August 8, 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!

Patient-Driven Payment Model (PDPM): What is it and What is it all About?
The Centers for Medicare & Medicaid Services (CMS) finalized new rules for both the Prospective Payment System (PPS) and the Patient Driven Payment Model (PDPM) on July 31. The final rule maintains "the 2.4 percent payment increase or $850 million more in aggregate payments that it outlined in a draft proposal in late April." CMS expects the PDPM to save providers as much as $2 billion annually by reducing reporting requirements and cutting payment group combinations by 80 percent. Read the CMS fact sheet on the final rule here.

The Patient-Driven Payment Model (PDPM) federal proposed rule was released on April 27 (click here) along with a federal CMS Fact Sheet. The new PDPM is anticipated to go into effect on October 1, 2019. The PDPM is a revision to what was previously discussed as RCS-1, which was floated as a possibility to replace RUGS-IV.

The PDPM would break down payment based on case mix scores in five different areas:

- Physical therapy
- Occupational therapy
- Speech language pathology
- Nursing
- Non-therapy ancillary services

Each component of reimbursement will be calculated based on diagnoses, clinical factors and other criteria.

The PDPM will shift the focus from therapy minutes to making nursing payment dependent on a wide range of clinical characteristics. Non-therapy ancillary services would reflect high-cost services such as HIV/AIDS, parental/IV feedings, infections and other high-cost comorbidities.

CMS’ goal of a more simplified payment system will not be achieved with the PDPM. It will be important for each facility to understand the impact on its reimbursement. CMS expects the new PDPM to improve payment accuracy as each component is based on a predicted resource utilization and introduces a variable per diem rate for PT, OT and non-therapy ancillaries.

Important items to consider are that ICD-10 coding will be critical to accurately reflect the resident’s condition and points will be dependent on diagnosis and therapies. Variable per diem means reduced payment as your resident’s...
length of stay increases. Also, the number of required assessments will significantly decrease from the current PPS schedule to a five-day PPS assessment, significant change in status and discharge assessment.

Optima Healthcare Solutions recently released a White Paper comparing the RUGS-IV, RCS-1 and PDPM payment models (click here).

You can view AHCA's summary of the final rule here.

**Seven Strategies for Treating Psychiatric Patients in SNFs**

Over the last few decades, the nationwide closing of psychiatric hospitals has created a situation in which nursing facilities now play a major role in providing care to individuals with serious and persistent mental illness. This has changed the whole landscape of post-acute care, in some cases inundating facilities with patients that staff is not trained to care for.

Once admitted, many of these residents will remain at the facility for an extended period of time due to sparse discharge resources for this population. Over time, a facility's census may come to be heavily weighted toward a psychiatric population. This shift in the facility's diagnostic demographics puts staff members at risk of becoming overwhelmed, as they are continually confronted by emotional and behavioral issues of a population they are not prepared to treat.

Nursing homes face a number of challenges when dealing with individuals with chronic mental illness. To maintain quality care, facilities must directly confront these issues – which include, but are not limited to:

- Demographic shifts. If the demographics of the facility get ahead of staff training, staff may burn out and feel frustrated about responding to residents with SPMI.
- Confusion and anxiety about how and when to utilize psychotropic medications. Increased scrutiny around psychotropic medication use in nursing homes has led to uncertainty about how to best utilize these drugs with patients who have historically benefited from them.
- Inadequate understanding of how to develop and use nonpharmacological interventions to manage behavioral challenges. These nonpharmacological interventions should be clearly stated in a resident's care plan and certainly be part of any care plan for a resident taking a psychotropic medication.
- A lack of or poorly integrated behavioral health services (psychiatry and psychology). Having psychiatry and psychology round in your facility is essential, but these specialties must also be integrated into your interdisciplinary structure, reviewing cases and creating realistic treatment plans. One helpful approach is to establish regularly scheduled behavioral rounds for the mental health providers, social work and nursing staff. Integrated care is essential to optimal care, and it all starts with good communication among disciplines.
- “Creeping institutionalization.” Over time, these residents may experience a degraded ability to function in the community. Establishing programs to maintain community living skills and promoting independence is necessary if the resident is going to be discharged back into the community.
- Frequent psychiatric hospitalizations. If SPMI residents don't receive optimal treatment, they may require rehospitalization. This is obviously of great concern clinically, since psychiatric issues are always best treated in-house, as well as financially, as rehospitalization rates are an important part of a facility's performance metrics.

While one could argue that nursing homes are a reasonable alternative to psychiatric hospitals, current regulations, funding issues and poor staff training set up nursing homes for failure unless they fully embrace the need to reinvent certain aspects of their care strategies for the SPMI population.

So what can be done to improve the care of the chronically mentally ill in the skilled nursing setting? There are seven strategies that can help.
• Don't allow the number of psychiatric patients admitted to overwhelm your facility's capability to appropriately address their needs. If the percentage of SPMI residents gets ahead of your ability to provide them with good treatment, it will have a significantly deleterious impact on all of your residents, as well as their families and your facility's reputation in the community.

One good indicator of readiness is the amount of training that your staff has received related to providing care to these patients. Another is your relationship with the behavioral health professionals — psychiatrists, psychiatric nurse practitioners and clinical psychologists — who deliver direct care and also consult with your primary care providers and the entire staff.

• Establish training programs for staff to upgrade their skills to better understand and manage the emotional and behavioral issues related to individuals with SPMI. Adding mental health topics to annual mandatory training would be a good start.

Nursing facilities need to establish a strong mental health team if they are going to successfully manage behavioral health issues. The most important training needs to be dedicated to the CNA staff since they have the most interactions with residents and therefore the most opportunities for positive contacts. A large percentage of behavioral issues can be avoided by creating a CNA staff that becomes adept at managing this population.

• Understand the CMS guidelines regarding psychotropic medications and gradual dose reductions as they apply to residents with chronic mental illness. The primary treatment for individuals with SPMI is receiving the correct medication on a consistent basis.

In the current regulatory climate, the threshold for the use of psychotropic medication has been raised, but with good documentation of diagnosis, clinical rational and the use of nonpharmacological interventions, the facility should be able to confidently provide the necessary pharmacological treatments.

• Charge the Therapeutic Recreation Department with the responsibility of developing more unique and focused therapeutic activities for a population with chronic mental illness. This population is often younger, with different interests than an elderly population. A proactive approach by therapeutic recreation can be one of the most important nonpharmacological interventions to reduce behavioral issues.

• If and when psychiatric hospitalization is indicated for an SPMI resident, it pays to have established strong relationships with local hospitals, emergency rooms and private psychiatric hospitals. Although I believe that most psychiatric hospitalizations from SNFs can and should be avoided with proactive behavioral health care, at times the only option is hospitalization. Unfortunately, hospitalization often results in a revolving door of care as the emergency room sends the person right back to the facility. Building relationships with the hospital can help make those admissions stick when they understand that you've done everything possible to treat in-house and are clear on the reasons why you believe inpatient care is needed.

• Make sure that you are capturing depression through the PHQ-9 on the MDS 3.0. The identification, treatment and additional compensation for the treatment of depression will help all involved —residents, primary care and the facility itself.

• Continue to expand and integrate telemedicine into the nursing home setting. There is a national shortage of psychiatry providers, but CMS will pay for telepsychiatry and telepsychology for facilities in a Provider Shortage Region.

Finally, recognize that almost all nursing home residents struggle with psychiatric, psychological and adjustment issues and that long term care should be as much about the psychological well-being of its residents as it is about their medical condition. All nursing homes need to become proficient in caring for the SPMI population, as well as the more traditional depression and anxiety that our residents have always evidenced.

*Article authored by Robert Figlerski, Ph.D and partially reprinted out of McKnight’s.*
Focus F-tag – F800 Provided Diet Meets Needs of Each Resident

This Regulatory Beat’s Focus F-tag is **F800 Provided Diet Meets Needs of Each Resident**. This regulation requires that facilities provide “each resident with a nourishing, palatable, well-balanced diet” that meets the resident’s daily nutritional needs, special dietary needs and in alignment with the person-centered focus of the updated RoPs, takes into consideration each resident’s preferences.

There is a clear emphasis on resident choice in the regulation, as well as in some recently cited deficiencies under the LTCSP. Common issues cited include residents who dine in their rooms not being provided with information related to alternate meal options, as well as identified food preferences not being addressed. The Interpretive Guidance (IG) states that reasonable efforts to accommodate the residents’ choices and preferences must be made by the facility, as this helps ensure that residents are offered meaningful choices for their meals/diets that are satisfying to the residents as well as nutritionally adequate. The regulation expects ongoing communication and coordination between all departments and staff to ensure that residents’ nutritional and dietary needs are met according to the individual resident’s assessment and care plan, and that the plan of care must also include the resident’s choices. This relatively brief regulation packs some wallop though! It concludes by directing the surveyors to cite this tag if there are “overall systems issues” identified in regard to how the facility manages and executes it food and nutrition services. You need to follow-up on all resident identified food concerns and always monitor your food/nutritional services systems.

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**Trending Statistics**

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

**Top 15 Most Commonly Treated Conditions**

**These 15 Conditions Account for 68 percent of Total Drug Spend.**

Here are the top 15 most commonly treated conditions, which drive 68 percent of total drug expenses, according to a [report](#) from Anthem’s pharmacy benefit manager IngenioRx:

1. Inflammatory/autoimmune conditions — 14 percent
2. Cancer — 13 percent
3. Diabetes — 8 percent
4. Multiple sclerosis — 5 percent
5. HIV — 4 percent
6. Hypertension/heart disease — 3 percent
7. Asthma — 3 percent
8. Attention deficit disorders — 3 percent
9. Depression — 3 percent
10. Contraception — 2 percent
11. High cholesterol — 2 percent
12. Inflammatory pain — 2 percent
13. Blood cell deficiency — 2 percent
14. Psychiatric disorders — 2 percent
15. Immune deficiency — 2 percent

All other commonly treated conditions — 32 percent.
1) The following federal CMS Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 18-19** – CLIA - Performance Specification Verification of Assays Authorized Under Emergency Use (EUA). CMS is providing guidance to surveyors, specifically if surveyors find a laboratory using an assay without an EUA that is testing for the same agent for which an emergency has been declared, or a modified EUA assay, they should notify their Regional Office (RO). Assays that have been issued an Emergency Use Authorization (EUA) by the United States Food and Drug Administration (FDA) remain subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) CLIA Regulations. At the onset of a public health emergency, there may be a very limited number of positive samples available for the verification of performance specifications. This does not necessarily prevent laboratories from utilizing assays authorized by an EUA. Centers for Disease Control (CDC) Developed Assays: Laboratories using a CDC assay authorized for emergency use should follow any and all instructions provided for verifying performance specifications. Non-CDC Developed Assays: For other non-CDC EUA assays, the Laboratory Director (LD) should determine the acceptable number of positive and negative samples needed for their laboratory to verify performance specifications of the EUA assay. In accordance with 42 CFR §493.1252(a), any manufacturer’s instructions for verification, if provided, must also be followed. The surveyor should confirm that the laboratory has followed its procedures for verification.

- **S&C 18-20** – CLIA - Clarification of the Operation of Multiple Laboratories at the Same Location and the Discontinued Use of the Term “Shared Laboratory.” CMS is clarifying the operation of multiple laboratories at the same location and the discontinued use of the term “shared laboratory” related to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Certification. Multiple laboratories with separate CLIA numbers may operate at one location as long as it can be demonstrated that each laboratory is operating as a separate and distinct entity. They are not to be referred to as “shared laboratories.” This memorandum supersedes all prior guidance regarding the registration of shared laboratories for CLIA.

- **S&C 18-21** – Hospitals - CMS Clarification of Psychiatric Environmental Risks. The Proposed Psychiatric Task Force to address the environmental risks associated with the care of psychiatric inpatients is not the most appropriate vehicle to foster the changes that are required. Ligature Risks Compromise Psychiatric Patients’ Right to Receive Care in a Safe Setting: The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is incorporating the outcomes of the TJC Suicide Panel (in which CMS participated) into comprehensive ligature risk interpretive guidance to provide improved direction and clarity for state survey agencies (SAs) and accrediting organizations (AOs). Interim Guidance: Until CMS’ comprehensive ligature risk interpretive guidance is released, the SAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility’s corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.

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

- The Payroll-Based Journal report for April – June 2018 is due August 14, 2018. Staffing data for Payroll-Based Journal must be submitted by August 14, CMS officials reminded providers last week. The reminder is especially timely given the news of almost 1,400 skilled nursing facilities losing a rating star. In an Open Door Forum call, CMS officials noted that only data that's been successfully submitted by the deadline is considered timely and used on the Nursing Home Compare in Five-Star Quality Rating System calculations. Once submitted, providers must check their final validation reports, which can be accessed in the CASPER folder. It may take up to 24 hours to receive the validation report, so providers must allow time to correct errors. Receiving a final validation report only confirms that the data has been submitted successfully, not that it is accurate or complete. To improve quality, CMS says that it may decrease the threshold for number of days with no RN reported that result in a one-star staffing rating in the future, in the hopes of further boosting quality. The agency now has a
requirement to have a registered nurse onsite eight hours a day, seven days a week, which was implemented in July. Currently, those who report seven or more days a quarter with no RN hours will receive a one-star rating in the staffing domain, dropping their overall composite star rating by one star for a quarter. As part of PBJ, CMS started posting the number of hours worked by other non-nursing staff, which includes all positions listed in the PBJ table, in July.

- **SNF FY 2019 Payment and Policy Changes.** On July 31, CMS issued a final rule outlining Fiscal Year (FY) 2019 Medicare payment updates and quality program changes for skilled nursing facilities (SNFs). Three major provisions of the rule:
  - Changes to the case-mix classification system used under the SNF Prospective Payment System (PPS)
  - SNF Value-Based Purchasing Program (VBP)
  - SNF Quality Reporting Program (QRP)

The final rule includes policies that continue a commitment to shift Medicare payments from volume to value, with continued implementation of the SNF VBP and SNF QRP.

Effective October 1, 2019, we will use a new case-mix model, the Patient-Driven Payment Model, which focuses on the patient’s condition and resulting care needs rather than on the amount of care provided in order to determine Medicare payment. The final rule also modernizes Medicare through innovation in SNF, meaningful quality measure reporting, reduced paperwork and reduced administrative costs.

Based on changes contained within this final rule, we estimate that the FY 2019 aggregate impact will be an increase of $820 million in Medicare payments to SNFs, resulting from the FY 2019 SNF market basket update required to be 2.4 percent by the Bipartisan Budget Act of 2018. Absent the application of this statutory requirement, the FY 2019 market basket update factor would have been 2.0 percent which reflects the SNF FY 2019 market basket index of 2.8 percent, reduced by the multifactor productivity adjustment of 0.8 percent. This 2.0 percent update would have resulted in an estimated aggregate increase of $670 million in Medicare payments to SNFs.

Find more information in the Fact Sheet.

- **New Medicare Card: Using Your MAC’s MBI Look-Up Tool.** When you use the Medicare Administrative Contractor (MAC) secure portal Medicare Beneficiary Identifier (MBI) look-up tool, you must use your patient’s own Social Security Number (SSN) along with your patient’s first name, last name and date of birth. Your patient’s SSN may differ from the number part of the Health Insurance Claim Number (HICN), which uses the SSN of the primary wage earner on whom benefits are based. The original Medicare card, with a HICN, of a spouse, widow, or other dependent will have the SSN of the wage earner; ask for your patient’s SSN to use in the look up tool. If you do not have access to the tool, sign up.

If you use your patient’s SSN and the look-up tool does not return an MBI, be sure you are using the full last name exactly as it appears on the Medicare card. You may want to include any suffix, such as Jr, Sr or III.

*Remember:* To ensure people with Medicare continue to get health care services, you can use the HICN through December 31, 2019, or until your patient brings in a new card with the new number.

*Reminder:* We finished mailing most cards to people with Medicare who live in Wave 1 and 2 states: Alaska, American Samoa, California, Delaware, District of Columbia, Guam, Hawaii, Maryland, Northern Mariana Islands, Pennsylvania, Oregon, Virginia and West Virginia. If your Medicare patients did not get a card:
  - Print and give them the “Still Waiting for Your New Card?” handout (in English or Spanish).
  - Or, tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.
E/M Coding Reform: Recording of Panel Discussion. CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. We held listening sessions all over the country and heard from thousands of providers and one thing they consistently brought up was how documentation was needlessly burdensome, was not improving patient care and was actually having a negative impact on patient care. We listened, and in response, we proposed streamlining the documentation requirements for Evaluation and Management (E/M) visits, as well as moving to single payment rates. Watch CMS Administrator Seema Verma, CMS Chief Medical Officer and Director of CCSQ Kate Goodrich, Dr. Donald Rucker, National Coordinator for Health Information Technology, Dr. Anand Shah, CMMI Chief Medical Office and Dr. Thomas A. Mason, ONC Chief Medical Officer discuss proposed E/M coding changes.

Watch videos on E/M:
- Panel discussion
- Introduction
- Office visits

Patients Over Paperwork July Newsletter. Read the CMS Patients Over Paperwork July newsletter about our ongoing effort to reduce administrative burden and improve the customer experience, while putting patients first. In this edition, we:
- Provide updates on how we are reducing burden for skilled nursing facilities/nursing homes, including regulatory actions, documentation review, Meaningful Measurement framework and health IT
- Describe how we are simplifying documentation requirements, including a change in procedures for therapeutic shoe inserts
- Provide updates on where we are meeting with stakeholders to talk about reducing burden
- Remind stakeholders of opportunities to give feedback through Requests for Information and proposed rules

More Information:
- Patients Over Paperwork website
- Past Newsletters

Hospice Quality Reporting Program Quick Reference Guide. An FY 2020 Hospice Quality Reporting Program Quick Reference Guide is available, including frequently asked questions, information on help desks, and links to additional resources. Visit the Reconsideration Requests webpage for more information.

Emergency Preparedness: Information on Radiological Incidents, DME and Blood. The most recent Express from the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) highlights:
- Webinar on Healthcare Challenges after Radiological Incidents
- New resources on Durable Medical Equipment (DME), blood, and blood products
- Upcoming events

HHS offers a comprehensive national knowledge center about emergency preparedness for health care, public health and disaster clinical practitioners. Sign up to receive the monthly Express and quarterly Exchange that highlight new and trending emergency preparedness resources.

For More Information:
- Healthcare Emergency Preparedness Information Gateway Fact Sheet
- ASPR TRACIE website

Qualified Medicare Beneficiary Program Billing Requirements FAQs. During the June 6 Medicare Learning Network call, CMS experts discussed Qualified Medicare Beneficiary (QMB) billing requirements and their
implications. Updated FAQ are available, including new FAQs on Advance Beneficiary Notices and statutorily excluded services and revised information for Medicare Advantage providers. For More Information:

- Materials from June 6 call
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program webpage

- Data Element Library Webinar: Video Recording. A video is available of the July 11 webinar about the Data Element Library, a public resource about CMS assessments. This video includes a review of the Improving Medicare Post-Acute Care Transformation Act of 2014, standardization and interoperability, and an overview and demonstration of the Data Element Library.

- CMS Administrator Address on Strengthening Medicare. On July 25, CMS Administrator Seema Verma delivered a speech focused on Strengthening Medicare at the Commonwealth Club of California. Learn more in the prepared remarks and video.

- Ophthalmology Services: Questionable Billing and Improper Payments — Reminder. The Office of the Inspector General (OIG) reports that Medicare is vulnerable to fraud, waste and abuse for wet Age-related Macular Degeneration (wet AMD) and cataracts:
  - Administration of Lucentis injections for wet AMD more than once every 28 days (based on local coverage determinations)
  - Billing for a second cataract surgery on the same eye
  - Submitting disproportionately more claims for complex than standard cataract surgery

Review the following resources for proper claims coding, billing and payment:

- Questionable Billing for Medicare Ophthalmology Services OIG Report, September 2015
- Cataract Removal, Part B MLN Matters® Special Edition Article
- Implementation of CMS Ruling Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries MLN Matters Article
- Multiple Procedure Payment Reduction on the Technical Component of Diagnostic Cardiovascular and Ophthalmology Procedures MLN Matters Article
- Medicare Vision Services Fact Sheet
- NCCI Policy Manual for Medicare Services, Chapter 8: Section D: Ophthalmology
- Medicare Benefit Policy Manual, Chapter 15: Section 120: Prosthetic Devices and Section 260.2: Ambulatory Surgical Center Services

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing. In a February 2018 report, the Office of the Inspector General (OIG) determined that Medicare payments to clinical laboratories and providers for specimen validity tests did not comply with Medicare billing requirements. A recent MLN Matters® Special Edition Article reminds laboratories and other providers about proper billing for specimen validity testing done in conjunction with drug testing; this article contains no policy changes. Current coding for testing for drugs of abuse relies on a structure of presumptive and definitive testing that identifies the specific drug and quantity in the patient. This article includes descriptors for:
  - Presumptive drug testing codes
  - Definitive drug testing codes

Use the following resources to bill correctly and avoid overpayment recoveries:

- Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests OIG Report, February 2018
- The National Correct Coding Initiative Policy Manual
• **ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — Tuesday, August 14, 1 - 2 pm CST.** Register for Medicare Learning Network events. During this call, learn about proposals for the End Stage Renal Disease Quality Incentive Program (ESRD QIP) in the CY 2019 ESRD Prospective Payment System (PPS) proposed rule. Topics include:
  - ESRD QIP legislative framework
  - Proposed updates to ESRD QIP measures, domain structure, and weights
  - Proposed modifications to data submission requirements and the National Healthcare Safety Network Validation Study
  - Methods for reviewing and commenting on the proposed rule

Please note: This call will not include a question and answer session.

• **Sharing Federal Strategies to Address the Opioid Epidemic Open Door Forum — Wednesday, August 15, 12:30 -2 pm CST.** CMS will host a Special Open Door Forum to educate opioid prescribers on federal resources and strategies to combat the opioid epidemic. The misuse of and addiction to opioids—including prescription pain relievers, heroin and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. Hear information from the following federal agencies:
  - CMS
  - Centers for Disease Control and Prevention
  - Food and Drug Administration
  - Substance Abuse and Mental Health Services Administration
  - Office of Inspector General, U.S. Department of Health & Human Services

Participation Instructions:
  - Participant Dial-In Number: 800-857-1738; Conference ID #: 7785347
  - TTY Communications Relay Services are available for the Hearing Impaired; dial 7-1-1 or 800-855-2880

A transcript and audio recording will be posted to the [Podcasts and Transcripts](#) webpage.

• **Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — Wednesday, August 22, 12:30 - 2 pm CST.** Register for Medicare Learning Network events. Proposed changes to the CY 2019 Physician Fee Schedule would increase the amount of time doctors and other clinicians spend with their patients by reducing the burden of Medicare paperwork. During this listening session, CMS experts will briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:
  - Streamlining Evaluation and Management (E/M) payment and reducing clinician burden
  - Advancing virtual care
  - Continuing to improve the Quality Payment Program to reduce clinician burden, focus on outcomes and promote interoperability

We encourage you to review the [proposed rule](#) prior to the call, as well as the following materials on the provisions to be covered:
  - Quality Payment Program Year 3 (2019) [Webinar Recording](#), [Transcript](#), [Presentation](#) and [Comparison Fact Sheet](#)
  - Slide presentation on E/M and Advancing Virtual Care
  - E/M Coding Reform videos: [Introduction](#), [Office Visits](#) and [Panel Discussion](#)

Note: feedback received during this listening session will not be considered formal comments on the rule. See the [proposed rule](#) for information on submitting these comments by September 10, 2018.
• Provider Minute Video: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services – New. Proper physician orders are important to you and your patients. Find out how they affect patient care/services, claim payment and medical review in the Provider Minute: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services. Learn about:
  o Importance of legible signed orders
  o Signed orders versus Intent to Order Services
  o Documentation of Medical Necessity

• PECOS Technical Assistance Contact Information Fact Sheet — Reminder. The PECOS Technical Assistance Contact Information Fact Sheet is available. Learn about:
  o Common problems and who to contact
  o Provider Enrollment, Chain, and Ownership System (PECOS) resources

• Medicare Enrollment Resources Educational Tool — Reminder. The Medicare Enrollment Resources Educational Tool is available. Learn about:
  o How to enroll in the Medicare Program
  o What to do if you run into problems
  o Where to locate enrollment forms

• IOM Update to Publication 100-02, Chapter 11 – ESRD MLN Matters Article — New. A new MLN Matters Article MM10809 on Internet Only Manual (IOM) Update to Publication 100-02, Chapter 11 - End Stage Renal Disease (ESRD), Section 100 is available. Learn about extending renal dialysis services paid under Section 1881(b) (14) of the Social Security Act.

• New Waived Tests MLN Matters Article — New. A new MLN Matters Article MM10819 on New Waived Tests is available. Learn about 17 newly added waived complexity tests.

• HCPCS Codes Used for SNF CB Enforcement: Annual Update MLN Matters Article — New. A new MLN Matters Article MM10852 on Quarterly Update to 2018 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement is available. Learn about updates to the lists for billing.

• Upcoming webinar sponsored by the Chief Medical Officers of CMS Regions VII, IX, and X to discuss the Notice of Proposed Rulemaking for Year 3 of the Quality Payment Program. You can click here to register.

3) The federal HHS Office of the Inspector General (OIG) reported:

• Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations (previously known as the Compendium of Unimplemented Recommendations) https://go.usa.gov/xUwrz. The HHS OIG’s 2018 Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations was previously known as the Compendium of Unimplemented Recommendations. The Unimplemented Recommendations includes the top 25 unimplemented recommendations and legislative recommendations, drawn from our audits and evaluations, to better protect the integrity of departmental programs and the welfare of those they serve. The Unimplemented Recommendations also includes a broader list of OIG’s significant unimplemented recommendations described in previous Semiannual Report(s) to Congress.

• Vulnerabilities in Hospice Care. The OIG is committed to ensuring that beneficiaries receive quality care and to safeguarding the hospice benefit. The agency has completed extensive work on the hospice program, including numerous evaluations and audits. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties and civil False Claims Act settlements. Learn more at https://go.usa.gov/xUv2W.
4) The National Institute of Nursing Research (NINR) recently published their **Updated Palliative Care Brochure**. NINR recently updated its brochure, Palliative Care: The Relief You Need When You Have a Serious Illness. The revised publication is available in English and Spanish. The brochure, originally titled Palliative Care: The Relief You Need When You’re Experiencing the Symptoms of Serious Illness, has been revised to reflect the most recent research, terminology, and practices. The purpose of this brochure is to provide patients with serious illnesses and their families with clear, evidence-based information about what palliative care is, who it benefits and how it works. The brochure also addresses certain misconceptions about palliative care, such as that it is only for those nearing the end of life. Download the brochure in English or Spanish. To order free print copies, please call 301-496-0207 or send an email with your name, mailing address, phone number, email address and requested quantities of English and Spanish to info@ninr.nih.gov.

5) The National Quality Forum has launched its next version of the **NQP Playbook: Antibiotic Stewardship in Post-Acute and Long-Term Care**. The playbook uses a variety of antibiotic stewardship resources in one tool to satisfy CMS requirements, the forum said. It provides implementation strategies, sample tools and resources that can help long term care facilities working on an comprehensive antibiotic stewardship program. “This new playbook is an important tool that builds on the previous work NQF has done on antibiotic stewardship. It is a practical guide that provides vital information to frontline staff that will help make care safer for all patients,” said Leah Binder, president and CEO of The Leapfrog Group. The forum also will host a webinar on antibiotic stewardship on August 7.

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of **Regulatory Beat**: 

- HFS posted an **Updated Taxonomy Default Table for 837P**. You may view the updated document [here](#).
- HFS posted a new provider notice regarding a **Notice of Informational Webinars on Provisional Eligibility – Implementation Process**. You may view the notice [here](#).
- HFS posted a new provider notice regarding **Fiscal Year 2019 Hospital Inpatient and Outpatient Assessment Programs Notice of Assessments**. You may view the notice [here](#).
- HFS published a new Provider Notice regarding **Integrated Assessment and Treatment Planning**. You may view the notice [here](#).
- HFS published a new Public Notice regarding **Mobile Crisis Response Services**. You may view the notice [here](#).
- HFS posted a new provider notice regarding **Integrated Health Homes Town Hall Meetings**. You may view the notice [here](#).
- HFS posted a **Provisional Eligibility Webinar**. You may view the webinar information [here](#).
- The calculations and amounts for the hospital **ACA Access Payments** for the period of May have been posted to the Department’s new website, and can be viewed [here](#).
- HFS posted a new provider notice regarding **Standardized “Provider Roster” Template**. You may view the notice [here](#).
- HFS posted a new provider notice regarding **Updated Pricing Calculators**. You may view the notice [here](#).
- HFS posted a new public notice regarding **Integrated Assessment and Treatment Planning**. You may view the notice [here](#).

7) The Illinois Department of Public Health (IDPH) continues with its **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:
8) The American Health Care Association (AHCA) and the Illinois Health Care Association (IHCA) recently reported on:

- AHCA issued a summary of the 2019 SNF PPS Final Rule. Please find a summary of the final rule here. Please note that an AHCA/NCAL log-in is required to view this document. You can view the FY19 Final Rule here, as well as the fact sheet here. The FY19 SNF PPS wage index will be posted in the coming weeks.

- AHCA issued a summary of the CMS Update on Payroll-Based Journal. CMS has updated the Nursing Home Compare (NHC) website with staffing data from the first quarter of 2018. The following measures on NHC have been updated based on PBJ data from January 1 - March 31, 2018:
  - Physical therapist hours per resident day
  - RN hours per resident day
  - Total nursing hours per resident day (RN + LPN + nurse aide hours)
  - RN staffing star rating
  - Staffing star rating
  - Overall five-star rating

- AHCA, through their Emergency Preparedness Committee provided a copy of the APIC 2018 slide presentation on Waterborne Pathogen Risk Management: A Mandate Issued, A Team Needed, What Now?

- AHCA releases the Webinar Recording of the FY19 SNF PPS Final Rule held on 8-1-18. If you were unable to join or would like another opportunity for review, a recording is available here on ahcancalED. We will keep you posted on our dialogue with CMS as we work to ensure the necessary corrections and updates to the final rule.

- AHCA announces that the 2019 National Quality Award Applications are now available. The National Quality Award Program is pleased to announce that the 2019 application packets are now available online. In addition, the 2019 program calendar and submission checklist have been posted to each award level page. This is an opportunity to show residents, family members and the community-at-large your organization’s commitment to continuous quality improvement, and to establish recognition on a national level. Get ready to begin your journey today! Please visit the Bronze, Silver or Gold application pages to download application materials specific to your respective award level to learn how your center should begin preparing. New for 2019, is our Gold criteria series, which is already available on ahcancalED. The Bronze and Silver criteria series will be available next week on ahcancalED. The Quality Award Program is also proud to introduce the Quality Award Portal, a new online application and payment portal. You may visit this portal starting now to get an early start on your application and submit your Intent-to-Apply.

- SNF VBP Performance Score Reports Now Available in CASPER. CMS has released the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Confidential Performance Score Reports, which contains each SNF’s payment adjustment for FY 2019 along with information on rehospitalization rates and scores used to calculate payment adjustments beginning October 1, 2018. These reports are available to access in the CASPER system as of last Thursday, August 2. Visit ahcancalED to view a short video on how to read and understand the Performance Score Reports and your payment adjustment. Details on how to access your reports via the Quality Improvement Evaluation System (QIES) and the CASPER reporting application can be found here. Please contact the QIES Technical Support Office (QTSO) Help Desk at help@qtso.com if you need assistance in accessing CASPER/QIES. For more information on the SNF VBP program and to access tools and resources on ahcancalED and other sites visit AHCA’s VBP website here.

9) The latest Telligen events/announcements can be found here.
10) Science Daily reports that Just 10 Minutes of Social Interaction a Day Improves Wellbeing in Dementia Care. An e-learning program that trains care home staff to engage in meaningful social interaction with people who have dementia improves well-being and has sustained benefits. The average person with dementia in a care home experiences just two minutes of social interaction each day. They also showed that out of 170 available training programs for nursing home staff, only three are evidence-based -- none of which improve quality of life. The Wellbeing and Health for people with Dementia (WHELD) program trained care home staff to increase social interaction from two minutes a day to ten, combined with a program of personalized care. It involves simple measures such as talking to residents about their interests and involving them in decisions around their care.

11) Kaiser reports that CMS Lowers Ratings of 1,400 Nursing Homes Due to Staffing Concerns. Kaiser Health News recently reported that according to federal records, CMS is lowering its "its star ratings for staffing levels in 1 in 11 of the nation’s nursing homes – almost 1,400 of them – because they either had inadequate numbers of registered nurses or failed to provide payroll data that proved they had the required nursing coverage." CMS, according to KHN, "only recently began collecting and publishing payroll data on the staffing of nursing homes as required by the Affordable Care Act...rather than relying as it had before on the nursing homes’ own unverified reports." In a statement, CMS said, "We’ve just begun to leverage this new information to strengthen transparency and enforcement with the goals of improved patient safety and health outcomes."

12) Medscape reports that Hospitals Testing Bundled Payments for Episodic Care for Certain Medical Conditions Did Not Substantially Lower Their Costs, Analysis Indicates. Medscape reports, "In an analysis of data from 2013 to 2015, hospitals testing bundled payments for episodic care for five common medical conditions, including congestive heart failure (CHF) and acute myocardial infarction (MI), failed to lower their costs substantially." Researchers found that "participating hospitals in the Center for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) received similar Medicare payments and showed about the same readmission and mortality rates compared with those not participating in the BPCI." The study was published in the New England Journal of Medicine.

13) Provider Magazine reports that Expert Offers Advice for Providers to Improve Encounters with Upset Families. Greg Dowdy, chief operating officer for American HealthCare, writes in the August issue of Provider Magazine about tips for dealing with upset families to handle interactions "more smoothly and with more satisfying results." He recommends that providers prepare for these encounters by remaining calm and meeting in a quiet area; permitting family members to finish what they are saying; working together with families toward a solution; setting and following conversational and behavioral "rules" for the interaction; and incorporate other staff members who are involved in the patient’s care, among other recommendations.

14) The Washington Post reports that Misunderstandings about End-Of-Life Documents Are “Surprisingly Common.” The Washington Post recently reported on misunderstandings involving documents meant to guide end-of-life decision-making, which Monica Williams-Murphy, medical director of advance-care planning and end-of-life education for Huntsville Hospital Health System in Alabama, said are "surprisingly common." According to the Post, a recent analysis conducted in Pennsylvania revealed that in 2016, Pennsylvania health care facilities "reported nearly 100 events relating to patients’ 'code status' – their wish to be resuscitated or not, should their hearts stop beating and they stop breathing. In 29 cases, patients were resuscitated against their wishes." Meanwhile, in an additional "two cases, patients weren’t resuscitated despite making it clear they wanted this to happen."

15) Modern Healthcare reports that CMS Eliminates So-Called “25 Percent Rule” on Long-Term Care Hospitals. Modern Healthcare reported that CMS finalized its rule, which would "eliminate the so-called 25% rule that would ding long-term care hospitals’ Medicare reimbursement rates." The policy held that "if more than a quarter of a long-term care hospital’s patients came from a single acute-care hospital, the long-term care hospital would receive a reduced Medicare reimbursement rate for patients exceeding that threshold."


**Governor Rauner Signs Medicaid Omnibus Bill.** Gov. Bruce Rauner signed legislation Friday implementing a series of changes to the Medicaid program. The omnibus package was hashed out by the same group of bipartisan lawmakers who worked on an update to the hospital program.

- Increases funding for Medically Complex for the Developmentally Disabled facilities. “Several years of analysis and design led up to this,” said Matt Werner, a health care consultant who worked on the issue.
- Increases transparency around the rate setting process for managed care organizations.
- Creates an advisory council to increase oversight of the transition of children with special needs into managed care.
- Reimburses hospitals for youth that are held in psychiatric units beyond what is medically necessary because there is nowhere else for them to go.
- Develops a more uniform process for paying for ambulance services.

The law also provided bridge funding for the hospital assessment program had it not been approved by the federal government by June 30. CMS signed off on the update in June and it went into effect July 1. Read more.

**Telemedicine Task Force Set to Wrap Up Work.** A state task force aimed at improving access to telemedicine has zeroed in on four categories and could take action on a list of final recommendations this week. Kim McCullough, deputy director for the Department of Healthcare and Family Services, told committee members they’re planning to focus on behavioral health transformation, chronic disease management, infrastructure changes and outreach and education. Nina Antoniotti, executive director of telehealth and clinical outreach for the Southern Illinois University School of Medicine, is concerned the categories don’t reflect the work of the group. “It’s been a long time since I’ve been completely stunned and I was completely stunned,” she told Health News Illinois. A spokesman for the Department of Healthcare and Family Services did not respond to a request for comment.

Howard Peters, co-chair of the task force, stressed at the last meeting that the categories are broad. Angela Grover, system director of advocacy for Presence Health, is, for now, reserving judgment. “I think most of what we talked about could fit into those categories,” she said. “And the large things we are trying to tackle, like payment parity and broadening where patients could receive care and could provide it, those kind of fundamental things are overarching things that apply to everything. Even those four buckets.” Antoniotti wants the state to expand the list of eligible providers and eligible originating sites to include all Medicaid participating providers and organizations. However, she expressed caution with legislation sitting on Rauner’s desk that would pave the way for all Medicaid-eligible facilities to bill for telemedicine services. That’s because the bill places extra focus on telepsychiatry and she’s concerned that could lead to Medicaid misinterpreting the intent. “Even though the bill is great, it’s a bit confusing and Medicaid may have an opportunity to continue to limit,” Antoniotti said.

**Rauner Signs Legislation Aimed at Streamlining Long Term Care Medicaid Enrollment.** Gov. Bruce Rauner signed a pair of bills last Thursday in Rockford that he says will streamline enrollment in long term care Medicaid. “We want to do everything possible in easing the bureaucratic burden on seniors and their loved ones as they enroll in Medicaid long term care,” Rauner said. “It is not fair to residents that it can take up to year to get approved for essential services. Our families deserve better.” Rauner approved legislation 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. He signed another bill that helps banks share information with the state for eligibility determinations. The aim of the bills is to help chip away at a backlog of nearly Medicaid eligibility determinations for seniors and persons with disabilities seeking long term care service. The issue has plagued providers for several years, although the state has made some progress this year after a U.S. district court ordered the state to start 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 current state budget also directs $300 million toward the backlog.
17) **McKnight’s reports:**

- **Officials Say Pain Interview is Most Helpful for Providers in IMPACT Act Testing.** McKnight’s Long Term Care News says that during a CMS Open Door Forum call on the IMPACT Act, CMS and RAND Corp. officials delivered a progress report on the Pain Interview for a new post-acute evaluation system, showing that it "has been the most useful thus far." The piece says that the "Pain Interview portion (4.25 out of a possible 5), Expression and Understanding (4.19), and Hearing and Vision (4.10) were the categories earning the highest average marks from providers." CMS has contracted with RAND, "which has been working to test the reliability and validity of possible data elements, and identify the best, most feasible subset of those elements to meet the requirements of" the Improving Medicare Post-Acute Care Transformation Act.

- **‘New Wave of Superbugs’ Becoming Resistant to Alcohol Disinfectants, Scientists Say.** Multi-drug resistant superbugs, which can cause dangerous infections, are becoming increasingly resistant to alcohol-based hand sanitizers and disinfectants, according to a recent study. The researchers, co-led by Tim Stinear, Ph.D., a microbiologist at Australia's Doherty Institute, found specific genetic changes over 20 years in vancomycin-resistant Enterococcus, or VRE, and described the bugs as a “new wave of superbugs.” The team was also able to track and show its growing resistance. Results were published in Science Translational Medicine. VRE bugs, which can cause urinary tract, wound and bloodstream infections, can be difficult to treat, mainly because they are resistant to several classes of antibiotics. Health care entities, including nursing homes, often use hand rubs and washes that contain alcohol in efforts to defeat superbugs such as VRE and MRSA, or methicillin-resistant Staphylococcus aureus. Stinear said in Australia alone, use of the alcohol-based hand hygiene has increased tenfold over the past 20 years. “So we are using a lot and the environment is changing,” he said.

- **CMS Updates Providers on Changes Coming Down the Pipeline Soon.** Staffing data for Payroll-Based Journal must be submitted by August 14, CMS officials reminded providers last week. CMS also noted that it is enthusiastic about the new rehabilitation model of Patient-Driven Payment Model. In October, CMS also reminded providers that will start posting a quality measure related to short-stay residents who were rehospitalized. It started confidentially posting rates of hospitalizations for long-stay residents in July. By the spring, it will be included in the Five-Star system. In February, CMS implemented a temporary freeze of the health inspection domain of the Nursing Home Compare Five-Star Quality Ratings system. During the one-year freeze, inspections conducted after November 2017 are not included in the ratings calculation. In October 2019, it will resume posting the average number of citations per inspection for each state and nationally. CMS says it is monitoring outcomes of the new inspection process and plans to resume health inspection calculation ratings in spring 2019.

18) **Interesting Fact:** There are more bacteria in a human mouth than there are people in the world.