June 26, 2018 Edition

Feature Focus

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

Recent Questions and Answers from CMS on Various RoP Issues

Bed Rails:

**Question:** We have a question re: the intent of F700. The regulations state: *The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails.*

We have facilities with bed rails that are already installed on their beds; however, the rails are not being utilized by the resident. Should we cite the facilities if the rails are actually on the bed, even if they are not being used? If the rails are utilized, they are performing the appropriate assessments and maintenance.

**CMS Response:**

The LTC regulations do not address when bedrails are already installed on beds, and there are no regulations that require bedrails be removed from beds when not in use. When bed rails are used, facilities must “*follow the manufacturers’ recommendations and specifications for installing and maintaining bed rails.*” This means there must be a process to ensure that the bedrails are properly installed, maintained, and that there is a process for ongoing monitoring and supervision.

Additionally, because of the risk associated with bedrails, facilities are required to attempt alternatives prior to installing (or using) a bedrail. CMS’ expectation is that when the decision to use a bedrail is made, the facility must attempt appropriate alternatives (if any) or document why they did not.

If when utilizing rails the facility is performing the appropriate assessments and maintenance they would be in compliance with Appendix PP F700.

Alarms as Restraints

Thank you for your question as it relates to alarms that may be restraints.

A “physical restraint” is defined as, any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:

- Is attached or adjacent to the resident’s body;
- Cannot be removed easily by the resident; and
- Restricts the resident’s freedom of movement or normal access to his/her body.
Appendix PP of the State Operations of Manual includes a discussion of position change alarms under Tag F604, but mentions only audible alarms. However, if the alarm meets all of the criteria above for “physical restraint,” such as having the consequence of inhibiting the resident’s freedom of movement, then it would be considered to be a physical restraint.

We value your interest and thank you for helping to optimize the health, safety and quality of life for people living in nursing homes.

**Abuse**

Thank you for your question related to situations where the facility does not substantiate an alleged violation of abuse, but the evidence suggests otherwise.

For all alleged violations of abuse, in addition to the reporting requirements, the nursing home must:

- Have evidence that the alleged violation is thoroughly investigated;
- Prevent further potential abuse while the investigation is in progress; and
- If verified, appropriate corrective action must be taken.

The survey team must review these requirements to assure that the nursing home responded appropriately (See Tags F609/F610). If the nursing home did not substantiate the allegation, but the facility’s evidence and the survey team’s findings do, there is question as to whether the facility thoroughly investigated the alleged violation, and took action to assure that residents are protected and that abuse will not recur.

In addition, the survey team should review whether the facility developed and implemented its policies and procedures to prohibit and prevent abuse (Tag F607). This would include whether staff are able to identify cases of abuse. Since the facility did not substantiate abuse even though evidence supports a finding, it raises questions as to whether staff understand the federal definition of “abuse” at 42 CFR 483.5, apply the definition in a correct manner, and identify it so that immediate action can be taken to protect residents.

**Pharmacy Services**

Thank you for your inquiry, as it relates to Pharmacy Services.

1. **Does the 14 day PRN psychotropic rule apply to a. Hospice? b. Palliative Care? c. Comfort care?**

The requirements for PRN orders for psychotropic medications do allow for some flexibility as a PRN order for psychotropic medications may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order and documents a rationale for the extension in the medical record.

With regard to PRN orders for anti-psychotic medications, there are no exceptions either for condition or for the time period. Use of these medications, on a PRN basis, is limited to 14 days. If the attending physician or prescribing practitioner wishes to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order is appropriate. If deemed appropriate, the new order would, again, be limited to 14 days.

2. **Does Melatonin count as a psychotropic medication (i.e. 14 day PRN restriction?)**

Melatonin does not fall under the requirements for psychotropic medications. Melatonin is a natural hormone that is classified as a dietary supplement by the Food and Drug Administration and, therefore, is not subject to the requirements of hypnotics under the new psychotropic medication category at 483.45(c)(3).

3. **What about Trazodone for sleep?**

Because Trazodone is classified as an anti-depressant, it does fall under the requirements for psychotropic medications. We understand that Trazodone is often used for sleep, however, the concerns related to psychotropic medications remain despite the indication for which the drug is being used.
Food and Nutrition Services

Question: My question is, our department goes by dietary or food services, with the new rule does that need to be changed to Food and Nutrition Services?

CMS Response: Thank you for your question as it relates to F801, §483.60(a)(2) for Food and Nutrition Services/Staffing.

The regulation is not intended to have a specific title, but to ensure that the staff has the proper qualifications with the appropriate competencies and skill sets to carry out food and nutrition services. Therefore it would not be necessary to make any changes to name titles or the names of departments.

Infection Prevention

Question: This class will certify for the IP requirements in the new rules of participation without other required classes correct?

When will the dates and site be available to view?

Thank you for your question as it relates to QSO 18-15-NH and §483.80(b) Infection preventionist.

CMS Response: Completion of this course will provide specialized training in infection prevention and control – yes, our intent is that it addresses the current regulatory requirements. The training is expected to take approximately 16 to 20 hours and a certificate of completion will be provided after successful completion of an online exam.

This course will be free of charge and available online and on-demand Spring 2019. The web address and release date for the training will be provided as soon as possible in a subsequent memo.

Reminder About the New CMS Medicare A Denial Notice

Most skilled nursing facilities use one of CMS’ five 20-year-old denial letters to inform beneficiaries they no longer qualify for skilled care. But that process has changed. As of April 30, 2018, CMS mandates the use of the redesigned SNFABN 10055 form, which was released as an option nearly 10 years ago (click here).

This is in addition to the current Notice of Medicare Non-Coverage (CMS-10123) (click here), also known as the Generic Notice. The new CMS-10055, required when a resident is being taken off Medicare and staying in the facility, notifies the resident that he/she is responsible for paying for his/her care after the date on the notice. CMS-10123, required at least 48 hours before the last covered day, gives the resident the opportunity to immediately appeal the non-coverage decision to the Quality Improvement Organization (QIO).

Confusion can arise over certain residents who elect hospice in the SNF. When a resident or responsible party chooses to begin hospice, the facility’s clinical team must decide whether the resident qualifies for dual coverage with Medicare A while on hospice. Although dual coverage is unusual and seldom appropriate, it is possible; therefore, the resident and/or family must be given the opportunity to appeal a decision to end Medicare A coverage when hospice begins.

Hospice or not, as of April 30, 2018, when coverage ends with Medicare days remaining and the resident continues living in the facility, the new SNFABN 10055 notice must be given. Staff should note in the 2018 designation on the lower left of the new form and remove all other denial cut letters from their systems.

Focus F-tag – F658 Services Provided Meet Professional Standards

Starting with this edition of Regulatory Beat, IHCA will start including a Focus F-tag for your review.

This Regulatory Beat’s Focus F-tag is F658 Services Provided Meet Professional Standards, which is part of the Comprehensive Resident Centered Care Plans regulatory group under the updated Requirements of Participation (RoPs). F658 requires that the care and services provided by the facility are provided according to accepted standards of clinical practice.
The regulation requires that if a negative or potentially negative outcome for a resident is determined to be related to the facility’s failure to meet these standards and the surveyors determine that a deficient practice has occurred, the facility should be cited under F658, as well as the appropriate area where the concern was identified. F658 has been cited at least 10 times at an Immediate-Jeopardy level on survey under the new LTCSP, more than a dozen times at an Actual Harm level, and hundreds of times at a lower scope/severity, so it’s worth paying attention to. Surveyors are reviewing the following criteria:

- If the services provided or arranged for by the facility that are defined in the resident’s comprehensive care plan reflect accepted standards of practice. If the facility provides information on an outdated standard of practice used in the facility that a surveyor is concerned about, the surveyor is required to provide evidence of a more up-to-date standard/widely used practice that is supported by recent clinical literature.
- If the references for standards of practice used by the facility are up to date and accurate for the services that are being provided.
- If the facility failed to provide or arrange for services/care that should have been provided with acceptable standards of quality.

Some areas where this has been cited include failure to provide basic life support (IJ), failure to follow professional standards of nursing practice for an unresponsive resident who had a hypoglycemic episode (IJ), administration of an excessive dose of an antipsychotic (IJ), failure to meet professional standards of practice for medication administration related to insulin (IJ) and failure to provide oxygen to a resident in respiratory distress (IJ). Citations in these areas, which are all high-risk clinical service areas, indicate, in many instances a lack of monitoring of a facility’s associated system to ensure standards of practice are being adhered to on a routine basis. If you are not monitoring system/protocol compliance on a routine basis, you should be.

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**Trending Statistics**

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

**Antipsychotic Drug Use in Nursing Homes: Trend Update**

CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington’s disease or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent residents received an antipsychotic medication; since then there has been a decrease of 36.6 percent to a national prevalence of 15.1 percent in the fourth quarter of 2017. Success varies by state and CMS region; some states and regions have a reduction greater than 40 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website. Illinois is currently at 19.3 percent and ranked 49th in the Nation.

For More Information:
- Visit the Partnership web page
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

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

1) Federal CMS released the following new federal Survey and Certification (S&C) Letter since the last issue of Regulatory Beat:
• **S&C 18-18 – NH** – Final Revised Policies Regarding the Immediate Imposition of Federal Remedies. This memo replaces the following Survey & Certification (S&C) Memos: 16-31-NH released July 22, 2016 and revised on July 29, 2016, and S&C: 18-01-NH, released in draft on October 27, 2017. The October 2017 memo solicited comments on a proposed directive requiring, for certain situations, immediate imposition of federal remedies on Medicare and Medicaid participating skilled nursing facilities. After reviewing comments, CMS is issuing a final version of the directive. Substantive revisions to the prior Immediate Imposition of Federal Remedies guidance include: When the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regional Offices may determine the most appropriate remedy; CMS clarified that Past Noncompliance deficiencies (as described in §7510.1 of this chapter) are not included in the criteria for Immediate Imposition of Remedies; and, For Special Focus Facilities (SFFs), S/S level “F” citations under tags F812, F813 or F814 are excluded from immediate imposition of remedies. Revisions to Chapter 7 of the State Operations Manual (SOM) (Attachment): The Centers for Medicare & Medicaid Services (CMS) has revised guidance in Chapter 7 of the SOM related to the Immediate Imposition of Federal Remedies as noted in this memo and its attachment. Other sections of Chapter 7 have been revised to ensure conformity and consistency with these revisions.

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

• **SNF Provider Preview Reports - Reminder to Review Your Data!** Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. Providers have until June 30, 2018 to review their performance data prior to public display on the Nursing Home Compare (NHC) site. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate. The SNF Provider Preview Report includes performance data on the following quality measures based on the subsequent Quarterly data:
  
  - **Quarter 1 – 2017 to Quarter 4 – 2017 data**
    1. Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (#0674)
    2. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
    3. Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (#2631).
  - **Quarter 4 – 2016 to Quarter 3 – 2017 data**
    1. Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure
    2. Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
  - **Quarter 4 – 2015 to Quarter 3 – 2017 data**
    1. Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

For more information:
- **SNF Quality Public Reporting** web page, **NHC Compare** and **Preview Report Access Instructions**

• **Hospice Provider Preview Reports - Reminder to Review Your Data!** Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® provider preview reports have been updated and are now available. These two separate reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from Quarter 4-2016 to Quarter 3-2017 and their facility-level CAHPS® survey results from Quarter 4-2015 to Quarter 3-2017. Providers have 30-days to review their HIS and CAHPS® results (June 1, 2018 through July 1, 2018).

Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the **Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data**
For more information on how to access these reports, view the [HIS Preview Report Access Instructions](#) and the [Hospice CAHPS® Provider Preview Reports Access Instructions](#).

- **CMS Leverages Medicaid Program to Combat the Opioid Crisis.** CMS released guidance aimed at building on our commitment to partner with states to ensure that they have flexibilities and the tools necessary to combat the opioid crisis. This new guidance provides information to states on the tools available to them, describes the types of approaches they can use to combat this crisis, ensures states know what resources are available and articulates promising practices for addressing the needs of beneficiaries facing opioid addiction. Notably, CMS released an Informational Bulletin that provides states with information they can use when designing approaches to covering critical treatment services for Medicaid eligible infants with Neonatal Abstinence Syndrome (NAS). Additionally, CMS issued a letter to states on how they may best use federal funding to enhance Medicaid technology to combat drug addiction and the opioid crisis.

- **Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program Review and Corrections.** CMS would like to thank all skilled nursing facilities (SNFs) that participated in Phase One of the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program’s Review and Corrections process. The Review and Corrections process provides SNFs with the opportunity to review the information that will be made public for the applicable performance period and submit correction requests to CMS. For the Phase One requests due March 31, 2018, SNFs were given the opportunity to submit corrections to their Fiscal Year (FY) 2016 information, which will be used as the baseline period RSRR used for the FY 2020 SNF VBP Program year. As a reminder, to submit a proper request, SNFs must submit only the following information to the SNFVBPinquiries@cms.hhs.gov mailbox:
  - The SNF’s CMS Certification Number (CCN)
  - The SNF’s Name
  - The correction requested and the reason for requesting the correction

We advise SNFs to not send protected health information or patient-level data with direct identifiers, such as health insurance claim numbers (HICNs), with review and corrections requests since the SNF VBP mailbox is not secured to receive this information.

- **Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program Exchange Function Analyses Report Now Available.** CMS has released a technical report to provide additional details on the empirical analyses that were considered when developing and finalizing the logistic exchange function that will be used to translate Skilled Nursing Facility (SNF) performance scores into incentive payments for the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program. CMS has adopted the logistic exchange function as the method that will be used to translate SNF performance scores into value-based incentive payments beginning in October 2018 (FY 2019).

  The report includes CMS’ analysis of historical Skilled Nursing Facility Readmission Measure (SNF RM) (NQF #2510) data, of the estimated effects that result from using other methodologies as part of our overall scoring process, and analyses of other exchange function forms. We concluded that the logistic function provided the largest percentage of SNFs with net-positive value-based incentive payments.

  To view the full technical report on our exchange function methodology and analyses, please [click here](#). For more information about the SNF VBP Program, please [click here](#) and refer to the FY 2018 SNF PPS final rule. If you have additional questions, please email them to SNFVBPinquiries@cms.hhs.gov.

- **Federal HHS Semiannual Regulatory Agenda.** The Regulatory Flexibility Act of 1980 and Executive Order (E.O.) 12866 require the semiannual issuance of an inventory of rulemaking actions under development throughout the Department, offering for public review summarized information about forthcoming regulatory actions.
• **CMS Opioids Roadmap.** Although some progress has been made in efforts to combat the opioid epidemic, the latest data from the Centers for Disease Control and Prevention indicate the crisis is not slowing down. CMS published a roadmap outlining efforts to address this issue of national concern. In this roadmap, they detail their three-pronged approach to combating the opioid epidemic, focusing on:
  o Prevention of new cases of opioid use disorder (OUD)
  o Treatment of patients who have already become dependent on or addicted to opioids
  o Utilization of data from across the country to target prevention and treatment activities

Current estimates show that over two million people suffer from opioid use disorder, with a prevalence in Medicare of 6 out of every 1,000 beneficiaries. In order to decrease that number, it is crucial that Medicare beneficiaries and providers are aware that there are options available for both prevention of developing new cases of OUD and the treatment of existing cases. CMS is working to ensure that beneficiaries are not inadvertently put at risk of misuse by closely monitoring prescription opioid trends, strengthening controls at the time of opioid prescriptions and encouraging health care providers to promote a range of safe and effective pain treatments, including alternatives to opioids. We are also working on communications with beneficiaries to explain the risks of prescription opioids and how to safely dispose of them, so they are not misused by others. This roadmap is only a start, and as we begin to implement many of our plans and programs, it will continue to evolve.

• **CMS Data Element Library Now Available.** CMS has launched the first CMS Data Element Library (DEL) -- a public resource for providers, vendors, researchers and other stakeholders that use CMS assessments. End users will be able to search and obtain reports on CMS post-acute care assessment contents, including questions, response codes, relevant attributes and importantly their associated health IT standards, in one location. The availability of the DEL will further support interoperability and the exchange and reuse of data across post-acute care and other providers by using common assessment standards and definitions to facilitate coordinated care and improved health outcomes. [Data Element Library (DEL)]

• **New Medicare Cards May Have QR Codes.** New Medicare cards may have a square code, also referred to as a QR code (a type of machine-readable code). The QR codes on Medicare cards allow the contractor who prints the cards to ensure the right card goes to the right person with Medicare or Railroad Retirement Board (RRB) benefits. Providers cannot use it for any other purpose. The RRB issued cards may have a QR code on the front of the card while all other Medicare patients may get a new card with a QR code on the back of the cards. These are legitimate (official) Medicare cards. Information on the transition to the new Medicare Beneficiary identifier:
  o New MBI Get It, Use It MLN Matters® Article
  o Transition to New Medicare Numbers and Cards MLN Fact Sheet
  o New Medicare Card information website
  o New Medicare cards are in the mail website for people with Medicare

• **Continuous Glucose Monitors: Changes Impacting Medicare Coverage.** CMS announced that it will modify Medicare’s published coverage policy for Continuous Glucose Monitors (CGMs) to support the use of CGMs in conjunction with a smartphone, including the important data sharing function they provide for patients and their families. Durable Medical Equipment Medicare Administrative Contractors will issue a revised policy article in the near future, at which time the published change will be effective. Visit the Durable Medical Equipment Center web page for more information.

• **Hospice Quality Reporting Program (HQRP) FY2019 Annual Payment Update (APU) Reminder and Other Important Dates.** CORMAC sends informational messages related to reconsideration issues to hospices on a quarterly basis. Their latest outreach communication can be found at Reconsideration Request web page. If you want to receive CORMAC’s quarterly emails, then add or update the email addresses to which these messages are sent by emailing to: QRPHelp@cormac-corp.com and be sure to include your facility name and CMS Certification Number (CCN) along with any requested updates.

• **FY 2019 ICD-10-CM Diagnosis Codes.** Final FY 2019 ICD-10-CM diagnosis code updates are available on the 2019 ICD-10-CM web page.
Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — Wednesday, June 27 from 1 to 2 pm CST. Register for Medicare Learning Network events. During this call, learn about proposed modifications to the way CMS calculates Home Health Quality of Patient Care star ratings, including:

- Removal of the Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care measure
- Addition of the Improvement in Oral Medications measure

CMS presents the rationale, proposed timing and impact of these changes. A question and answer session follows the presentation.


Medicare Claims Processing Manual Update, Chapters 18 and 35: IDTF MLN Matters Article — New. A new MLN Matters Article on Update of Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 18 - Preventive and Screening Services, and Chapter 35 - Independent Diagnostic Testing Facility (IDTF) is available. Learn about requirements and payment policies for screening mammography services furnished by IDTFs.

Transition to New Medicare Numbers and Cards Fact Sheet — Revised. A revised Transition to New Medicare Numbers and Cards Fact Sheet is available. Learn about:

- New Medicare numbers, which will replace Health Insurance Claim Numbers on new Medicare cards
- What you need to do to get ready for the change
- Where to find help

CMS Web Wheel Educational Tool — Revised. A revised CMS Web Wheel Educational Tool is available. Find web pages to learn about:

- Educational resources
- CMS initiatives
- Medicare Administrative Contractor resources

Remittance Advice Resources and FAQs Booklet — Reminder. A revised Remittance Advice Resources and FAQs Booklet is available. Learn about:

- How to read institutional or professional Remittance Advice (RA)
- Assigned and unassigned claims
- Balancing an RA

CMS Updates Related to Nursing Home Compare and Payroll-Based Journal Date:

- Long-Stay Hospitalization Quality Measure. CMS continues to focus on reducing hospitalizations to improve the health and safety of nursing home residents. Hospitalizations are expensive, disruptive and place residents at risk for an increased decline in health. Over the last several years, CMS has launched initiatives aimed at reducing hospitalizations, such as the Skilled Nursing Facility Value Based Purchasing program and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. In 2015, CMS added a quality measure to the Nursing Home Compare website and Five-Star Quality Rating System, which reported the percentage of short-stay residents who were re-hospitalized. Posting this quality measure was aimed at informing stakeholders about the rates of re-hospitalizations for each nursing home, and incentivizing nursing homes to implement interventions to reduce these instances and improve quality. Similarly, CMS will begin posting rates of hospitalizations of long-stay residents for the same objectives. In July 2018, CMS will provide rates of hospitalizations for long-stay residents in each facility’s confidential “Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report.” In October 2018, the long-stay hospitalization measure will be posted on the Nursing Home Compare website as a long-stay quality measure. In the spring of 2019, this quality measure will be
A federal Agency for Healthcare Research and Quality (AHRQ) reports:

- **Report Affirms Effectiveness of Some Non-Opioid Alternatives for Managing Chronic Pain.** A new AHRQ evidence review concludes that exercise, cognitive behavioral therapy, chiropractic care and acupuncture are among non-drug treatments that can effectively manage some chronic pain conditions for more than one month after treatment. The report follows an update to Centers for Disease Control and Prevention guidelines, which recommend non-pharmacological interventions as a first line of treatment for chronic pain before initiating opioid therapy. Authors of AHRQ’s report reviewed the evidence on non-pharmacological therapies for common conditions including chronic low back and neck pain, knee and hip osteoarthritis, chronic headache tension and fibromyalgia. The AHRQ review found no published studies that directly compared opioids to alternatives for pain management, and most lacked evidence on long-term effectiveness. The findings in this report can help
clinicians, patients and policymakers make better-informed decisions to improve the management of chronic pain.

- **New AHRQ Views Blog Post – Shifting Focus: Non-Opioid Strategies for Chronic Pain.** In an AHRQ Views blog post, Arlene Bierman, M.D., director of AHRQ's Center for Evidence and Practice Improvement, highlights a new AHRQ report that provides important information about the best evidence on alternatives for treating chronic pain. The new report – *Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review* – summarizes the existing literature to inform future chronic pain guidelines, as well as help plan future HHS initiatives to address the opioid epidemic.


5) The federal HHS Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE) released their [June 2018 issue of ASPR TRACIE Exchange](https://www.asprtracie.gov/).  


- **Rauner taps Hursey as interim leader of Healthcare and Family Services.** Gov. Bruce Rauner named Medicaid Director Teresa Hursey interim director of the Department of Healthcare and Family Services. She takes over for Felicia Norwood, who joined Anthem as executive vice president and president of its government business division. In a statement, Rauner’s office said a permanent director would be named in two weeks. Hursey has been with HFS since 2013. “It was an honor to work under Director Norwood’s leadership to transform behavioral health in Illinois,” Hursey said. “I look forward to continuing that important work as interim director and with our future director.”


- HFS noted that due to recent programming to the [Medicaid Electronic Data Interchange (MEDI) system](https://www.hfs.illinois.gov/index.cfm?fa=documents.notices) related to the Medicare-only admissions policy, providers should note the following changes to ensure a successful transaction.  
  - Submitting a transaction that includes a Determination of Need (DON) score requires providers to report the DON score as a 3-digit number. (e.g. previous entry “29”; new entry “029”)  
  - Fields requiring a ZIP code must now be entered utilizing the United States Postal Service’s Enhanced ZIP + 4 format (e.g., 12345-6789). MEDI will currently accept a 4-digit placeholder number such as “0000” if the correct suffix cannot be found. There are free on-line tools to assist in identifying this enhanced ZIP code.  

  The new Private Pay Rate field is a required field and must contain the facility’s private pay rate.


- HFS posted a new provider notice regarding [Updated Timelines for Reporting Admissions and Resident Status Changes](https://www.hfs.illinois.gov/index.cfm?fa=documents.notices). You may view the notice here.

- HFS posted a new provider notice regarding [Reporting Resident Discharges or Death through MEDI](https://www.hfs.illinois.gov/index.cfm?fa=documents.notices). You may view the notice here.

• HFS posted a new Public Notice regarding Integrated Health Home Services. Click here to view.

• HFS issued a new Informational Notice regarding Fee For Service (FFS) – Hospital Access Payment Adjustment available here.

• HFS posted an updated Dental Fee Schedule. You may view the revised schedule here.

• HFS posted a public notice regarding Dental Coverage for Adults. You may view the notice here.

• HFS posted a public notice regarding Ambulance Provider Rate Increase. You may view the notice here.

• HFS posted updated information to the Long Term Care Direct Billing web page regarding Timely Filing Guidelines and Voiding and Rebilling Incorrectly Submitted Claims.

• HFS posted a new provider notice regarding Vaccines for Children (VFC) program - Private Stock Vaccines (Title XXI) Funding Extended Through June 30, 2019 for Title XXI and State-funded Enrollees. You may view the notice here.

• HFS posted a new provider notice regarding Specialized Mental Health Rehabilitation Facilities (SMHRFs) Reimbursement Rate Increase Effective July 1, 2018. You may view the notice here.

• HFS posted a new provider notice regarding NF Rate List 7/1/18. You may view the notice on this page.

7) The Illinois Department of Public Health (IDPH) recently announced the list of Town Hall Meetings for 2018. Notices are being sent to the individual providers prior to the meeting in their location. Reservation information is included in that letter. The dates and locations are:

• July 10, DuPage County 1-3pm
• August 14, Brookens Bldg, Urbana 1-3pm
• September 11, Abington of Glenview 1-3pm
• October 16, Pekin Manor 1-3pm
• November 14, Oak Trace, Downers Grove 1-3pm

8) The American Health Care Association (AHCA) and the Illinois Health Care Association (IHCA) recently reported on:

• CMS Updates PDPM Tools to Correct Errors. In the past weeks, several members have noted unusual outputs from the CMS Patient-Driven Payment Model (PDPM) tools. Since then, AHCA has been in contact with CMS and they have updated several tools to correct errors. In regard to their updates, CMS notes:

"A few typographical and usability issues were recently identified by certain stakeholders with SNF PDPM the classification logic (SNF PDPM 'Classification Walkthrough, Grouper Tool, and NTA Comorbidity Mapping). In order to address these issues, we have posted revised versions of the three files below. Stakeholders should use these revised SNF PDPM files (Version 2) to inform their comments on the proposed rule."

At their SNF Payment Model Research web page (click here), CMS has posted these updated versions and noted the specific corrections. Each is listed below with hyperlinks:

○ SNF PDPM Classification Walkthrough, Version 2
  ▪ Corrected typo on page 23 in definition of Extensive Services category "ES2"

○ SNF PDPM Grouper Tool, Version 2
  ▪ Corrected typo in ES1 and ES3 labels on the nursing tab
  ▪ Added D0600 logic to depression flag
  ▪ Added support item "did not occur" logic to ADL construction
- Improved clinical category logic so that the tool assigns the default clinical category for patients who have procedure info that will not impact category assignment
- Corrected GG-based function score rounding
- Updates final payment calculation to include proposed 18% nursing add-on for patients with HIV/AIDS
- **SNF PDPM NTA Comorbidity Mapping, Version 2**
  - Added ICD-10 code mapping for the category "Major Organ Transplant Status, Except Lung"

**Suggested Member Next Steps**
If your company has begun modeling PDPM and/or mapping patients into PDPM manually, AHCA recommends revisiting the outputs with the updated resources. Be sure you are using Microsoft EXCEL 2010 or a more recent version - AHCA members have noticed some problems using earlier versions. Please alert us to any observations you might have that indicate additional flaws in the technical design of the CMS tools. CMS will not respond to suggested changes in the tools for easier use (i.e. you prefer direct number entry instead of a drop-down menu) or that related to matters of policy (i.e., NTAS should not taper, etc.). Use the changes above as a guide for what is appropriate to submit to CMS.

Please submit any additional issues to Dan Ciolek and dcioleck@ahca.org and me at mcheek@ahca.org.

9) The latest Telligen events/announcements can be found [here](#).

10) **Today's Geriatric Medicine** reports, [Frailty Syndrome: Identify and Implement an Exercise Regimen](#). Providers can proactively identify frailty and develop a resistance exercise program to improve muscle strength and mass, which are reduced in aging and further decreased by frailty.

11) [Kaiser Health News](#) reports on Re-Hospitalizations More Common for Nursing Home Patients on Medicare. Kaiser Health News recently reported that with "hospitals pushing patients out the door earlier, nursing homes are deluged with increasingly frail patients," and "return trips from nursing homes to hospitals are far from unusual." Many understaffed homes "often fail to handle post-hospital complications — or create new problems by not heeding or receiving accurate hospital and physician instructions," KHN reports, adding that federal records show, "1 in 5 Medicare patients sent from the hospital to a nursing home boomerang back within 30 days, often for potentially preventable conditions such as dehydration, infections and medication errors." Such rehospitalizations "occur 27 percent more frequently than for the Medicare population at large." KHN says that according to Dr. David Gifford, a senior vice president of quality and regulatory affairs at the American Health Care Association, nursing home residents often return from the hospital more confused or with a new infection.

12) [Skilled Nursing News](#) reports that Most Providers Will See Payment Increase Under PDPM, But Some Could Suffer. Skilled Nursing News reports, according to Health Dimensions Group executive Brian Ellsworth, under the new Patient Driven Payment Model (PDPM), most SNFs will gain financially but some will be forced to "take a look at their clinical and operational focus and really begin to kind of rethink things." He observed, in the article’s words, "PDPM is budget-neutral before any assumptions about behavior change... meaning that if SNFs behave exactly as they have under the current Resident Utilization Group – Version 4 (RUG-IV), payments under the new system would equal payments under RUG-IV."

13) **Provider Magazine** reports:

- **Expert Explains Steps Providers Must Take to Mitigate Threat of Cyberattacks, Data Breaches.** David Hosack, insurance and risk management professional with Marsh & McLennan Agency, in [Provider Magazine](#) explains steps long term and post-acute care providers should take to minimize the threat of being a target for cybercrimes. He says that data protection should begin with assessing a provider’s risk, and notes the importance of ensuring compliance with state and federal agencies, preparing for a potential data breach, selecting appropriate insurance, and minimizing the likelihood of an attack, among other points.
• SNF Occupancy Levels Down During First Quarter, NIC Reports Says. Provider Magazine says the National Investment Center for Seniors Housing & Care’s (NIC) Skilled Nursing Data Report released recently indicates that SNF occupancy rates "at the end of the first quarter of 2018 decreased to 81.6 percent, with occupancy declining on a year-over-year basis for urban and rural areas, while increasing for urban cluster properties from the prior quarter." The report said SNF occupancy for the first quarter "is 30 basis points lower from the prior quarter (the fourth quarter of 2017) and down 210 basis points year-over-year," the piece says.

14) Health News Illinois reports:

• Report: Illinois Premiums Projected to Increase Significantly Next Year. The annual premium for a benchmark plan in Illinois could increase significantly in 2019 due to actions taken by the Trump administration, according to a recent analysis by the left-leaning Center for American Progress. The organization projected that by 2019, the annual premium for a benchmark plan for a 40-year-old Illinoisan would be $1,211 higher due to the repeal of the individual mandate penalty and a proposed expansion of short-term health plans. The Center for American Progress used projections by the Urban Institute to estimate potential premium changes in each state.

• State Chips Away at Backlog of Long-Term Care Applications. With a court-ordered deadline of June 28 quickly approaching, the state is making some progress in chipping away at a backlog of pending long-term care Medicaid application and admission determinations. As of June 7, there were 10,106 pending admissions over 45 days old, down nearly 20 percent from last month. There were 2,626 pending applications past the deadline, a 50 percent decrease from May 1. In March, U.S. District Judge Joan Gottschall ordered the state to start by June 28 paying benefits for anyone deemed eligible for long-term care benefits after Feb. 1, 2015, but still waiting longer than 45 days for a final determination. The state has asked the judge to reconsider, arguing that it would be “impossible” to meet that timeline. Meanwhile, state lawmakers are also taking a swipe at the issue. The Legislature passed a proposal in the final days of the session requiring that the state cover people whose applications pend past the required deadline. They approved another bill allowing the state to conduct electronic searches of a person’s finances to see if they meet Medicaid standards and renew them automatically if they do. In addition, the state budget directs $300 million towards the backlog, according to Matt Werner, a lobbyist for several long-term care associations. He estimates the delayed liability for pending admissions is $285.4 million. “This was just huge news for nursing homes because we had the fear that we're going to win in the court and the court was going to force them to do this and then the state's hands would be tied because they didn't have the money in the budget to make it happen,” Werner said.

15) McKnight’s reports:

• Payment Levels Remain Unknown With New PDPM. McKnight’s Long Term Care News reported that some providers are treating the proposed Patient Driven Payment Model as "a breath of fresh air...because it will utilize 80% fewer payment group combinations than its suggested predecessor, RCS-1." It also aims to "use more standardized items for payment calculations and ‘greatly simplify’ paperwork requirements by comparison, Centers for Medicare & Medicaid Services officials said." However, according to Cynthia Morton, executive director of the National Association for the Support of Long-Term Care, "The big question is whether the application of the new model will result in assessing patients and then reimbursing for their care appropriately."

• FDA Releases New Guidelines on Developing Antibiotics, Antifungals to Tackle Antimicrobial Infections. McKnight's Long Term Care News reports that the FDA "released draft guidelines that should make it easier to develop new antibiotics and antifungal drugs," part of "a multi-pronged approach to limiting antimicrobial infections in long-term care settings and elsewhere." Commissioner Scott Gottlieb said while announcing the Limited Population Pathway for Antibacterial and Antifungal Drugs, "We must tackle this issue on all fronts and seek new approaches to this persistent and potentially deadly problem."

• VA Introduces First Rankings for 133 Nursing Homes. McKnight’s Long Term Care News reports that the Department of Veterans Affairs released its rankings of 133 federally run nursing homes for the first time this week, showing how they compare to "thousands of privately operated ones ranked by the Centers for Medicare
The starred rating system will be updated annually, the VA said, in an effort to foment "transparency and accountability." The data show that, "Of the 15,487 homes rated by CMS, almost 29% have five-star ratings, compared to about 26% of VA homes," while "the VA had a smaller percentage receive one-star ratings: 8% compared to 13% for private homes."

- **Data On VA Nursing Home Quality Withheld From Public, Reports Say.** *McKnight’s Long Term Care News* says that according to reporting by *USA Today* and the *Boston Globe*, the Department of Veterans Affairs "has hidden poor quality ratings at Veterans Affairs nursing homes from the public." The VA "tracked detailed quality and safety measures at its nursing homes for years," and new data indicate that nearly "half of the VA facilities, about 60, received the agency’s lowest ranking out of five stars as of the end of last year." The reports "point out that VA homes fared worse on nine of 11 key indicators when compared to their private sector counterparts."

- **Training CNAs As Medication Assistants Can Mitigate Impact Of Staffing Shortages, Study Suggests.** *McKnight’s Long Term Care News* reports, a new study in the *Annals of Long Term Care* indicates that providers facing a shortage of licensed nurses can rely on "certified nurse aides trained as medication assistants...[as] a viable alternative." Researchers found that "using medication assistants who received specialized training" helped to improve "medication error rates, along with staff satisfaction, re-hospitalization, call light response and fall rates."

- **Relias Releases Free VR Dementia Course To Boost Caregiver Empathy.** *McKnight’s Long Term Care News* reports, technology company Relias announced last week the release of its free "A Day in the Life of Henry: A Dementia Experience" virtual reality course which is also accessible to caregivers in a desktop computer version. Relias Chief Marketing Officer Alex Osadzinski said, "The overwhelming feedback was it had direct emotional impact to the point of tears for some folks. ... The goal is to see the world through the eyes of Henry. You are trying to get through the day with your desires being met." The course "offers CE credit for professional caregivers."

- **It’s Not Just You: Everything’s Hard About Phase 2 Requirements of Participation.** An interesting phenomena occurred when *McKnight’s* asked providers for the toughest part of complying with Phase 2 provisions of the Requirements of Participation. There were five options given and the hundreds of respondents nearly couldn't make up their collective mind. Internally, it was widely expected that infection control/antibiotic stewardship would be the clear (dis)favorite. It did lead all vote-getters with just over 25 percent of the electorate. But the other four were unexpectedly close — to the leader and to one another. Facility assessment was runner-up at 20.2 percent, closely followed by QAPI (19.3 percent), antipsychotics (18.9 percent) and baseline care plans (15 percent). That is not what one can fairly call unanimity, which means that when CMS designed their massive overhaul of regulations, it got something right. The agency clearly found a variety of gaps in providers' preparedness.

16) **Interesting Fact:** The FIFA World Cup is the most-watched sporting event in the world.