Summary of the September 18, 2018 IDPH LTC Provider Association Meeting
On Tuesday, September 18, 2018, the Illinois Department of Public Health (IDPH) Bureau of Long-Term Care held their Quarterly LTC Provider Association Meeting. A summary of the issues presented and discussed are as follows:

1) Updated status of IDPH required rulemakings:
   - Subpart S Rulemaking
     - Still under internal IDPH review. No stated timeframe for proposal.
   - Distressed Facility Rulemaking and Legislation
     - IDPH will delay proposing of this rulemaking until our legislative fix is considered by the General Assembly, probably in the spring.
   - Informed Consent Rulemaking
     - Rules are being drafted within IDPH. Will share with our members as soon as they become available.
   - Behavioral Health Unit Rulemaking
     - DHS has the lead on drafting these regulations and no progress was noted.
   - Electronic POCs – Rulemaking requiring a facility specific email address
     - IDPH is proceeding on developing a process for electronic POCs. They have a meeting with federal CMS on October 15, 2018 to discuss and develop a plan to move forward on this. REMINDER for facilities to create a facility specific email address that will not change. This will be vital for the implementation of electronic POCs.
   - PA 99-822 New Dementia Requirements – Effective 9-1-17
     - Draft rules were developed and sent to the State Board of Health for their review and approval. As soon as they act on the draft rules, they will then be sent to the Long Term Care Advisory Board for their review. Expect proposed rulemaking on this sometime this winter.

2) Can we get an updated OHCR LTC Organizational Chart? There have been a lot of changes.
   - IDPH provided a revised Office of Health Care Regulation/Long Term Care Organization Chart (click here).
3) Any progress of information regarding rulemaking or guidance with regard to electronic monitoring devices and medical marijuana? The issue of medical marijuana in LTC facilities is beginning to ramp up and many facilities are being approached about this.

- IDPH has a new General Counsel in their Legal Department and this new person is reviewing the need for rulemaking with regard to electronic monitoring devices. IHCA has stipulated all along that rules are needed to flesh out the legislation and clarify several issues.
- IDPH stated that there has not been any internal discussion or movement with regard to the resident use of medical marijuana in long term care facilities. IHCA asked that a workgroup comprising of the various LTC Associations, the IDPH Office of Health Care Regulation, IDPH Legal and the IDPH Office of Health Promotion be formed to discuss this topic and provide some direction moving forward. With the acceptance of persons using medical marijuana, it is imperative that IDPH provide direction and guidance for health care facilities to address the use of medical marijuana by residents and facility staff.

4) IDPH Legal review of Section 483.12a(3) of the new federal ROPs? Rule seems to prohibit waivers? Status report from IDPH Legal?

- IDPH Legal stated that they would not provide this information to us. They stated that IDPH Legal is there to provide legal guidance to IDPH employees and not outside groups or individuals. IHCA will include this issue on the December CMS Region 5 Six State Meeting for resolution.

5) Status of the Identified Offender Program DRAFT Guidelines? Any further update on this?

- The IDPH Identified Offender Program has developed a Web Portal process for the Identified Offender Program. The Program is to provide IHCA a summary and an instruction document for this process. We will provide this information to our members as soon as it becomes available.

6) Status of the ID/DD Statement of Deficiencies conforming with the LTC Statement of Deficiencies? There are differences in how IDPH processes statements between the ID/DD facilities and the LTC facilities. The statute/process is the same for both. IDPH stated that they are internally reviewing this issue and agreed to address and correct discrepancy in the near future – status?

- IDPH agreed that this is something that needs to get resolved. It has not been high on their priority list but they stated the will try to get this done as soon as possible.

7) Update on the implementation of the new survey process. Major issues noted, most common deficiencies, guidance for providers?

- Connie Jensen made several comments on the survey process:
  - Facilities need to make sure their Facility Assessment aligns with the types of residents it provides care for. There have been several cases where a facility has refused to take a resident back after a hospitalization which conflicts with the Facility Assessment.
  - IDPH is reviewing the daily status report removal and the exit conference process. IDPH understands that there are some problems in this area and is considering several options to make the facility notification of issues timelier and clearer.
  - IDPH stated that facilities need to make sure that care plans align with resident care. The new survey process looks deeper into the whole care plan process than before.
  - IDPH is developing a new entrance form. The purpose is to provide guidance and information to the facility about the survey process for both complaints and for annuals.
  - Later this fall, IDPH plans to implement an electronic complaint process. Federal CMS has not developed this yet, but IDPH has developed an electronic process that will be used in Illinois.
  - IDPH clarified that staff interview forms should be made available to the interviewed staff member.
Federal CMS, on look behind surveys, is focusing on resident on resident abuse — zeroing in on the term “willful.” Review tag F608-610 on this issue.

8) Update on the implementation of the new emergency preparedness requirements. Most common deficiencies and any guidance for providers?

- Most of the tags cited under the Emergency Preparedness requirements have been cited by the LSC surveyors. Facilities can expect that the health surveyors will drill down deeper on the various E-tags they are responsible in the future. One of the issues that Connie noted was that facilities are not training their new staff on their emergency preparedness plans. Make sure that your new staff orientation training include emergency preparedness. Also, facilities should be doing after action reports after exercises and making necessary changes to the Emergency Plan.

9) How to address CNAs walking out during their shift — resident abandonment — action that can be taken by IDPH? At the last meeting, IDPH stated they would review this issue with Legal and get back to us.

- IDPH stated that they will share this issue with Nurse Aide Registry Program and have them review and be prepared to discuss this at our next meeting.

10) We noted that the Trump Administration issued a report on cutting back on LTC fines. Have you received any guidance on this from CMS?

- IDPH stated that they have not received any information or guidance from federal CMS on this issue. IHCA will add this to the agenda for the December CMS Region 5 Six State Meeting.

11) IDPH Fine Reduction. IDPH takes the position that any state fines can’t be reduced to 25 percent until the federal fine has been paid. They rely on the word “paid” in the statute. This to the LTC Industry is another example of IDPH taking an unreasonable position. The timing of a provider paying the federal fine shouldn’t dictate whether we are entitled to the 75 percent reduction. What if we waive the state fine and pay 65 percent. Is there a mechanism to get back the money from IDPH once we’ve paid the corresponding federal fine? To us, IDPH should just accept that the federal fine is going get paid at some point and just let us pay the 25 percent. IDPH LTC understands the issue and will discuss with IDPH Legal for possible solutions and report back at the next Quarterly meeting.

- This issue is currently under review between the IDPH LTC Program and IDPH Legal. Will report back at the next Quarterly Meeting.

12) Guidance on how IDPH will implement PA 100-0217 with regard to nurse staffing waivers? When will the rules be ready?

- IDPH is internally drafting these regulations. They will be presented to the Long Term Care Advisory Board when completed.

13) Follow-up on last meeting with regard to Involuntary Discharges. There was discussion about arranging a meeting with the Chief ALJ. Can this be arranged? Issues include:

- ALJs refusing to rule when the discharge is for Non-Payment due to a Medicaid Pending, even though the Pending has exceeded the 45-day limit;
- ALJs allowing multiple re-filing of Medicaid Apps to delay an Involuntary Discharge; and
- ALJs refusing to rule on “the safety of individuals in this facility is endangered,” when the discharge also includes Non-Payment.

- IDPH was to have the Chief IDPH Administrative Law Judge appear at this meeting to discuss the above issues. However, the Chief ALJ resigned and a new Chief ALJ has not yet been appointed. IHCA will continue to press IDPH on these important concerns.
14) What can a family paid caregiver do in a LTC facility? Is the facility liable for anything the paid caregiver does? Can a family give a waiver and will CMS/IDPH accept it should something go wrong? Is strict liability in play here?
   - IDPH stated that they are reviewing this issue with IDPH Legal and promised an answer/guidance in the very near future.

15) Why doesn’t IDPH send out letters to LTC facilities when there are no Life Safety Code (LSC) deficiencies?
   - IDPH understands the concerns and is reviewing to determine how to best address the concerns.

16) IDPH stated that they were going to develop a Q&A on the new survey process for Illinois LTC providers. Any update on this?
   - IDPH has a draft and will share in the very near future.

17) Any other information/guidance from IDPH/CMS to be passed on to our members?
   - IDPH clarified that an Involuntary Discharge From does not need to be completed for a resident that is sent to the hospital for treatment/evaluation with the expectation that the resident will be coming back to the facility. The facility must inform the resident and the resident representative in writing, of the transfer and the facility’s bed hold policy. A notice must also be provided to the ombudsman in this type of transfer within a month. The facility must also document in the facility/resident record that the notice was given to all parties.
   - Another issue that IDPH could not respond to but IHCA will include in the December CMS meeting is the issue of ACO/MCO denial/stopping payment and how the facility is to address this regarding transfer/discharge.

Infection Prevention, Control and Immunizations (Part 3 in the Series – Mandatory LTC Survey Pathways)

Another MANDATORY LTC Survey Pathway that surveyors must review is the Infection Prevention, Control and Immunization Survey Pathway. This facility task must be used to investigate compliance at F880, F881 and F883. For the purpose of this task, “staff” includes employees, consultants, contractors, volunteers and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) program must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it will be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care and medication pass observations which include central lines, peripheral IVs and oral/IM/respiratory medications. The infection control survey task will be reviewed by all survey staff throughout the whole survey.

One surveyor coordinates the facility task to review for:
   - The overall Infection Prevention and Control Program (IPCP);
   - The annual review of the IPCP policies and practices;
   - The review of the surveillance and antibiotic stewardship programs; and
   - Tracking influenza/pneumococcal immunization of residents.

Team assignments must be made to include the review of:
   - Laundry services;
   - A resident on transmission-based precautions, if any;
   - Five sampled residents for influenza/pneumococcal immunizations; and
   - Other care-specific observations if concerns are identified.

The surveyors will focus on:
   - Did the facility staff implement appropriate hand hygiene (F880)?
   - Did facility staff implement appropriate use of personal protective equipment (PPE) (F880)?
   - Did the facility staff implement appropriate transmission-based precautions (F880)?
   - Did the facility store, handle, transport and process linens properly (F880)?
- Did the facility develop and implement an overall Infection Prevention and Control Program, including policies and procedures that are reviewed annually (F880)?
- Did the facility provide appropriate infection surveillance (F880)?
- Did the facility conduct ongoing review for antibiotic stewardship (F881)?
- Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate (F883)?

**Focus F-tag – F727 RN 8 Hours a Day/7 Days a Week**

This Regulatory Beat’s Focus F-tag is **F727 RN 8 hours a day/7 days a week**, Full Time DON, which is part of the Nursing Services Regulatory Group. This regulation is one that all providers are aware of, but it warrants a reminder **thanks to a QSO memo released late recently about the Payroll-Based Journal (PBJ).**

The regulation states that unless a waiver is in place:
- A facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
- The facility must designate a registered nurse to serve as the director of nursing on a full-time basis (35 or more hours per week). The Interpretive Guidance states that the DON requirement can be fulfilled by using two or more RNs so long as the roles and responsibilities for all RN staff serving as the DON are clearly defined and facility staff understand how the responsibilities are shared.
- The director of nursing may only serve as a charge nurse when the facility’s average daily census is 60 or fewer residents.

The QSO memo regarding the use is Payroll-Based Journal staffing data for Nursing Home Compare and the Five-Star Quality Rating staffing domain emphasizes the importance of RN hours in the nursing home. Facilities that have more than 7 days per quarter where RN hours per this regulation are not met will receive a 1-star rating for staffing for that quarter. This includes facilities that have received an RN waiver. Even though these facilities do not have to have an RN on staff 8 hours a day/7 days a week, they will be subject to the same rating methodology applied to facilities that have 7 or more days/quarter without RN staffing submitted to the PBJ system.

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**Trending Statistics**

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

**AARP’s Profile of Long-Term Services and Supports in Illinois**

*Across the States 2018: Profiles of Long-Term Services and Supports* ([click here](#)) is the 10th edition of the AARP Public Policy Institute’s state long-term services and supports (LTSS) reference report.

Published for the past 24 years, *Across the States* presents comparable state-level and national data from a large number of studies and data sources—including some original analysis not found elsewhere—into a single volume. The purpose of this flagship publication is to help policy makers, administrators and stakeholders make informed decisions about LTSS public policies and programs. Topics include: age demographics and projections; living arrangements, income and poverty; disability rates; costs of care; private long term care insurance; Medicaid long term services and supports (LTSS); family caregivers; home- and community-based services (HCBS); and nursing facilities. The full Illinois report can be found [here](#).
1) No new federal CMS Quality, Safety and Oversight Letters (formerly known as Survey and Certification (S&C) Letters) were released since the last issue of Regulatory Beat.

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

- **CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers.** On September 17, CMS announced a proposed rule to relieve burden on health care providers by removing unnecessary, obsolete or excessively burdensome Medicare compliance requirements for health care facilities. Collectively, these updates would save health care providers an estimated $1.12 billion annually. Taking into account policies across rules finalized in 2017 and 2018, as well as this and other proposed rules, savings are estimated at $5.2 billion.

  CMS developed the proposed rule in response to President Trump’s charge to federal agencies to “cut the red tape” and reduce burdensome regulations. In addition, feedback from Requests for Information the agency issued seeking stakeholder input on regulatory burdens helped inform this proposed rule.

  “We are committed to putting patients over paperwork, while at the same time increasing the quality of care and ensuring patient safety and bolstering program integrity,” said CMS Administrator Seema Verma. “With this proposed rule, CMS takes a major step forward in its efforts to modernize the Medicare program by removing regulations that are outdated and burdensome. The changes we’re proposing will dramatically reduce the amount of time and resources that health care facilities have to spend on CMS-mandated compliance activities that do not improve the quality of care, so that hospitals and health care professionals can focus on their primary mission: treating patients.”

  Includes proposed changes for:
  - Conditions of participation and conditions for coverage
  - Emergency Preparedness policies
  - Hospitals
  - Critical access hospital, rural health centers, and federally qualified health centers
  - Ambulatory surgical centers
  - Transplant centers
  - Hospices
  - Comprehensive outpatient rehabilitation facilities
  - Community mental health centers
  - Portable x-ray services
  - Religious nonmedical health care institutions

  See the full text of this excerpted CMS Press Release and Fact Sheet (issued September 17).

- **eCQM Value Sets: Updates for 2019 Reporting and Performance Periods.** CMS and the National Library of Medicine (NLM) published updates to the electronic Clinical Quality Measure (eCQM) value sets to align with recent releases to terminologies, including, ICD-10-CM/PCS, SNOMED CT, LOINC and RxNorm. This addendum affects the electronic reporting of eCQMs for the following programs:
  - Quality Payment Program: Merit-based Incentive Payment System and Advanced Alternative Payment Models
  - Comprehensive Primary Care Plus
  - Hospital Inpatient Quality Reporting
  - Medicare and Medicaid Promoting Interoperability Programs

  Where is the addendum posted? All changes to the eCQM value sets are available through the NLM Value Set Authority Center website in the download tab. The value sets are available as a complete set, as well as value sets per measure.
For More Information:
  - Addendum FAQs
  - eCQI Resource Center website: Updated measure information, including revised technical release notes
  - Report questions on the addendum, value sets, and mapping to the ONC eCQM Issue Tracker

- **Hospice Provider Preview Reports: Review Your Data by October 5.** Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:
  - Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the first to fourth quarter of 2017
  - Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey provider preview report: Review facility-level CAHPS survey results from the first quarter of 2016 to the fourth quarter of 2017

Review your HIS and CAHPS® results by October 5. This update includes the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235).

If you believe the denominator or other HIS quality metric is inaccurate or if there are errors in the results from the CAHPS survey data, request a CMS review:
  - HIS Preview Reports and Requests for CMS Review webpage
  - CAHPS Preview Reports and Requests for CMS Review webpage

Access Instructions:
  - Hospice Provider Preview Report
  - Hospice CAHPS Provider Preview Reports

- **Hand in Hand: A Training Series for Nursing Homes.** Do you need in-service training on dementia management and resident abuse prevention? Hand in Hand: A Training Series for Nursing Homes focuses on caring for residents with dementia and preventing abuse. This training is updated and available in two formats:
  - Self-Paced Online Training
  - Downloadable Materials for Instructor-Led Training

For help with registration and technical issues, contact the Helpdesk at cmstraininghelp@hendall.com.

- **New Medicare Card Mailing Update – Wave 6 Begins, Wave 4 Ends.** CMS started mailing new Medicare cards to people with Medicare who live in Wave 6 states: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington and Wyoming. We finished mailing cards to people with Medicare who live in Waves 1, 2, 3, and now Wave 4 states and territories. If your Medicare patients say they did not get a card, ask them to:
  - Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
  - Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

- **August 2018 Hospice Quality Reporting Program Webinar: From Data to Measure Training Materials Now Available for Download.** Training materials from the Hospice Quality Reporting Program Webinar: From Data to Measure training, held on August 16, 2018, are now available for download. The aim of this training is to help providers understand how CMS takes raw HIS data, calculates hospices’ performance on the HIS quality
measures (or QMs) using the QM specifications, and determines publicly reported scores. Additionally, providers will learn how to interpret two QM reports in CASPER (both the Hospice-level QM Report and the Patient stay-level QM Report) to understand their hospice’s quality performance. This training is intended for advanced HIS audiences; it is recommended that providers have a basic understanding of the HIS, a working knowledge of the HIS-based QMs, and some familiarity with the QM reports to maximize benefit from this webinar. To download the Hospice Quality Reporting Program Webinar: From Data to Measure training materials, please refer to the Downloads section of the Hospice Quality Reporting Training – Training and Education Library webpage.

- **Final Modifications to the Quality of Patient Care Star Rating Algorithm Call** — Wednesday, October 3 from 2 to 3 pm ET. Register for Medicare Learning Network events. During this call, learn about planned modifications to the 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 Management of Oral Medications measure
  - CMS presents the rationale, timing and impact of this change. A question and answer session follows the presentation.

- **The Affordable Care Act Federal Upper Limits Have Been Updated.** The updated Affordable Care Act Federal upper limits (FUL) calculated in accordance with the Medicaid Covered Outpatient Drug final rule with comment are now available on the Medicaid.gov website. States will have up to 30 days from the September 1, 2018 effective date to implement these updated FULs.

- **SP Pricing Files and Coverage for Drugs.** The Average Sales Price (ASP) files include payment amounts for Medicare Part B drugs. These files are not intended indicate whether a drug or biological is covered under Part B:
  - The absence or presence of a HCPCS code and payment allowance limit does not indicate whether Medicare covers the drug
  - The inclusion of a payment allowance limit within a specific column (for example clotting factor) does not indicate whether Medicare covers the drug in that specific category

Remember: Medicare Part B drug coverage determinations are made by your Medicare Administrative Contractor.

- **Submitting Your Medicare Part A Cost Report Electronically Webcast** — Monday, October 15, 1:30 - 3 pm ET. Register for Medicare Learning Network events. Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCReF) system. Use MCReF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCReF or mail or hand deliver it to your Medicare Administrative Contractor. You must use MCReF if you choose electronic submission of your cost report. For more information, see the MLN Matters Article and MCReF webpage. During this webinar, CMS discusses:
  - Changes based on user feedback
  - How to access the system
  - Detailed overview
  - Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.
• **CMS Provides New Flexibility to Increase Prescription Drug Choices and Strengthen Negotiation for Medicare Enrollees.** Currently, if a Part D plan includes a particular drug on its formulary, the plan must cover that drug for every FDA-approved indication, or patient condition, even if the plan would otherwise instead cover a different drug for a particular indication. The requirement to cover drugs in this manner can discourage Part D plans from including more drugs on their formularies and limit their power to negotiate discounts. Currently, if a Part D plan includes a particular drug on its formulary, the plan must cover that drug for every FDA-approved indication, or patient condition, even if the plan would otherwise instead cover a different drug for a particular indication. The requirement to cover drugs in this manner can discourage Part D plans from including more drugs on their formularies and limit their power to negotiate discounts. The memo explains that starting in 2020 plans will have new flexibility to tailor their formularies so that different drugs can be included for different indications. This policy, known as “indication-based formulary design,” is used in the private sector and will enable Part D plans to negotiate lower prices for patients. Targeted formulary coverage based on indication will also provide Part D beneficiaries with more drug choices and will empower beneficiaries to select a plan that is designed to meet their unique health needs. To view a fact sheet on today’s announcement, [click here](#).

• **CMS Provider Minute Video: The Importance of Proper Documentation — Reminder.** Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payment and medical review in the [Provider Minute: The Importance of Proper Documentation video](#). Learn about:
  - Top five documentation errors
  - How to submit documentation for a Comprehensive Error Rate Testing review
  - How your Medicare Administrative Contractor can help

• **Review of Opioid Use during the IPPE and AWV MLN Matters® Article — New.** A new MLN Matters Article SE18004 on [Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)](#) is available. Learn about inclusion of opioid use in the “Review of Medical and Family History” elements of the IPPE and AWV.

• **Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised.** A revised MLN Matters Article MM10824 on [Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement](#) is available. Learn about implementing one new Benefit Enhancement for program year four.

• **Medicare Provider-Supplier Enrollment National Educational Products — Reminder.** [A Medicare Provider-Supplier Enrollment National Educational Products Listing](#) is available. Learn about:
  - Enrollment
  - Requirements
  - Resources

• **Hospice Quality Reporting Program: Training Materials from August Webinar.** Training materials from the August 16 Hospice Quality Reporting Program Webinar: From Data to Measure training are available. For more information, visit the [Hospice Quality Reporting Training and Education Library webpage](#).

• **Influenza Vaccine Payment Allowances: Annual Update MLN Matters Article — New.** A new MLN Matters Article MM10914 on [Influenza Vaccine Payment Allowances - Annual Update for 2018-2019 Season](#) is available. Learn about payment allowances for influenza virus vaccines updated on August 1.

• **Influenza Virus Vaccine Code: January 2019 Update MLN Matters Article — Revised.** A revised MLN Matters Article MM10871 on [Quarterly Influenza Virus Vaccine Code Update - January 2019](#) is available. Learn about new influenza virus vaccine code 90689.
• **Certification Statement Policies MLN Matters Article — Revised.** A revised MLN Matters Article MM10845 on *Update to Chapter 15, Pub. 100-08, Certification Statement Policies* is available. Learn about modifications to certain provider enrollment certification statement policies.

• **Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised.** A revised MLN Matters Article MM10583 on *Revisions to the Telehealth Billing Requirements for Distant Site Services* is available. Learn about use of the GT modifier on institutional claims billed under critical access hospital Method II.


• **Medicare Claims Processing Manual, Chapter 23: Update MLN Matters Article — New.** A new MLN Matters Article MM10924 on *Update to the Medicare Claims Processing Manual, Chapter 23, Section 60.3* is available. Learn about potential sources for gap-filling.

• **Procedure Coding: Using the ICD-10-PCS Web-Based Training — New.** With Continuing Education Credit. A new Procedure Coding: Using the ICD-10-PCS Web-Based Training course is available through the Learning Management System. Learn about:
  - Coding tips, information, and resources
  - Format and features
  - How to find correct codes

• **ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised.** A revised MLN Matters Article MM10859 on *International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)* is available. Learn about coding updates.


• **Preventive Services Poster Educational Tool — Revised.** A revised Preventive Services Poster Educational Tool is available. Learn about:
  - Coding
  - Coverage requirements
  - Patient cost-sharing for each Medicare preventive service

• **Medicare Fraud & Abuse Poster — Revised.** A revised Medicare Fraud & Abuse Poster is available. Learn about:
  - Web-based trainings
  - Publications
  - Frequently asked questions

3) The [National Institutes of Health (NIH)](https://www.nih.gov) recently reported, **NIH Study Broadens Understanding of High Impact Chronic Pain in the U.S.** Researchers have demonstrated that disability is as likely in the chronic pain population as it is in those with kidney failure, emphysema or stroke. This is the reality for 11 million U.S. adults with High Impact Chronic Pain (HICP), a new concept that describes those with pain lasting three months or longer and accompanied by at least one major activity restriction. These findings directly address recommendations suggested in the National Pain Strategy by more accurately characterizing the HICP population to further understanding of chronic pain. This study — conducted by scientists at the National Center for Complementary and Integrative Health (NCCIH) and the National Institute of Neurological Disorders and Stroke (NINDS) at the National Institutes of Health as well as the Kaiser Permanente Washington Health Research Institute, Seattle — was published in the [Journal of Pain](https://www.journalofpain.org).
4) The federal Agency for Healthcare Research and Quality (AHRQ) recently reported on:

- **Openings Available for Long-Term Care Facilities to Join Free Antibiotic Stewardship Program.** Get the resources and training that your facility needs to run an effective antibiotic stewardship program by joining a free, 12-month national project. Beginning in December, the AHRQ Safety Program for Improving Antibiotic Use will provide participating long-term care facilities with antibiotic use guidelines, expert coaching, online education, improvement tools and patient education materials to help reduce harms, such as *Clostridium difficile* infections. Participants will also have the opportunity to earn continuing education credits. To learn more, register for one of eight one-hour webinars between Sept. 13 and Nov. 7.

- **New Reports Highlight AHRQ’s Support for National Opioids Awareness Week.** Two new AHRQ reports about the impact of opioids on seniors are part of the agency’s contributions to this week’s HHS Prescription Opioid and Heroin Epidemic Awareness Week. One report from AHRQ’s Healthcare Cost and Utilization Project shows that nearly 125,000 hospitalizations among older Americans involved opioid-related diagnoses in 2015. Another report from the agency’s Medical Expenditure Panel Survey indicates that, in 2015 and 2016, nearly 4 million seniors, on average, filled four or more opioid prescriptions. AHRQ has joined the battle against opioids by developing an opioids webpage designed to increase access to evidence and support the work of policymakers, clinicians, researchers and others tackling the public health crisis. The resource includes:
  - Statistical briefs that quantify trends in prescription opioid use and opioid-related hospitalizations and emergency department visits
  - Clinical tools that provide guidance on team-based management of patients on chronic opioid therapy and integration of behavioral therapy in primary care
  - Resources related to opioids research, including opioid-related journal publications; a summary of AHRQ projects developed to increase the use of medication-assisted treatment; and a new special emphasis notice that underscores the agency’s interest in receiving health services research grant applications aimed at finding solutions to the opioids crisis
  - An opioids newsroom that links to opioid-related press releases, AHRQ Views blog posts and infographics

Access AHRQ’s newsroom for press releases, statistical briefs and a collection of infographics highlighting the impacts of opioids.

5) The federal Food and Drug Administration (FDA) recently released a letter, The FDA Encourages Use of Enteral Device Connectors that Reduce Risk of Misconnection and Patient Injury. The FDA is concerned by continued reports of misconnections with enteral devices. To reduce the risk of misconnections and patient injury, the FDA recommends hospitals and clinicians use enteral devices with connectors that meet the International Organization for Standardization (ISO) 80369-1 or ISO 80369-3 standard, or that are otherwise designed to reduce the risk of misconnections. There are currently marketed enteral connectors that meet the 80369-3 standards, many of which are identified by the tradename ENFit. Misconnections between enteral devices and other medical devices, such as tracheostomy tubes, have been associated with patient death and serious injuries. Since 2011, the FDA has received reports of 2 deaths, 24 serious injuries, and 32 device malfunctions related to enteral misconnections. The FDA is also concerned that many misconnections, including enteral misconnections, are not reported, or are reported as medication errors.

6) U.S. Surgeon General Releases Spotlight on Opioids. Facing Addiction in America: The Surgeon General’s Spotlight on Opioids calls for a cultural shift in the way Americans talk about the opioid crisis and recommends actions that can prevent and treat opioid misuse and promote recovery. The Spotlight – the Surgeon General’s newest update on opioid addiction – also provides the latest data on prevalence of substance misuse, opioid misuse, opioid use disorder and overdoses. The Surgeon General today also released a digital postcard, highlighting tangible actions that all Americans can take to raise awareness, prevent opioid misuse and reduce overdose deaths. For the full document and to view the digital postcard, visit http://addiction.surgeongeneral.gov.

7) The federal Centers for Disease Control and Prevention (CDC) announces the Kickoff of the 2018-2019 Flu Vaccination Campaign. Thursday, Sept. 27, marks the annual kickoff of the flu vaccination campaign led by CDC, the
National Foundation for Infectious Diseases (NFID), and many partners working together to protect people from flu during the 2018-19 flu season. Register to tune in at 10:00 a.m. ET to the NFID press conference taking place at the National Press Club in Washington, D.C.

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

- HFS posted a new provider notice regarding Better Care Illinois Behavioral Health Initiative: Intensive In-Home Pilot Program. You may view the notice here.
- HFS posted a new Public Notice regarding Home and Community Based Services Waiver. You may view the notice here.
- HFS posted an updated 837P Taxonomy Table. You may view the updated table here.
- HFS posted updated IHH HCPC codes. You may view the updated codes here.
- HFS posted a new provider notice regarding Motorized Wheelchairs. You may view the notice here.
- HFS posted an updated version of the Integrated Health Homes Frequently Asked Questions. You may view the updated FAQs here.
- HFS posted a new PowerPoint presentation on Integrated Health Home Staffing Ratios. You may find the presentation here.
- HFS posted a new Public Notice regarding the Statewide Transition Plan. You may view the new notice here.
- HFS posted a new provider notice regarding Illinois Hospital Provider Assessment Payment Procedure. You may view the notice here.
- HFS posted a new link entitled Provisional Eligibility Process Questions and Answers to their Long Term Services and Supports website. You may view it here.
- HFS posted a new link on the Long Term Services and Supports website entitled IMPACT – Integrated Health Homes. You may view the new link here.
- HFS posted a new provider notice regarding Medical Electronic Data Interchange (MEDI) System – Automatic Updates for Increases and Decreases to the Resident’s Patient Credit Amount. You may view the notice here.
- HFS posted a new provider notice regarding Payment Change for Therapeutic Leaves of Absence. You may view the notice here.
- HFS posted a new Public Notice regarding Intensive In-Home Pilot Webinar. You may view the public notice here.
- HFS posted an updated Handbook for Pharmacy Electronic Processing. You may view the updated handbook here.
- HFS posted a new provider notice regarding ALERT: Fraudulent Prescription Requests. You may view the notice here.
- HFS posted a new provider notice regarding Hospice Coverage in Managed Care Plans. You may view the notice here.
- HFS posted a new provider notice regarding Stage 4 Cancer Medications. You may view the notice here.
- HFS posted an updated IHH FAQ document. You may view the updated document here.
- HFS posted a new provider notice regarding Annual Rate Changes Effective October 1, 2018. You may view the notice here.
9) 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:

- October 16, Pekin Manor 1-3pm
- November 14, Oak Trace, Downers Grove 1-3pm

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

- **National Influenza Survey Open Enrollment – Help Spread the Word.** A team of nationally recognized long term care researchers from Brown University led by Stefan Gravenstein, MD, MPH and Vincent Mor, PhD are undertaking a large-scale quality improvement study to evaluate the impact of the annual influenza vaccine on long term care residents' hospitalization risk for the 2018 influenza season. AHCA/NCAL recommends that members consider participating in this national study. Please help spread the word and share with your colleagues and peers. Nursing centers that meet eligibility and agree to participate will be asked to complete a short survey and receive financial compensation of $150. If you are interested in participating in this important project, please call or email the study coordinating center, Insight Therapeutics, LLC, at 757-625-6040 or NHFlustudy@inther.com.

- **New! LTC Trend Tracker Quality Initiative Progress Publication.** We are excited to announce that a new publication was released in LTC Trend Tracker, *Your Quality Initiative Progress*, on Tuesday, September 18, 2018. This publication will feature metrics and graphs that outline an individual SNF’s progress through the Quality Initiative 3.0. For additional information about the AHCA Quality Initiative 3.0, please visit www.ahcancal.org.

- **Become an Expert on the CMS SNF VBP Program Today!** The CMS SNF Value-Based Purchasing (VBP) 10-year program starts October 1, 2018. The SNF VBP program will adjust SNFs’ part A payment rates based on their performance on the rehospitalization rate. AHCA has developed an in-depth, online training that covers how CMS calculates the following:

  1. Rehospitalization rates, including how they are risk adjusted;
  2. SNF’s performance score;
  3. Resulting incentive payment multiplier, which is used to adjust a SNF’s Part A payments.

  The course is divided into six distinct modules that you can review at your own pace and in the order most helpful to you. The course also provides demonstrations on how to access and interpret your CMS feedback reports, which contain your SNF rehospitalization rates, your incentive payment multiplier information and AHCA’s SNF VBP prediction tool that allows a SNF to estimate the financial impact different rehospitalization rates will have on your revenue.

  Lastly, tips on how to more effectively lower your rehospitalization rates to avoid a payment cut are provided. Have Questions or want to register? Email educate@ahca.org.

11) The latest Telligen information can be seen [here](#).

12) **Health News Illinois** reports Medicaid Managed Care Rolls Grew in June and July. The state’s Medicaid managed care rolls inched in up in June and July. There were 2,235,427 members in Health Choice Illinois as of August 1, up from 2,207,457 on June 1. Most health plans increased their membership during that period, with Meridian Health Plan leading the way with a 5 percent bump. Blue Cross and Blue Shield of Illinois and NextLevel Health Partners lost members. The enrollment totals, as of Aug. 1, were:

- Meridian Health Plan: 603,149 (5 percent increase from June 1)
- Blue Cross and Blue Shield of Illinois: 427,687 (6 percent decrease)
- County Care Health Plan: 335,484 (2 percent increase)
IlliniCare Health Plan: 337,802 (4 percent increase)
Harmony Health Plan: 255,402 (1 percent increase)
Molina Healthcare: 218,294 (2 percent increase)
NextLevel Health Partners: 57,609 (2 percent decrease)

Read more.

13) Provider Magazine reports Change in Payment Models Encourages Partnerships Between Hospitals and Nursing Homes. In the cover story of its September issue, Provider Magazine reports that the move in payment models from fee-for-service to value-based medicine presents opportunities for hospitals and nursing centers to "maximize quality care and manage costs." The growing number of hospitals that are part of accountable care organizations (ACOs) and bundled payment efforts are seeking out post-acute partners "they are confident will enable them to meet targets, keep costs down, and get patients home safely – without bouncing back to the hospital or nursing center." Another advantage of switching from setting-based to population-based care is "that it encourages better communication and relationships between hospitals and nursing centers." Because all providers are responsible for quality care and lowering costs, "hospitals and nursing centers are learning to coordinate care and focus on doing what is right for the patient, regardless of the care setting."

14) Kaiser Health News reports that Understaffed Nursing Homes Blamed for Thousands of Sepsis Cases. Kaiser Health News recently reported on thousands of lawsuits across the country "that allege enfeebled nursing home patients endured stressful, sometimes painful, hospital treatments for sepsis that many of the lawsuits claim never should have happened." An investigation by Kaiser Health News and the Chicago Tribune found that, "year after year, nursing homes around the country have failed to prevent bedsores and other infections that can lead to sepsis." Examining data related to nursing home residents who were transferred to hospitals and later died found "that 25,000 a year suffered from sepsis, among other conditions," and their treatment "costs Medicare more than $2 billion annually." Regulators and patient advocates blame poor staffing levels for the spike in sepsis cases. Kaiser says "staffing levels for nurses and aides in Illinois nursing homes are among the lowest in the country." Matt Hartman, executive director of the Illinois Health Care Association, "acknowledged low staffing is a problem that diminishes the quality of nursing care," and blamed the state's subpar Medicaid payment rates for nursing homes.

15) CNN reports that Marijuana Use Among Older Americans Has Doubled in the Past Decade. CNN reported on a new study published in the journal Drug and Alcohol Dependence, which found the percentage of US adults aged 50 to 64 who have used marijuana in the past year is nine percent, double what it was a decade ago. Meanwhile, adults older than 65 "have seen a seven-fold increase in that period" to 2.9 percent. According to the report, "past-month use prevalence was 5.7% among middle-age adults and 1.7% among older adults." The study also found higher rates of unhealthy substance use of other products by aging adults: "nearly 5% of middle-age marijuana users had alcohol use problems, 9% depended on nicotine, and 3.5% misused opioids; among older adults, 1.5% had alcohol use problems, 3.5% depended on nicotine, and 1.2% misused opioids."

16) Imprivata released a White Paper entitled The C-Suite Battle Plan for Cyber Security Attacks in Healthcare. Cyber space is the modern frontier and cyber security is the modern health care organization’s most treacherous battlefield. Data is one of your most precious resources and your attackers will do anything they can to get their hands on it. In 2014 alone, a record-breaking 47 percent of American adults had their data hacked. The landmark Anthem attack has drawn intense scrutiny and pressure on the health care industry, highlighting health care as a high-risk target. And the FBI has issued a private industry notification warning that health care systems suffer an acute risk of cyber attack for financial gain and are more vulnerable to attack than financial and government sectors. Patients’ private health records now fetch higher black market prices than stolen credit card on the black market. This reality is fueling an unprecedented number of fraudulent insurance claims, identity thefts and a growing number of attacks targeting healthcare organizations.
17) **Skilled Nursing News** reports on:

- **Preliminary Results Show Bundled Payment Model Reduced Medicare Spending By Cutting Skilled Nursing Facilities.** Skilled Nursing News reports that "preliminary results from the bundled payment initiative focused on joint replacements suggest that savings under the program has come largely from cutting skilled nursing and other long-term care services." Early results from the Comprehensive Care for Joint Replacement (CJR) bundled payment model came shortly after CMS announced that the Next Generation Accountable Care Organization (ACO) Model saved $62 million by cutting spending in its SNFs. Skilled Nursing News says the evaluation results "suggest that CJR hospitals responded to the model by taking actions that moved patients to less intensive post-acute settings, which in turn led to statistically significant reductions in total episode payments."

- **Consultant Offers Advice for SNFs as Hospitals Build Skilled Nursing Networks.** Skilled Nursing News reports that "the size of hospitals’ preferred skilled nursing networks varies wildly depending on location and patient volume ... and the savviest operators are the ones with a pulse on their particular market landscape." According to Brian Fuller, an independent health care consultant, "There’s no right number that applies to all hospitals," but "there’s some common factors that determine what the right size is. I’ve seen networks as small as six or seven, and as big as 30, and everything in between." According to the article, Fuller says it’s best not to look at a SNF network as an unchanging roster of providers as "sending 70% to 80% of patients to a trusted group of high-quality SNFs is more the norm, with the remainder going to other providers for a variety of reasons, including geographic location and consumer preference."

18) **HealthDay** reports on:

- **Seniors Who Take Benzodiazepine Sedatives at Risk of Developing Dependency.** HealthDay reports, new research in the journal *JAMA Internal Medicine* suggests that older adults who use benzodiazepines, such as Valium or Xanax to calm anxiety or help them sleep may have a higher risk of becoming dependent on them. The study of nearly 600 adults found that "about one in four who were prescribed these types of benzodiazepine sedatives ended up using them for at least a year."

- **Modified Tai Chi May Prevent More Falls Among Older Adults Than Strength Training, Study Suggests.** HealthDay reported that new research in the journal *JAMA Internal Medicine* suggests tai chi may be more beneficial for preventing falls among older adults than strength training and aerobics. Researchers found that a "modified senior-centered tai chi program reduced falls nearly a third better in a head-to-head comparison with an exercise regimen that combined aerobics, strength training and balance drills."

19) **McKnight's** reports on:

- **Skilled Nursing Providers Will Receive 2.4% Increase Under Patient-Driven Payment Model.** *McKnight’s Long Term Care News* reported that skilled nursing providers will "receive a healthy 2.4% Medicare market basket increase, starting Oct. 1 2019," due to the "newly released Patient-Driven Payment Model." The raise was included in the Bipartisan Budget Act of 2018. In the year prior, "skilled care saw a 1% boost, amounting to $370 million in additional pay." AHCA President and CEO Mark Parkinson called the 2.4 percent boost "essential." Additionally, *McKnight’s Long Term Care News* reported that skilled nursing providers "also cried foul over provisions of the new Patient-Driven Payment Model system." AHCA President and CEO Mark Parkinson said, "The therapy language in the rule criticizes skilled nursing providers for providing therapy when CMS has promulgated rules over the last 20 years that encourage therapy." Parkinson adds, "Rather than focusing on outcomes associated with therapy delivery as we requested, this rule micromanages patient care and therapy minutes." *McKnight’s* says the industry is concerned about a 25 percent limit on concurrent and group therapy. Parkinson said, "Decisions about how much therapy is provided should not be made from a government office."

- **AHCA Vows to Push Back Against IRS Rule Preventing For-Profit SNFs from Benefiting From New Tax Law.** *McKnight’s Long Term Care News* reports AHCA President and CEO Mark Parkinson vowed to appeal an IRS
decision that prevents for-profit skilled nursing properties from receiving a 20 percent tax cut. Parkinson said, "We will definitely submit comments and will forcefully advocate our position. If we don't prevail in the rulemaking process we intend to go to the Hill and seek legislative relief." He explained the rule should apply to skilled nursing because the intent of the rule "was to provide tax cuts to job creators and those willing to put capital into the economy. We are both."

- **Medicare Underpaying For Beneficiaries With Functional Limitations, GAO Says.** *McKnight’s Long Term Care News* reports that according to an analysis by the Government Accountability Office, the Centers for Medicare and Medicaid Services "may be underpaying for Medicare Advantage beneficiaries with functional limitations." CMS pays a fixed amount for individuals covered by those health plans, "but isn't taking into account beneficiaries’ ability to perform routine tasks such as bathing," the article explains. The GAO estimates about 40 percent of beneficiaries had functional limitations, saying accurate risk adjustments could "reduce any financial disadvantages plans may experience" when enrolling beneficiaries with those limitations.

- **MCOs Appear To Select Nursing Homes Based On Cost Rather Than Quality, Study Suggests.** *McKnight’s Long Term Care News* reports a new study from the Universities of California in Berkeley and San Francisco indicates that managed care organizations (MCOs) which aim to serve dual-eligible beneficiaries may "be picking their nursing home partners based on costs, rather than quality factors." Data from 17 MCOs in California’s Coordinated Care Initiative indicated "that managed care paid 'limited attention to using quality criteria,' with the 602 network nursing homes scoring significantly lower on six selected quality measures when compared to their 117 non-network counterparts."

20) Interesting Fact: Fall colors are caused by the amount of sugar in leaves. The more red in the leaf, the more sugar that leaf is storing. That is why Maple trees are so vibrant. Evergreens don’t change because their leaves have a thick wax covering that protects the chlorophyll (green) in the leaves.

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