home staff members to focus on resolving specific issues bothering the patients and not to automatically sedate them” or give them powerful antipsychotic medicines. The findings were presented at the Alzheimer’s Association International Conference. HealthDay points out, “Since 2008, the US Food and Drug Administration has required a boxed warning with all antipsychotic medications noting the increased risk of death in elderly patients with dementia-related psychosis.”

- Health Day reports that Americans spent $30 billion in 2012 on such alternative treatments as chiropractic care, acupuncture, yoga and natural supplements. Much of this spending is out-of-pocket as not all insurers cover alternative treatments.

13) Contributor James Bailey writes in a US News & World Report piece that Medicare would be the most likely culprit if the US government were to become bankrupt, because the program is consuming “an ever-growing share of the federal budget.” He says that in the 1970s, policymakers used certificate of need laws to attempt to rein in Medicare spending, to no avail. Instead, Medicare costs rose by 6 percent. Bailey adds that HHS “used its control of Medicare funding to push states to adopt certificate of need laws in the first place, reflecting the prevailing view of the federal government at that time.” He points out that since then, HHS has changed its position, but the department “could go further to correct its old mistake, and join the DOJ in advising states to drop laws which are ineffective in so many ways.”

14) Forbes reports that Obama Signs Opioid Legislation, Despite Funding Concerns. President Barack Obama signed a bill into law to address the country’s ever-growing opioid epidemic, despite issues with funding. “This legislation includes some modest steps to address the opioid epidemic,” the president said in a statement. “Given the scope of this crisis, some action is better than none.”

15) Infection Control Today reports CDC Funding Accelerates Antibiotic Resistance Efforts. The Centers for Disease Control and Prevention (CDC) is providing $67 million to help health departments nationwide tackle antibiotic resistance and other patient safety threats, including healthcare-associated infections. The new funding for antibiotic resistance, part of the awards available through CDC’s Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement (ELC) announced last week, also supports seven new regional laboratories with specialized capabilities allowing rapid detection and identification of emerging antibiotic resistant threats. These funds will be distributed to all 50 state health departments, six local health departments (Chicago, the District of Columbia, Houston, Los Angeles County, New York City and Philadelphia) and Puerto Rico. The awards support activities related to CDC’s Antibiotic Resistance Solutions Initiative and implementation of the surveillance, prevention, and stewardship activities outlined in the National Action Plan for the Combating Antibiotic-Resistant Bacteria.
16) **Medical News Today** reports:

- **Pain Profiling Has Potential to Improve Quality of Life for Older Patients.** A two-part paper published recently in *Age & Ageing*, the scientific journal of The British Geriatrics Society, reveals that pain profiling in older patients has the potential to improve quality of life, and help target resources to those most at risk of disability. The study also found that the use of new pain profiles, which took into account the impact of pain and its subjective nature, might enable better management of pain, and more accurate predictions of healthcare utilization among older people.

- **Here’s Why the Epidemic Strain of C. difficile is So Deadly – and a Way to Stop It.** A new, epidemic strain of *C. difficile* is proving alarmingly deadly, and new research from the University of Virginia School of Medicine not only explains why but also suggests a way to stop it. Until now, scientists have not understood what made this strain worse than other strains of the bacteria, the most common cause of hospital-acquired infections. The new strain kills up to 15 percent of infected patients, including those who receive antibiotics, and has become increasingly common over the last 15 years. This has prompted the federal Centers for Disease Control and Prevention to label it an "urgent threat."

17) **Medscape** reports:

- **Dementia Drugs Increase Survival, Save Money.** For patients with Alzheimer’s disease (AD), early treatment with currently recommended medications may prolong survival and save healthcare dollars, compared with non-treatment, according to a longitudinal retrospective study. "The arguments for early treatment are myriad, but this study shows greater survival and less all-cause healthcare costs among those receiving treatment for dementia," Christopher M. Black, MPH, from Merck Research Laboratories, said in a statement.

- **New Initiative Safely Halts Antipsychotic Use in Dementia Patients.** Australian researchers have successfully reduced the use of antipsychotics to treat behavioral and psychological symptoms in dementia patients in 23 long term care facilities in New South Wales. In the Halting Antipsychotic use in Long Term care (HALT) Project, regular antipsychotic medication was eliminated from the treatment plan in the majority of participating patients. Successful stopping of antipsychotics was achieved through training of nurses in long-term care facilities in nonpharmacologic and person-centered approaches to managing behavioral and psychological symptoms of dementia (BPSD).

- **Advance Directives in Dementia: When to Discuss?** It is never too early to discuss care preferences for patients with Alzheimer disease or other dementias. Alzheimer disease is a life-limiting disease with a median survival time from diagnosis of 4.2 years for men and 5.7 years for women; the prognosis is worse for other dementias. Thus, there is a short time horizon for events that are likely to require advance care planning.

18) **Kaiser Health News** reports:

- **Long Term Care is an Immediate Problem – For the Government.** Experts estimate that about half of all people turning 65 today will need daily help as they age, either at home or in nursing homes. Such long-term care will cost an average of about $91,000 for men and double that for women, because they live longer.

- **Medicaid is Not Enough For To Cover Many Senior’s Long-Term Services and Supports.** A report by the Kaiser Family Foundation shows that Medicare does not cover many seniors’ long-term services and supports (LTSS). According to the article, almost half of seniors “residing in the community have an LTSS need to a cognitive or physical limitation.” Considering how expensive LTSS is, low income seniors are “unlikely to be able to afford paid help, and few have private long term care insurance to meet their needs.” Federal and state policymakers need to consider “improving access to LTSS for seniors is likely to remain a major public health issue,” and they are encouraged to “meet the growing need for LTSS for our nation’s seniors in a manner that promotes community integration and autonomy, supports caregivers, and provides adequate access to needed care while managing costs.”
Federal Government to Punish More Than Half of Nation’s Hospitals For Excess Readmission Rates. *Kaiser Health News* reports records released show “the Federal government will punish more than half of the nation’s hospitals – a total of 2,597 – for excess readmissions by withholding more than half a billion dollars in Medicare payments over the next year.” The piece notes such penalties have long been the subject of a debate over “whether the government should consider the special challenges faced by hospitals that treat large numbers of low-income people,” who tend to have more difficulty recuperating and are more likely to be readmitted. However, CMS says those hospitals serving low-income people “should not be held to a different standard.”

10 Essential Facts About Medicare and Rx Drug Spending. The Kaiser Family Foundation has published an *interesting chart series* on Medicare drug spending and the potential impact of new therapies on the cost of the program in coming years.

15 Years of Medicaid Surveys. The Kaiser Family Foundation has published an annual review of state Medicaid program statistics for the past 15 years. So, if anyone would have a good perspective on the twists and turns of the program, it might be them. [See for yourself.](#)

State Medicaid Programs Struggling to Pay For More Long Term Care as Population Ages. *Kaiser Health News* reports many state Medicaid programs, including California’s Medi-Cal, are spending more on long term care for the elderly at home and in nursing homes as their populations age. Experts expect federal Medicaid spending on long-term care to increase by almost 50 percent by 2026 as the population continues to age.

19) *MedlinePlus* reports:

- **Behavior Changes May be First Signs of Alzheimer’s.** Certain behavior changes may be a harbinger of Alzheimer’s disease, and researchers say they’ve developed a symptom “checklist” that might aid earlier diagnosis. Experts have long focused on so-called mild cognitive impairment as an early warning sign of Alzheimer’s disease. That refers to problems with memory and thinking that may or may not progress to full-blown dementia.

- **1 in 10 Alzheimer’s Patients at Risk for Avoidable Hospital Stays.** Some people with Alzheimer’s disease and related dementias may often land in the hospital simply because of poor management of other health problems they have, a new study suggests. One in 10 people with Alzheimer’s disease or dementia had at least one hospital stay in 2013 that may have been preventable, the researchers reported.

20) *McKnight’s* reports:

- **Medication Underuse Increases Hospitalization, Death Risk.** Older adults who underuse essential medications increase their risk of being hospitalized or dying, according to the results of a newly published study in the [British Journal of Clinical Pharmacology](#). The researchers found that 58 percent of the study participants were taking five or more medications for chronic conditions every day. Few of the older adults were taking medications appropriately, with 67 percent underusing their drugs and 56 percent misusing them (some overlap exists between these groups). Just 17 percent of the study population was not affected by any kind of underuse or misuse.

- **Hospice Can Pay SNFs For Dual Eligibles, Feds Say.** Federal health officials have given a green light to a hospice provider’s proposal to make supplemental payments to skilled nursing facilities for dual eligible patients. The payment arrangement, proposed by an unnamed nonprofit hospice provider, would have the hospice pay nursing facilities directly for hospice patients eligible for both Medicare and Medicaid, in addition to payments the facility receives from a state managed care organization. The proposal would ensure the nursing facilities would receive the same amount of payment they would have if a patient had not elected hospice care, the provider said. The arrangement would also take away incentives for facilities to provide a lower level of care to hospice patients, or discourage patients from electing hospice.

- **Hundreds of Hospitals Join Fight with HHS Over ‘Two-Midnight’ Rule.** More than 200 hospitals have filed new lawsuits in the ongoing battle between providers and the Department of Health and Human Services over its
controversial “two-midnight” rule. The new suits are the latest in a series of challenges from hospitals who oppose the rule’s 0.2 percent reduction of inpatient compensation. The earlier legal challenges led to HHS killing the payment cut in April for fiscal year 2017, and temporarily increasing payment rates. Both lawsuits, filed by a total of 211 hospitals, allege the agency violated federal regulations when it implemented the pay cuts and did not take hospital’s concerns into accounts.

- **New Treatment May Prevent Antibiotic-Resistant Facility ‘Superbugs’**. A first-of-its-kind treatment to prevent bacterial skin infections could play a vital role in the fight against “superbugs” in health care facilities, a new study finds. Researchers from the University of Sheffield in the United Kingdom used proteins found in human cells called tetraspanins to make it more difficult for bacteria to attach to skin wounds such as bedsores and pressure ulcers. Use of the proteins has been proven to effectively treat antibiotic-resistant bacteria, according to the report. Antibiotic-resistant bacteria, otherwise known as “superbugs,” include MRSA, Norovirus and CRE.

- **Payment Hike Achieved, Providers Turn Focus to Quality Aspects of FY 2017 Rule**. The release of the final skilled nursing payment rule for fiscal year 2017 gave relief to providers, and rightfully so: it boosted payments to the sector by $920 million. But other provisions tucked in the rule now need attention, provider groups told McKnight’s. Along with the 2.4 percent payment increase, CMS’ skilled nursing rule for FY 2017 included four new quality measures, including one — the SNF 30-Day Potentially Preventable Readmission Measure — that will be used for the sector’s value-based purchasing program, set to start in FY 2019.

- **Value-Based Purchasing for SNFs Will Likely Expand, Expert Says**. Value-based purchasing programs for nursing homes will likely follow other health care sectors’ lead and place additional quality measures after hospital readmissions, according to one healthcare expert. The inevitable expansion will likely mirror similar value-based programs for other provider types, such as hospitals, that began with readmissions, Fred Bentley, vice president at Avalere Health, told Bloomberg BNA on Monday. The value-based purchasing readmission measure was included in the Centers for Medicare & Medicaid final fiscal year 2017 payment rule, released last month. The rise of value-based purchasing will likely push nursing home providers to become more data-focused, Bentley noted. Operators who haven’t already will also be wise to adopt technologies that will help them better track residents and choose the treatments most likely to reduce readmissions. CMS also should provide the readmission data it will use to calculate skilled nursing facilities’ payments before the value-based purchasing program starts, Bentley told Bloomberg, so that providers can be ready to make required changes once the program takes effect.

21) **Interesting Fact**: The Centers for Disease Control (CDC) estimates that food poisoning affects about 1 in 6 Americans each year. Symptoms of food poisoning include fever, abdominal pain, nausea, vomiting and diarrhea.

*If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*