September 27, 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!

Notice of Interim Final Rule (IFR) Adjusting Civil Monetary Penalties (CMPs)
As reported in Provider, the Centers for Medicare & Medicaid Services (CMS) has begun immediately imposing civil monetary penalties (CMPs) and other federal remedies before giving skilled nursing facilities an opportunity to correct deficiencies.

In a related move, the Department of Health and Human Services (HHS) issued an interim final rule increasing CMP amounts, consistent with the requirements of the Bipartisan Budget Act of 2015. This rule is effective immediately. See also Survey and Certification Letter (S&C) 16-40.

The rule includes increases to CMPs that can be imposed by CMS, the Office of Inspector General, and Administration for Children and Families. This initial increase includes a “catch-up adjustment” based on inflation since the last time the CMP was modified or adjusted. Relevant regulations are also amended to provide for continued annual CMP adjustments for inflation.

An interim final rule allows agencies to publish a final rule that becomes effective soon after publication—without going through the proposed rule stage and bypassing public notice and comment. HHS says the statutory requirement for these increases “provides a clear formula for adjustment of the civil money penalties, leaving agencies little room for discretion.”

The following is a summary of new penalties related to Skilled Nursing Facility and Nursing Facility survey and certification CMPs.

Penalty for failure of covered individuals to report to the secretary and one or more law enforcement officials any reasonable suspicion of a crime against a resident or individual receiving care from a long term care facility:
- Prior maximum penalty: $200,000
- New maximum penalty: $217,490

Penalty for failure of covered individuals to report to the secretary and one or more law enforcement officials any reasonable suspicion of a crime against a resident or individual receiving care from a long term care facility if such failure exacerbates the harm to the victim of the crime or results in the harm to another individual:
- Prior maximum penalty: $300,000
- New maximum penalty: $326,235

Penalty for a long term care facility that retaliates against any employee because of lawful acts done by the employee or files a complaint or report with the state professional disciplinary agency against an employee or nurse for lawful acts done by the employee or nurse:
- Prior maximum penalty: $200,000
• New maximum penalty: $217,490

Penalty per day for a Skilled Nursing Facility or Nursing Facility that has a Category 2 violation of certification requirements:
  • Prior minimum penalty: $50
  • New minimum penalty: $103
  • Prior maximum penalty: $3,000
  • New maximum penalty: $6,188

Penalty per instance of Category 2 noncompliance by a Skilled Nursing Facility or Nursing Facility:
  • Prior minimum penalty: $1,000
  • New minimum penalty: $2,063
  • Prior maximum penalty: $10,000
  • New maximum penalty: $20,628

Penalty per day for a Skilled Nursing Facility or Nursing Facility that has a Category 3 violation of certification requirements:
  • Prior minimum penalty: $3,050
  • New minimum penalty: $6,291
  • Prior maximum penalty: $10,000
  • New maximum penalty: $20,628

Penalty per instance of Category 3 noncompliance by a Skilled Nursing Facility or Nursing Facility:
  • Prior minimum penalty: $1,000
  • New minimum penalty: $2,063
  • Prior maximum penalty: $10,000
  • New maximum penalty: $20,628

Penalty per day and per instance for a Skilled Nursing Facility or Nursing Facility that has Category 3 noncompliance with Immediate Jeopardy:
  • Prior per day (minimum): $3,050
  • New per day (minimum): $6,291
  • Prior per day (maximum): $10,000
  • New per day (maximum): $20,628
  • Prior per instance (minimum): $1,000
  • New per instance (minimum): $2,063
  • Prior per instance (maximum): $10,000
  • New per instance (maximum): $20,628

Penalty per day of a Skilled Nursing Facility or Nursing Facility that fails to meet certification requirements. These amounts represent the upper range per day:
  • Prior minimum penalty: $3,050
  • New minimum penalty: $6,291
  • Prior maximum penalty: $10,000
  • New maximum penalty: $20,628

Penalty per day of a Skilled Nursing Facility or Nursing Facility that fails to meet certification requirements. These amounts represent the lower range per day:
  • Prior minimum penalty: $50
  • New minimum penalty: $103
  • Prior maximum penalty: $3,000
  • New maximum penalty: $6,188
Penalty per instance of a Skilled Nursing Facility or Nursing Facility that fails to meet certification requirements:

- Prior minimum penalty: $1,000
- New minimum penalty: $2,063
- Prior maximum penalty: $10,000
- New maximum penalty: $20,628

Grounds to prohibit approval of Nurse Aide Training Program—if assessed a penalty of not less than $5,000. (Not CMP authority, but a specific CMP amount that is the triggering condition for disapproval.):

- Prior penalty amount: $5,000
- New penalty amount: $10,314

Grounds to waive disapproval of Nurse Aide Training Program—reference to disapproval based on imposition of CMP not less than $5,000. (Not CMP authority but CMP imposition at this level determines eligibility to seek waiver of disapproval of Nurse Aide Training Program.):

- Prior penalty amount: $5,000
- New penalty amount: $10,314

**Preparing for Value-Based Care: Questions for Every SNF**

Next year CMS will begin creating the Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP) that is scheduled to be launched in 2019. Based on what CMS has shared about the program so far, and considering what it has done with other value-driven programs, it is evident that the SNFVBP will make payments to participating nursing homes based on the quality of care (not quantity of services) they provide. That means the program will offer financial incentives for things like quality of care, resident experiences and for resident health outcomes.

Federal CMS is hosting a SNF Value-Based Purchasing Program Call on **September 28, 2016, 12:30-2:00 PM Central Time.** Learn how the implementation of the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program will affect your Medicare payment. During this call, CMS experts discuss the legislative background, along with the SNF 30-Day Potentially Preventable Readmission measure, performance standards, and scoring methodology finalized in the FY 2017 SNF Prospective Payment System final rule. Also, find out about the confidential quarterly feedback reports you will receive beginning on October 1, 2016. A question and answer session will follow the presentation. The SNF VBP Program rewards SNFs with incentive payments for quality of care, promoting better clinical outcomes for SNF patients. The program will begin in FY 2019. To register for an MLN Connects Call, please visit the MLN Connects Event Registration website.

In order to be ready for the payment changes that will accompany the SNFVBP, nursing homes need to begin preparing now. Below are some questions nursing homes should ask (and answer) to evaluate their readiness for value-based payments. “Yes” answers indicate readiness in a particular area. “No” responses suggest that there is still work to do to prepare for the transition from fee-for-service to value based care.

**Are we involving residents and their families in care planning?**

It is more effective to align care plans with the needs of individuals when residents and their family members are engaged and involved in care planning. That is why nursing homes need work to include both residents and family members in planning meetings whenever possible. The nursing home team should listen to concerns, answer questions and encourage residents to be reasonably involved in making decisions about their care. This involvement will create more resident-centered care, as well as a better overall care experience.

**Are we asking residents and families for feedback to measure their overall satisfaction?**

Some value-based payment models use satisfaction as a quality measure that impacts reimbursement. Therefore, it is important to ask for feedback and try to understand how people feel about the services they are provided. Nursing homes can use questionnaires and surveys to gather feedback. Then, based on the responses, they can determine where changes are needed in order to improve resident and family satisfaction.
Do we have procedures in place that are designed to help residents adjust as they transfer in and out of our facility? Are they effective?
Care transitions can be particularly difficult for elderly residents. During and after transitions, residents are more likely to experience complications and require acute care. It is important to monitor patients closely and put precautions in place to help prevent transition-related issues. This can include doing things like revising transfer forms and working with hospitals to improve procedures for communicating information prior to transitions.

Are we using electronic health records?
A lot of nursing homes have not adopted EHR technology because of the investment it takes to put an EHR system in place. But EHRs can be a game-changer for nursing homes. Updating from paper to electronic records makes data sharing easier. It also brings efficiency into facilities and it helps staff better track changes in the health of residents. Organizations that do not have an EHR system in place need to make it a priority to remove any barriers and gain access to this technology.

Are we using hospital transfer data to determine a baseline, set goals and measure our progress toward reducing hospital readmissions?
CMS could not be more clear about the fact that it wants to reduce hospital readmissions, or that it expects hospitals and nursing homes to work together to accomplish this goal. In light of this, nursing homes need to be measuring and really keeping an eye on readmission rates for their organizations. That means looking at hospital transfer data and making comparisons each month, each quarter, etc., to determine whether you are making progress toward reducing readmissions.

Do we have good working relationships with the hospitals and home health providers in our community?
Forming strong working relationships with hospitals, home health providers, pharmacies, and others that serve shared patients not only makes it easier to offer more coordinated and safer care to residents, but it is necessary to be successful under value-based care models that reward care coordination. Nursing homes can form a community-based coalition to bring providers together and discuss how all parties can work together to improve care coordination.

Is there a trusted person or partner in charge of directing our quality improvement efforts?
Nursing homes are still awaiting the official launch of CMS' Quality Assurance and Performance Improvement (QAPI) era, but many are already preparing for the rollout of the program. QAPI programs must address all systems of care and management; focus on clinical, quality of life and resident choice areas; use evidence to define and measure indicators of quality and set goals; and reflect a facility's unique resident make up and services. Nursing homes should assign one person (or a team) within their organization the job of managing quality improvement. It may also make sense to bring in a knowledgeable partner to assess an organization's current quality improvement efforts, develop improvement strategies and help charter performance improvement project teams.

Questions like the ones above can help nursing homes understand what they need to do to prepare for shifting payments. However, answering these questions is the easy part. The next step is making organizational changes – and it is much more complicated. That is why nursing homes need to get to work now and utilize the time they have before the SNFVBP and other value-driven regulations are put into effect.

Parts of this article written for McKnight’s by Richard A. Royer, MBA who is the chief executive officer of Primaris.

AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 10 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: Clinical Assessment**

Key Takeaways: Clinical Assessment

- A thorough clinical assessment identifies issues precisely to enable high quality care.
- Clinical assessment has various components (observation, interpretation, etc.) and a given health care professional or licensed staff person may not be equally adept at all of those aspects.
- Performing an accurate and adequate assessment enables subsequent interpretation and clinical decision making.
- Interpretation of findings must be done prudently based on knowledge of the resident/patient and on understanding how to interpret the information, not just on knowledge of the topic (falls, behavior, pain, etc.)

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<tr>
<th>Probing Questions for Team Reflection and Discussion:</th>
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<td>1. How good are the assessments that our staff and practitioners do?</td>
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<td>2. Are we getting enough information and organizing it effectively to allow for appropriate interpretation?</td>
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<td>3. Do we obtain a chronological story and useful background information to support our assessments of all situations and symptoms?</td>
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<td>4. Do we focus enough on improving the processes, not just the tools (forms, etc.)?</td>
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<td>5. What factors impede completion of thorough and accurate clinical assessments? How can we address and minimize those factors?</td>
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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.*
Second Half of 2016 – National Seniors Housing Report

Aging Population Steers New Development; Low Interest Rates Keep REITs Active in Seniors Housing Market

Aging Americans driving growth of seniors housing construction. Strong demographic trends are propelling the seniors housing market forward this year.

Click here to view the National Seniors Housing Report for the second half of 2016.

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 16-37 – All** - Office of Civil Rights (OCR) Clearance. CMS worked collaboratively with the OCR to revise the OCR clearance process for new providers and Changes of Ownership (CHOW). The new process requires that providers successfully submit electronically an attestation of compliance with the civil rights requirements to the OCR before the State Survey Agencies (SA) and Regional Offices (RO) may process requests for initial surveys or CHOWs. Confirmation from OCR of successful submission of the attestation will meet the requirements for OCR clearance and eliminates the need for CMS ROs to issue provisional provider agreements. OCR will begin receiving electronic attestations on September 1, 2016.

- **S&C 16-38 – All** - Notification of Final Rule Published- Emergency Preparedness. Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers: On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017. The next issue of Regulatory Beat will contain an article fully explaining the new requirements for emergency preparedness requirements for nursing centers.

- **S&C 16-39 – All** - Certification Number (CCN) State Codes –State Operations Manual (SOM) Section 2779A Revisions. SOM Section 2779A: CMS has made revisions to this section in the SOM, which provides guidance regarding the numbering system for CCNs for Medicare-participating providers and suppliers. The revision, specifically in Section 2779A1 for Medicare providers reflects the addition of new State Codes. Additional State Codes: Due to a lack of available CCNs for some providers wishing to enroll or modify their current certification in Medicare, additional State codes are being added to the Automated Survey Processing Environment (ASPEN), the Accrediting Organization System for Storing User Recorded Experiences (ASSURE), as well as Medicare payment processing systems, effective October 1, 2016.

- **S&C 16-40 - NH/HHA/CLIA** - Notice of Interim Final Rule (IFR) Adjusting Civil Monetary Penalties (CMPs). The Department of Health and Human Services (HHS) has published in the Federal Register on September 6, 2016 an IFR that adjusts for inflation CMP amounts authorized under the Social Security Act. (See Adjustment of Civil Monetary Penalties for Inflation) The IFR establishes new section 45 CFR Part 102, which lists the new CMP amounts and ranges as adjusted by the IFR for affected regulations. The changes made by the IFR are effective on September 6, 2016. The IFR addresses all applicable CMPs under the authority of HHS but we are highlighting only on those CMPs assessed for Skilled Nursing facilities (SNFs), Nursing Facilities (NFs), SNFs/NFs, Home Health Agencies (HHAs), and Clinical laboratories. See lead article in this issue of Regulatory Beat.

2) Federal HHS/CMS released the following notices/announcements:

- **Office of Civil Rights (OCR) Clearance** - CMS will require Medicare providers to electronically submit proof of compliance with civil rights requirements, according to a memo sent last week. The new process, which is effective immediately, was a collaboration between CMS and the Department of Health and Human Services' Office of Civil Rights, according to the memo. New providers or providers undergoing an ownership change will
now be required to electronically submit an attestation of compliance with the requirements to the OCR before state survey agencies and regional offices process requests for initial surveys and CHOWs. Successful submission of the attestation to OCR will help eliminate the need for CMS regional offices to issue provisional provider agreements, officials said. If the OCR receives discrimination complaints before an initial certification or CHOW it may use enforcement tools, such as compliance reviews, new policy guidance and educational opportunities to help a provider become compliant, CMS said. See S&C 16-37 above.

- **Survey Alert**: CMS has told State Survey Agencies to start reviewing nursing homes’ policies on the use of social media by employees. The reviews follow a memo released last month in response to recent incidents of nursing home employees sharing photos and videos of nursing home residents being abused on social media.

- **SNF 30-Day Potentially Preventable Readmission Measure** — Updated. The updated Skilled Nursing Facility (SNF) 30-Day Potentially Preventable Readmission (PPR) Measure estimates the risk-standardized rate of unexpected PPRs within 30 days for people with Fee-For-Service Medicare who were inpatients at Prospective Payment System, critical access, or psychiatric hospitals. See the draft technical report and Final Measure Specification for more in-depth information on the measure. Visit the SNF Value-Based Purchasing Program webpage for more information on the program.

- **Coudé Tip Catheters**. Avoid delays. Bill it right the first time. The CMS Provider Minute: Coudé Tip Catheters video includes pointers on how to provide the correct documentation when submitting claims for this item. Learn about:
  - Importance of documenting medical necessity
  - Requirement of providing the KX modifier

  This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

- **SNF Value-Based Purchasing Program Call** — Wednesday, September 28 from 12:30 to 2 pm CST. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. Learn how the implementation of the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program will affect your Medicare payment. During this call, CMS experts discuss the legislative background, along with the SNF 30-Day Potentially Preventable Readmission measure, performance standards, and scoring methodology finalized in the FY 2017 SNF Prospective Payment System final rule. Also, find out about the confidential quarterly feedback reports you will receive beginning on October 1, 2016. A question and answer session will follow the presentation. The SNF VBP Program rewards SNFs with incentive payments for quality of care, promoting better clinical outcomes for SNF patients. The program will begin in FY 2019. Target Audience: SNFs, administrators, and clinicians.

- **Advance Care Planning Fact Sheet** — A new Advance Care Planning Fact Sheet is available. Learn about:
  - Beneficiary eligibility
  - Provider and location eligibility
  - Diagnosis requirements

- **ICD-10 Information**
  - Track ICD-10 Progress and Manage Your Revenue Cycle. Now is a good time to review how you use ICD-10. The following Key Performance Indicators can help you manage your revenue cycle and track your ICD-10 progress:
    - Assess progress to identify any productivity or cash flow issues
    - Address opportunities to improve revenue cycle management
    - Maintain progress and keep up-to-date on ICD-10

  To find out more about tracking and improving how you use ICD-10, check out the Next Steps Toolkit. Visit the ICD-10 website for the latest news and official resources, including the Quick Start Guide and a contact list for provider Medicare and Medicaid questions.
**IMPACT Act: Data Elements and Measure Development Call** — Thursday, October 13 from 12:30 to 2 pm CST. 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. Target Audience: PAC providers, healthcare industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

**Overview of the SNF Value-Based Purchasing Program MLN Matters® Article** — An MLN Matters Special Edition Article on Overview of the Skilled Nursing Facility Value-Based Purchasing Program is available. Learn about value-based incentive payments Skilled Nursing Facilities (SNFs) may receive based on performance of specified quality measures for services beginning October 1, 2018.


**CMS Midwest Division Provider Update** (click here).

**Skilled Nursing Facility Quality Reporting Program – Provider Training Questions and Feedback on MDS 3.0** (click here).

**Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information** (click here). The IMPACT Act of 2014 requires the Secretary to implement specified clinical assessment domains using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF and HHA providers. The Act further requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons.

**CMS “has issued a set of tools for states to fight rising improper Medicaid payment rates.”** The agency reported that “the improper payment rate for the Medicaid program climbed to 9.8 percent in 2015, representing $29.12 billion in improper payments.” The figure is “more than double the dollar amount it was in
2013, CMS said.” The agency has “compiled a set of solutions to help states remedy several common problems in the Medicaid program, such as payments going to ineligible and excluded providers, provider identity theft, and incorrect coding.”

- **Emergency Preparedness Requirements Call** – October 5 from 12:30 to 2 pm CST. To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early. The Emergency Preparedness Requirements [final rule](#) established national requirements for Medicare and Medicaid providers. During this call, we will discuss the new requirements and revisions in the final rule, as well as how to plan for both natural and man-made disasters, while coordinating with other emergency preparedness systems. A question and answer session will follow the presentation.

3) The Centers for Disease Control and Prevention (CDC) recently released [Frequently Asked Flu Questions – 2016-2017 Influenza Season](click here). Note: For the 2016-2017 season, CDC recommends use of the flu shot (inactivated influenza vaccine or IIV) and the recombinant influenza vaccine (RIV). The nasal spray flu vaccine (live attenuated influenza vaccine or LAIV) should not be used during 2016-2017. The [2016-2017 influenza vaccination recommendations](#) are now available.

4) The [Illinois Department of Healthcare and Family Services (HFS)](#) posted the following Notices:

- HFS has posted a new provider notice Introducing the ILLINOIS Rx Portal Website. You may view the provider notice [here](#).
- Click [here](#) to find a Notice of Proposed Class Action Settlement and Fairness Hearing regarding the class action lawsuit N.B. v. Norwood, No. 11-C-6866, in the United States District Court for the Northern District of Illinois. You are receiving this email and the attached Notice because you or your organization have been identified as a provider or other organization that serves or interacts with individuals that are likely to be members of the N.B. v. Norwood class, defined as: “All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders.” Pursuant to the Court’s order, the Illinois Department of Healthcare and Family Services (HFS) is providing you or your organization with this Notice so that you or your organization will share it with anyone who may be an N.B. v. Norwood Class Member or any other interested individuals. For more information on the Proposed Settlement Agreement, the fairness hearing, and the rights of Class Members, please see the Notice linked above and the following websites: [https://www.illinois.gov/hfs/info/legal/PublicNotices](https://www.illinois.gov/hfs/info/legal/PublicNotices) and [https://www.illinois.gov/hfs/info/legal/Pages/N.B.vNorwood.aspx](https://www.illinois.gov/hfs/info/legal/Pages/N.B.vNorwood.aspx).
- HFS has posted a new provider notice. The notice is a REMINDER for IMPACT Provider Enrollment Revalidations. You may view the notice [here](#).
- HFS is preparing to implement the second phase of the State’s Integrated Eligibility System (IES) project on September 26, 2016. As part of this phase we are also launching new Manage My Case features on the ABE web portal for our clients. Please be aware of the following:
  - In order to prepare for the transition, ABE will not be available on Thursday, September 22 through Sunday, September 25. ABE will be back up on Monday, September 26, with a new set of Manage My Case features. Clients will also be able to file Appeals online in ABE. HFS will be posting user guides and an overview of the new ABE features on the [HFS website](#) within the week.

- **Before September 22, work down and submit any applications currently pending in ABE.** With the updates to ABE, there may be issues if someone tries to return to complete an application that was started before Go-Live.
  - If someone is unable to submit an application before 9/22 and encounters problems after 9/26, submit the application “as is.” A caseworker will follow up with the client for any missing information.
Starting on September 26, clients can track the status of their application, including requests for verifications, through Manage My Case (MMC), where the client can upload any requested documents. A reminder that for new applicants, their application must be registered in the system before they can link their ABE account to their case for MMC.

- Family & Community Resource Centers (FCRCs), Bureau of All Kids and Health Benefits for Workers with Disabilities (HBWD) will have limited services on Thursday, September 22 and Friday, September 23. FCRCs will be accepting paper applications, processing Expedited SNAP and issuing Emergency LINK cards. Customers may also drop off verifications and forms. However, no applications, other than Expedited SNAP, will be processed on these days by any office.

- The ABE Customer Call Center will not be able to take new applications over the phone on Thursday, September 22 or Friday, September 23.

- The ABE Customer Call Center will not be able to take new applications or answer calls on September 30 or October 3 either because they are relocating the office.

- Beginning September 26, the ABE Partner Portal will be protected by Multifactor Authentication, as we’ve discussed with the All Kids Application Agents (AKAAs), Medicaid Presumptive Eligibility (MPE) providers and App Assistors at Stroger Hospital who use the Partner Portal. Please review the MFA overview.

HFS and DHS are very excited about reaching this major milestone and the many benefits it will provide to customers. Thank you for your patience as we make this transition. Email questions to HFS.ABEpartnerportal@illinois.gov.

- HFS has posted a new provider notice regarding Crisis and Referral Entry Services (CARES) Telephone Response Service Transition to Integrated Eligibility System (IES). You may view the notice here.

- ABE/IES Announcement - Dear Community Partners and Medicaid Providers:

It is very important for all of us at the State of Illinois that we provide the highest quality service to our customers. We have been working diligently to have the IES system, including ABE’s new Manage My Case and Appeals Portals, live up to that expectation.

Thanks to thorough testing done by both Healthcare and Family Services (HFS) and the Department of Human Services (DHS), processing issues were identified that could not be fixed in time to continue with the September 26 launch. These must be addressed to assure Phase 2 correctly executes. Therefore, to avoid any service disruption, we have decided to postpone the deployment of IES Phase 2.

Obviously, this is disappointing. But the state team is hard at work addressing these issues. We will let you know when we have a new Go Live date.

The Legacy systems are back online today, Friday 9/23. We expect ABE to be back online over the weekend. It will take longer to bring IES back online, but we have targeted Monday 9/26. Caseworkers will not be able to process applications until IES is back online.

We would like to thank our dedicated State team for their continued diligence and hard work. We’d also like to thank you, our community partners and providers, for your patience as we work to ensure we have an IES system that allows us to effectively serve our customers.

IES Project Team
• **LTC Providers Technical Assistance Calls** - Technical Assistance (TA) calls are being scheduled for LTC providers on Friday, September 30, 2016 at the following times: Supportive Living Providers – 9am; Nursing Facilities – 11am; and ICF/IIDs – 1 pm. Similar to the previous TA calls, all calls are scheduled to be 60 minutes and will allow for providers to ask HFS questions regarding the Direct Billing process. Please access the [HFS LTSS Direct Billing webpage](https://www.telligenqinqio.com/) for the appropriate call in numbers.

• HFS has posted a new provider notice regarding New Third Party Liability (TPL) Code to Identify Participants in a Medicare Advantage Plan (MAP) Effective with Dates of Service Beginning October 1, 2016. You may view the notice [here](#).

• HFS has posted a new Medicaid Preferred Drug List. You may view the list [here](#).

• HFS has posted a new Public Notice regarding Behavioral Health Services Clarification. You may view the Public Notice [here](#).

5) **The Illinois Department of Public Health (IDPH)** remaining 2016 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.

- 10/19 – Brookens Building – Champaign – 1-3pm
- 11/15 - Friendship Village – Schaumburg – 10-12noon

• IDPH announced that effective August 16, 2016, Michelle Millard assumed the duties of Section Chief of the Long-Term Care Field Operations Special Investigations Unit. Michelle has been in an acting position since January 1, 2016. Michelle began her career with the State of Illinois in March of 1987 at Lincoln Developmental Center as a Mental Health Technician. She obtained her nursing degree through the Upward Mobility Program and began working as a Registered Nurse in April of 2001.

• IDPH also announced that Dan Levad is the new Section Chief for the ICF/IID section. Dan began his State career with the Illinois Department of Public Aide as an Inspector of Care III, working with the IOC process and conducting IOC surveys. After two years with IDPA, Dan joined IDPH as a surveyor for the ICF/IID section in the Edwardsville office. Dan brings 23 years of IDPH survey experience to his new position.

• At the recent IHCA Annual Convention, Connie Jensen reported on the Top 10 deficiencies for the period of 1-1-16 thru 6-30-16:
  
  I. F323 – lack of supervision and falls
  II. F441 – infection control issues, handwashing, tracking of employee illnesses
  III. F309 – hospice care, dialysis care, knowledge of resident and care planning, non-pharmaceutical pain options
  IV. F371 – food service sanitation, prevention of food borne illnesses
  V. F312 – residents dependent on staff for ADL’s, provision of services, resident cleanliness and oral care
  VI. F314 – prevention of pressure ulcers, turning and treatment of ulcers, dietary interventions with wound care
  VII. F157 – lack of notification of physician and family of changes in resident’s condition, communication issues
  VIII. F226 – operationalizing policies and procedures with respect to abuse and neglect
  IX. F315 – urinary tract infections, catheter use and care, antibiotic use
  X. F225 – reporting of allegations of abuse and neglect and proper investigations of such

6) The latest Telligen events/announcements can be found at [https://www.telligenqinqio.com/](https://www.telligenqinqio.com/).
7) The American Health Care Association (ACHA) provided several email updates:

- **Infection Prevention Control Officer Training** – AHCA expects CMS to release the new Nursing Center Requirements of Participation soon. We already know that one new requirement will be that each center have a trained Infection Prevention and Control Officer (IPCO). AHCA/NCAL is ready to help our members meet the new IPCO requirement. We have developed a top-notch training program that will be available to our members in late 2016, shortly after the new requirements are released by CMS.

- **CMS Issues Emergency Preparedness Final Rule** - CMS yesterday issued the final rule, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. This will impact Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The final rule was officially published Friday, September 16, 2016, in the Federal Register.

8) [Here](#) is the most recent IHCA Educational Update.

9) **Kaiser Health News** reports Patients With Dementia Present Communication Challenges in Hospice Care. Hospice’s purpose, at least one of them, is to ease a dying patient’s pain at the end of life and improve the quality of that life. But what’s to be done when a dementia patient in her waning days can’t communicate her pain or help identify the cause? Or resists taking medications?

10) **The Washington Post** reports More Patients Leaving Hospice Care Alive. According to the Post, “the number of patients who outlived hospice care in the United States has risen dramatically,” and one reason may be that, according to the Office of Inspector General of the Department of Health and Human Services, around one-third of patients enrolled in hospice care were not told that it meant “that they intended to forgo a cure for their terminal illness.” In addition, in around 14 percent of cases they physician who approved hospice care “paid only cursory attention.” Another reason may be that Medicare pays a daily rate irrespective of the cost of the patient. That may encourage enrollment of patients who will need less expensive care. The Post says it found that for-profit hospice centers had more patients leave alive than non-profit centers. In addition some states had higher rates, with Mississippi having 41 percent of hospice patients leave alive and Alabama 35 percent. The Post says 15 percent is a typical amount.

11) **HealthDay News** reports Many Seniors Satisfied With and Open to Learning About Social Technologies. According to the article, “many older people enjoy using social technology,” and such activity may even be healthy, according to a new study published in Cyberpsychology, Behavior and Social Networking. Michigan State University researcher William Chopik reviewed survey responses from almost 600 seniors in the US and found that over 95 percent were “somewhat” or “very” satisfied with “social technology,” and 72 percent were not opposed to learning how to use new technologies.

12) **Modern Healthcare** reports Nearly All 50 States Reduced Avoidable Hospital Readmissions, CMS Data Shows. New data from CMS revealed that nearly every state in the US except Vermont, “has reduced its avoidable hospital readmission rates since 2010.” In a blog post announcing the new data, Dr. Patrick Conway, principal deputy administrator and chief medical officer for CMS, and Tim Gronniger, the deputy chief of staff for CMS, wrote, “The Hospital Readmissions Reduction Program is just one part of the Administration’s broader strategy to reform the healthcare system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality.” They added, “The data show that these efforts are working.”

13) **The New York Times** reports:

- **Many Seniors ERRONEOUSLY Denied Medicare Coverage.** The New York Times reports that beneficiaries are often told Medicare will no longer cover physical therapy or nursing home stays because they are “stable and chronic,” or have reached “maximum functional capacity,” or they have plateaued. Seniors “with chronic and progressive diseases – dementia, Parkinson’s, heart failure” – are typically given this incorrect assessment, even though a 2013 settlement of a class-action suit mandated that Medicare “cover skilled care and therapy when they are ‘necessary to maintain the patient’s current condition or prevent or slow further deterioration.’” In addition, last month, a Federal judge ordered CMS “to do a better job of informing health care providers and Medicare adjudicators that the so-called improvement standard was no longer in effect.” The judge said that while CMS does not have to further update its manuals, it must do a better job of educating the medical
community about these changes.

- **Evidence Linking Loneliness to Physical Illness, Functional and Cognitive Decline Increasing.** On the front of its Science Times section, the *New York Times* reports in a nearly 1,800-word article on the physical and mental effects of loneliness experienced by the elderly. In the UK and in the US, “roughly one in three people older than 65 live alone.” Investigators “have found mounting evidence linking loneliness to physical illness and to functional and cognitive decline.” Loneliness, “as a predictor of early death” even surpasses obesity.

14) **MedlinePlus** reports:

- **FDA Cracks Down on Antibacterial Soaps.** The U.S. Food and Drug Administration is banning most antibacterial soaps and body washes currently on store shelves, arguing that the products create potential health risks but don’t perform any better than plain old soap and water. The ban covers soaps and body washes containing triclosan and triclocarban, the two most common antibacterial ingredients, the FDA says. Another 17 active ingredients also are included in the ban.

- **Early Palliative Care Improves Patient’s Quality of Life.** Starting palliative care shortly after a person is diagnosed with incurable cancer helps patients cope and improves their quality of life, a new study shows. It also leads to more discussions about patients’ end-of-life care preferences, the researchers added. Palliative care, also called comfort care, is given to improve the quality of life for patients who have a life-threatening disease or terminal illness, such as cancer. The goal is not to cure the patient, but to manage the symptoms of the disease, according to the U.S. National Cancer Institute.

15) **Medical News Today** reports:

- **Simple Measures Cut Sepsis Deaths Nearly in Half.** Sepsis, commonly called blood poisoning, is a common affliction that can affect people of all ages. A series of simple measures tested at a Norwegian hospital can make a difference in successfully treating sepsis. Researchers were able to cut the number of patients who died from sepsis, or infections that spread to the bloodstream, by 40 percent (from 12.5 percent to 7.1 percent) after the introduction of relatively simple steps at the wards at Levanger Hospital in Nord-Trøndelag, Norway.

- **Study Validates Tgen-Developed Test for Health Care-Acquired Infections.** A new study by the Translational Genomics Research Institute (TGen) details the design and validation of a low-cost, rapid and highly accurate screening tool - known as KlebSeq - for potentially deadly healthcare-acquired infections (HAIs), such as Klebsiella pneumoniae. HAIs affect hundreds of thousands of patients annually and add nearly $10 billion in associated healthcare costs. The findings, to be published in the *Journal of Clinical Microbiology*, detail the workings of the KlebSeq test at detecting HAIs earlier, in particular Klebsiella, which has multiple strains, such as ST258, that are increasingly resistant to treatment by antibiotics.

16) **Medscape** reports:

- **Antipsychotic Medications May Raise Pneumonia Risk in Patients With and Without Alzheimer’s.** *Medscape* reports, “Antipsychotic medications raise the risk for pneumonia in patients with (and without) Alzheimer’s disease (AD),” researchers found. Investigators report “the risk is highest at the start of antipsychotic treatment but remains increased with long-term use.” The findings of the 60,584-participant study were published online Aug. 30 in CHEST.

- **Change to ICD-10 Mental Health Code on the Way.** Key changes to diagnostic codes in the mental health chapter of the *International Classification of Diseases, Tenth Edition, Clinical Modification* (ICD-10) will take effect October 1 and reflect the updated diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). "These include changes to align the terminology used in DSM-5 with that used in the mental health chapter of ICD-10. In response, the fiscal year 2017 version of ICD-10, which takes effect October 1, will include most of DSM-5's terminology," the American Psychiatric Association (APA) notes in a release. The APA adds that in some cases, new codes have been added to ICD-10 to accommodate the new diagnoses that were added to the DSM-5.
17) **Provider Magazine** reports:

- **Hiring Increasing, But Wages Behind Inflation for Nurse Assistants.** *Provider Magazine* reports the hiring of nurse assistants has increased, but wages have not kept up with inflation, according to a new report from the Paraprofessional Healthcare Institute. The report also found that the rate of health insurance coverage has increased 11 percent among skilled nursing center caregivers.

- **Hospital Readmissions Rate Fell Between 2010 and 2015.** *Provider Magazine* reported the national hospital readmission rate decreased by 8 percent between 2010 and 2015, according to data from CMS. The article notes that one of the key objectives of the American Health Care Association’s Quality Initiative is to reduce hospital readmissions. Dr. David Gifford, the senior vice president of quality and regulatory affairs of the American Health Care Association, said, “Hospital readmissions not only have the potential for negative physical, emotional, and psychological impacts on individuals in skilled nursing care, but also cost the Medicare program millions of dollars. Preventing these events whenever possible is always beneficial to patients and is an opportunity to reduce overall health care system costs through improvements in quality.”

- **Advance Directives May Help Reduce Penalties Under ACA.** *Provider Magazine* reports that “advance directives play a key role in reducing hospitalizations that could do more harm than good, but reluctance on the part of providers, families, and residents to discuss them continues to be a roadblock to better end-of-life care.” Provider points out that “some health care observers suggest that advance directives could play a role in reducing the penalties associated with readmissions under new quality initiatives in the Accountable Care Act (ACA), while making better-informed decisions about patient care.” According to David Gifford, MD, senior vice president for quality and regulatory affairs with the American Health Care Association, even before “these reporting measures existed, many elderly residents went in and out of the hospital without showing signs of improvement, which meant that a proper discussion on advance care planning needed to take place.” If public reporting “is what it took to trigger this dialogue, that’s great. But it should have taken place a long time ago,” he says.

- **New Wound Treatment May Help Address MRSA.** *Provider Magazine* reports that a study published last month in the journal PLOS ONE “highlights a new skin wound treatment that may help address antibiotic-resistant bacteria, such as MRSA.” Provider explains that “researchers used proteins called ‘tetrapanins’ to make the ‘sticky patches’ on human cells—which bacteria take over to launch an infection—less adhesive, enabling bacteria to be washed away easily.” According to Peter Monk, BSc, PhD, faculty member at the University of Sheffield, United Kingdom, “We have developed this potential treatment with chronic skin wounds, such as ulcers in diabetics and pressure sores in the elderly and immobile, in mind. ... It is likely to be helpful [in the elder population], in particular for long-term use in slow-healing wounds, to help overcome possible problems of toxicity or resistance emerging.”

18) **McKnight’s** reports:

- **NIC’s Robert Kramer: Investors Paying More Attention to Quality Metrics, Readmission Rates.** *McKnight’s Senior Living* interviews Robert Kramer, National Investment Center for Seniors Housing & Care (NIC) CEO. Kramer says that in addition to financial metrics, investors are placing a higher premium on “metrics (like 30-day readmission rates), especially on the skilled side but more and more on the private-pay side,” as well as “Centers for Medicare and Medicaid Services star ratings and the operator’s ratings history.”

- **CMS’ QIO Resumes “Two-Midnight Rule” Auditing.** *McKnight’s Long Term Care News* reports Quality Improvement Organizations have resumed auditing hospitals for compliance with the “two-midnight rule.” The article explains that the CMS halted the audits earlier this year in order to improve the QIO program.

- **GAO Report Finds Gaps, Limitation in Data about Direct Care Workers.** *McKnight’s Long Term Care News* says a report published by the Government Accountability Office recently found “gaps and limitations in data about direct care workers, such as nursing assistants and home health aides, that hinder workforce planning efforts.” The Department of Health and Human Services “agreed with the report’s findings, stating in a response that it will ‘continue to explore’ options to expand the available data on the direct care workforce.” One of those
options “is a planned collaboration between HRSA and the CMS’ Division of Nursing Homes in fiscal year 2017.” The partnership “would ‘allow HRSA to inform and support’ CMS’ workforce initiatives, and result in a ‘framework’ for workforce development, assessment and planning in the nursing home setting, officials said.”

- **HHS Issues Final Rule on the ACA’s Anti-Discrimination Provisions.** Effective July 18, skilled nursing facilities (together with certain other healthcare providers) had to start complying with a new anti-discrimination rule issued in May by the Department of Health and Human Services. It implements the prohibition on discrimination under Section 1557 of the Affordable Care Act. This article highlights some key provisions of the rule to help SNF providers in their compliance efforts.

- **Medicaid Anti-Fraud Efforts Recovered $25 Million From SNFs in 2015.** Federal authorities recovered roughly $25 million from skilled nursing facilities during criminal and civil investigations in fiscal year 2015, a new report from the Department of Health & Human Services Office of Inspector General shows. The OIG’s Medicaid Fraud Control Units annual report for FY 2015, which was published Wednesday, shows the units recovered $744 million overall in criminal and civil fraud, abuse and neglect cases over the course of the year.

- **Innovative Payment Model Shows Early Progress, CMS Says.** A federal initiative to transform health care delivery and payment at the state levels has shown “promising progress,” according to a report released recently. The first round of the Center for Medicare & Medicaid Innovation's State Innovation Models, which launched in 2013, gave funding to Arkansas, Massachusetts, Maine, Minnesota, Oregon, and Vermont to implement plans to “accelerate system transformation.” Those plans include the expansion of multi-payer payment models and delivery systems, strengthening health information technology and improving workforce development.

- **Bundled Payments Significantly Cut SNF Lengths of Stay and Use, Report Shows.** The average length of skilled nursing facility stay dropped 1.3 days for patients who underwent orthopedic surgery through the Bundled Payments for Care Improvement initiative, according to a new federal report. The report, prepared for CMS by health care policy research firm the Lewin Group, is the second annual evaluation of the BCPI program’s impact on care costs and quality. Report authors found the decrease in skilled nursing stays to be significant when compared to the lengths of stay for beneficiaries discharged from non-BPCI hospitals, which “remained virtually unchanged.”

19) **Interesting Fact:** According to the Centers for Disease Control and Prevention (CDC), 18 million courses of antibiotics are prescribed for the common cold in the United States per year. Research shows that colds are caused by viruses. 50 million unnecessary antibiotics are prescribed for viral respiratory infections.

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!

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