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!

MDS Section GG - Q & A
Renee Kinder, MS, CCC-SLP, RAC-CT, Director of Clinical Education for Encore Rehabilitation provides answers to your top 10 questions on the new MDS Section GG changes.

1. What are the new areas being added to the Self-Care item set?
   - GG0130E. Shower/bathe self: The ability to bathe self, including washing, rinsing and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
   - GG0130F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
   - GG0130G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
   - GG0130H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

2. What are the new areas being added to the Mobility item set?
   - GG0170A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back on the bed.
   - GG0170G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
   - GG0170I. Walk 10 feet: Once standing, the ability to walk at least 10 feet (3 meters) in room, corridor or similar space.
   - GG0170L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
   - GG0170M. 1 step (curb): The ability to step over a curb and/or up and down one step.
   - GG0170N. 4 steps: The ability to go up and down four steps with or without a rail.
   - GG0170P. 12 steps: The ability to go up and down 12 steps with or without a rail.
   - GG0170O. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

3. How is Section GG associated with the Quality Reporting Program (QRP)?
October 1 not only introduces new MDS areas, it also places SNFs into a data collection window from October 1-December 31, 2018, which will impact their FY 2020 annual payment update.
SNFs that do not submit the required measure data may receive a 2 percent REDUCTION to their annual payment update for the applicable payment year with 80 percent of assessments needing to have 100 percent of the data related to the following areas: Drug Regimen Review; Changes in skin integrity post-acute care: pressure ulcer/injury; Change in Self Care Score; Change in Mobility Score; Discharge Self Care Score; Discharge Mobility Score.

For the SNF Quality Reporting Program, a minimum of one self-care or mobility discharge goal must be coded.

4. My team is trying to determine how to account for differences in how an individual performs in therapy versus with the nursing assistants. Can you provide a reminder on the definition of Usual Performance?
Per the RAI Usual Performance is defined as: A resident’s functional status which can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status.

If the resident’s functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worst performance, but rather record the resident’s usual performance.

5. What do I need to know related to GG0100. Prior Functioning: Everyday Activities?
The item rationale for this area includes knowledge of the resident’s functioning prior to the current illness, exacerbation or injury may inform treatment goals. The area is assessed by asking the resident or his or her family about, or reviewing the resident’s medical records describing, the resident’s prior functioning with everyday activities.

The areas assessed include: Self-Care; Indoor Mobility; Self-Care; and Functional Cognition.

6. What items are included in GG0110, Prior Device Use?
Manual wheelchair; motorized wheelchair and/or scooter; mechanical lift; walker; and orthotics/prosthetics.

7. When coding for GG0130A, Eating what do we consider for a resident receiving tube feedings or total parenteral nutrition?
When impacted by a new onset medical condition:
If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN because of a new (recent-onset) medical condition, code GG0130A as 88, not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding Eating.

When not impacted by a new onset medical condition:
If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, exacerbation or injury, code GG0130A as 09, Not applicable – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation or injury. Assistance with tube feedings or TPN is not considered when coding Eating.

When partial oral intake occurs:
If the resident eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding Eating.

8. What is included and excluded when coding GG0130E, Shower/bathe self?
- Inclusions: Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area and feet.
- Exclusions: Do not include washing, rinsing, and drying the resident’s back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.

Set up considerations: If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.
9. What items should be considered a piece of clothing when coding the dressing items?
If donning and doffing an elastic bandage, elastic stockings or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.

10. How do you code wheelchair items when wheelchair is used for transport?
- You do not.
- Per the RAI Manual: Do not code wheelchair mobility if the resident uses a wheelchair only when transported between locations within the facility or for staff convenience (e.g., because the resident walks slowly).
- Only code wheelchair mobility based on an assessment of the resident’s ability to mobilize in the wheelchair.
- If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.

Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review (Part 5 in the Series – Mandatory LTC Survey Pathways)
This Mandatory LTC Survey Pathway is divided into two sections – QAA Review and QAPI Plan Review.

QAA Review - This review should occur at the end of the survey, after completion of investigation into all other requirements. However, identification of systemic concerns to be reviewed during the QAA review should begin with offsite preparation and occur throughout the survey. During the surveyor’s offsite review, they will make note of concerns identified during offsite preparation, which will be further investigated during the survey (repeat deficiencies, ombudsman concerns and complaints/facility-reported incidents). These represent possible systemic issues, which if validated during the survey, should be cited under the relevant outcome tag, and incorporated into the QAA review for investigation.

During the survey end of the day Team Meetings, the survey team discusses potential systemic issues or shared concerns for further investigation, or those that have been validated for incorporation into the QAA review.

- Were any offsite concerns (repeat deficiencies, ombudsman concerns and complaints/facility-reported incidents) validated during the survey?
- Were new systemic concerns validated (concerns which will likely be cited at pattern or widespread, or substandard quality of care) during the survey?
- Has more than one surveyor identified and validated the same concern?
- Note: Disclosure of documents generated by the QAA committee may be requested by surveyors only if they are used to determine compliance with QAA regulations.

QAA Committee: Determine through review of the information requested by the TC during Entrance, an interview with the QAA contact person and review of QAA records:

- Does the facility have a QAA committee that meets at least quarterly?
- Does the QAA committee include the required members?
  - Director of Nursing Services;
  - Medical Director;
  - Nursing home administrator, owner, board member, or other individual in a leadership role; and
  - Two other staff members.

For every systemic issue identified and validated during the survey, determine if the QAA committee also has identified the issue and made a “Good Faith Attempt” to correct it. To determine this, do the following: a) interview the QAA contact person, and b) review evidence in order that will answer the following questions:
• Is the QAA committee aware of this issue?
• Is the issue a high risk, high volume or problem-prone issue that the committee should know about?
• Has action been taken to correct this issue since it was identified?
• Is the QAA committee monitoring to ensure the corrective action has been implemented and the correction is being sustained?
• Is the issue corrected? That is was the facility in substantial compliance as of the first day of the survey because of the corrective action taken? If corrected, consider citing the related tag as Past Noncompliance.
• Has the QAA committee revised its corrective action based on its monitoring and evaluation?

If No to any of the above, surveyors will interview the staff responsible for conducting QAA activities to determine how the facility is able to identify and correct its own quality deficiencies any time they occur throughout the facility. Select from among the following questions, or ask your own:

• How does the QAA committee know when an issue arises in any department?
• How does the QAA committee know when a deviation from performance or a negative trend is occurring?
• Is there a mechanism for staff to report quality concerns to the QAA committee?
• How does the QAA committee decide which issues to work on?
• How does the QAA committee know that corrective action has been implemented?
• How does the QAA committee know when improvement is occurring?
• How long will the QAA committee monitor an issue that it has corrected? How is this decided?
• Interview staff in various departments to determine whether they know how to bring an issue to the attention of the QAA committee.

Surveyors will review QAA under the following tags:

• Did the QAA committee develop and implement appropriate plans of action to correct identified quality deficiencies? (F867).
• Does the QAA committee consist of the minimum, required members? (F868).
• Does the facility have a QAA committee that meets at least quarterly? (F868).
• Does the QAA committee put forth Good Faith Attempts to identify and correct its own quality deficiencies? (F865).

QAPI Plan Review. Surveyors will review the QAPI Plan to ensure it includes policies and protocols describing how the facility will identify and correct its own quality deficiencies. Does the QAPI plan have policies/protocols describing how it will:

• Track and measure its performance?
• Establish goals and thresholds for performance measurement?
• Identify and prioritize deviations from performance and other problems and issues?
• Systematically investigate and analyze to determine underlying causes of systemic problems and adverse events?
• Develop and implement corrective action or performance improvement activities?
• Monitor and evaluate the effectiveness of corrective action/performance improvement activities?

Surveyors will review QAPI under the following tag:

• Does the facility have a QAPI plan containing the necessary policies and protocols describing how they will identify and correct their quality deficiencies? (F865).
Focus F-Tag – F679 Activities Meet Interest/Needs of Each Resident

This Regulatory Beat’s Focus F-tag is part of the Quality of Life regulatory group, F679 Activities Meet Interest/Needs of Each Resident. The regulatory requirement has been updated under the new RoPs to state that “based on the comprehensive assessment and care plan and preferences of each resident,” facilities must provide ongoing resident-centered activities programming to “support residents in their choice of activities” that have been designed to meet the individual interests of the residents while encouraging both independence and interaction in the community.

Activities must be meaningful and incorporate the resident’s interests, hobbies and cultural preferences. The Interpretive Guidance (IG) states that activities are considered “meaningful” when they reflect the resident’s lifestyle and interests, are enjoyable to the resident, help the resident feel useful and provide the resident with a sense of belonging.

For residents living with dementia, the IG further states that activities for PLWD must be individualized and customized based upon the individual’s previous lifestyle, preferences and comforts. The IG contains a multitude of examples for activity interventions that facilities can try for different residents and is a good starting point for some ideas. The outcome for activities, per the IG, is that there is either a decrease/elimination of a behavior, the validation of the activity intervention or an indication that something different needs to be tried for that resident. This means that care plan interventions and planned activities need to be updated based on these outcomes to better meet each resident’s needs.

During survey, surveyors will utilize the Activities Critical Element Pathway to ensure that the activities for each resident are person-centered and support his/her well-being. Facilities need to ensure that they include specific information about how each resident prefers to participate in activities that meet his/her interest, if special adaptations need to be made for participation and how activity programming is adjusted to accommodate the needs of residents with varying levels of cognition and capabilities. Also note that surveyors will be conducting observations to see if residents are engaged and whether the activities are compatible with their known interests/preferences.

Resident engagement should be a facility-wide goal with staff participation from all departments feasible; an “activity” does not need to be led/directed by a member of the Activities/Therapeutic Recreation Department. And remember, there are also a variety of community-based activities, such as shopping, local concerts, church services and visits to the library, that afford a resident the opportunity to pursue lifelong interests, spirituality as well as meet their goal, needs and strengths. Your team should be conducting an assessment that identifies this information.

Trending Statistics

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

Illinois Sees Increase In Adult Obesity

More than 30 percent of Illinois adults are obese, according to data released last week by the Centers for Disease Control and Prevention.

The state’s rate has increased 4 percentage points since 2011. Illinois was ranked 27th among the 50 states and the District of Columbia when it came to having the highest percentage of adults with obesity.

Non-Hispanic black adults reported an obesity prevalence of 39.5 percent, the highest of any group outlined in the report. Hispanic adults reported an obesity prevalence of 35.9 percent, and white adults reported a prevalence of 30.3 percent.

Nationally, young adults were half as likely to be obese as middle-aged adults. Just 16.5 percent of young adults reported obesity, compared to 35.8 percent of adults aged 45 to 54.
Important Regulations, Notices & News Items of Interest

1) Federal CMS released the following CMS Quality, Safety and Oversight Letter (formerly known as Survey and Certification (S&C) Letters) since the last issue of Regulatory Beat:

- **QSO 19-01 – RTC** – FY 2017 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program.

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

- **SNF Provider Preview Reports are Now Available.** Skilled Nursing Facility Provider Preview Reports have been updated and are now available. Providers have until November 30, 2018 to review their performance data on quality measures based on Quarter 2 -2017 to Quarter 1 - 2018 data, prior to the January 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate. For More Information we invite you to visit: CMS SNF Quality Public Reporting webpage, which also includes directions for accessing your preview report.

- **HHS Advances Payment Model to Lower Drug Costs for Patients.** On October 25, CMS announced and sought input on a new International Pricing Index (IPI) payment model to reduce what Americans pay for prescription drugs. Under the IPI model, described in an Advance Notice of Proposed Rulemaking (ANPRM), Medicare’s payments for select physician-administered drugs would shift to a level more closely aligned with prices in other countries. Overall savings for American taxpayers and patients are projected to total $17.2 billion over five years.

  The move from current payment levels to payment levels based on international prices would be phased in over a five-year period, would apply to 50 percent of the country, and would cover most drugs in Medicare Part B, which includes physician-administered medicines. They are considering a randomized approach to determine which areas in the country would participate in the model.

  The IPI model would achieve several goals:
  - Reduce costs for Medicare beneficiaries, and thereby increase adherence and access to prescription drugs
  - Introduce competition to the system of paying for physician-administered drugs by bringing in private-sector vendors
  - Reduce providers’ burden and the financial risk associated with managing drug inventories, so physicians can focus on patient care
  - Maintain financial stability for physicians, while removing incentives for higher drug prices
  - Address the disparity in drug prices between the U.S. and other countries
  - Reduce costs to the American taxpayers and Medicare beneficiaries who fund these programs

  CMS will carefully review comments and consider issuing a proposed rule for the IPI in the spring of 2019, with a potential model start in spring 2020. We will accept comments on the ANPRM until December 31.

  For More Information:
  - Advance Notice of Proposed Rulemaking
  - Fact Sheet
See the full text of this excerpted HHS Press Release (issued October 25).

- **SNF Quality Reporting Program Data on Nursing Home Compare.** CMS announced the first release of Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) quality data on Nursing Home (NH) Compare. NH Compare allows you to find and compare SNFs that are certified by Medicare and nursing homes that are certified by Medicaid. This website contains quality of resident care and staffing information for more than 15,000 nursing homes around the country and will now include SNF QRP quality data that can be used to compare SNF providers.
  - 5 SNF QRP measures are now displayed on NH Compare:
    - Assessment-based measures:
      - Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (National Quality Forum #0678)
      - Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
      - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
    - Claims-based measures:
      - Medicare Spending Per Beneficiary-PAC SNF QRP
      - Discharge to Community-PAC SNF QRP

For More Information, visit the SNF QRP Public Reporting webpage. See the full text of this excerpted CMS Fact Sheet (issued October 24).

- **IRF, LTCH and SNF Quality Reporting Programs: Submission Deadline November 15.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) and Skilled Nursing Facility (SNF) Quality Reporting Programs for the second quarter of 2018 is 1:59 pm PT on November 15. For More Information:
  - IRF Quality Reporting Data Submission Deadlines webpage
  - LTCH Quality Reporting Data Submission Deadlines webpage
  - SNF Quality Reporting Program Data Submission Deadlines webpage

- **Hospital Cost Report Data: User-Friendly Version.** CMS developed a user-friendly version of the Hospital Cost Report Public Use File (PUF) for 2014 in a simplified Excel format. The PUF includes information for 6,248 facilities, including all hospital facility types and all payers. It covers 33 million discharges, 180 million days, $876 billion in net revenue, and $889 billion in operating expenses. Visit the Hospital Cost Report PUF webpage for more information.

- **RAND Forum Announcement and RSVP.** On behalf of CMS, the RAND Corporation is hosting an overview of the results from its national test related to data element standardization for post-acute care providers on Tuesday, November 27, 2018, from 12pm to 4pm ET at the RAND offices in Arlington, VA. RAND will provide updates on and early findings from the National Beta Test of candidate standardized patient assessment data elements (SPADEs), discuss areas of support and key concerns raised by stakeholders during prior engagement activities, and answer questions from attendees. In-person attendance will be available on a first come, first served basis. A call-in option will also be available. Please register to attend at http://www.rand.org/SPADE. For questions about this meeting, contact SPADEForum@rand.org.

- **CY 2019 OPPS and ASC Rule Encourages More Choices and Lower Costs for Seniors.** On November 2, CMS released a final rule that strengthens the Medicare program by providing seniors more choices and lower cost options in making the best decisions on their care. The policies adopted in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period will help lay the foundation for a patient-driven healthcare system. For More Information:
Read the full text of this excerpted CMS Press Release (issued November 2).

- **Medicare Diabetes Prevention Program: New Covered Service.** November is National Diabetes Month. The 2019 Medicare & You Handbook includes information on the Medicare Diabetes Prevention Program (MDPP), a new Medicare-covered service. Help your patients prevent or delay Type 2 diabetes and understand their treatment options. For More Information:
  - Review materials from the September 26 Medicare Learning Network call and the beneficiary brochure
  - Become familiar with beneficiary eligibility criteria and coverage; screen at-risk patients for eligibility
  - Access the MDPP Supplier Map or view a list of all current MDPP suppliers; refer eligible patients to a nearby MDPP supplier
  - Visit the MDPP Expanded Model webpage

MDPP is a new program that is still ramping up. If you do not see an organization that offers services in your community, keep checking the list. New MDPP suppliers are added to the list on a regular basis.

- **November is Home Care and Hospice Month.** Did you know that Medicare covers a wide range of health care services that can be provided in the home to treat an illness or injury for homebound beneficiaries who require skilled services? In addition, hospice care empowers people with life-limiting illnesses to remain at home, surrounded and supported by family and loved ones at the end of life. Talk to your Medicare patients about appropriate home care and hospice services. For More Information:
  - Home Health Prospective Payment System Fact Sheet
  - Medicare Home Health Benefit Fact Sheet
  - Medicare Home Health Benefit Web-Based Training course: Available through the Learning Management System
  - Hospice Payment System Fact Sheet

- **New Medicare Card: Handouts and Videos for Patients.** CMS offers New Medicare Card English & Spanish Beneficiary Resources you can use to educate your patients.
  - Have we finished mailing new Medicare cards in your state? Register and order (or print):
  - Still Waiting for Your New Card? tear-off sheets (Product #12023)

Mailing in your state not complete?
  - Poster, 11”x17” (Product #12009-P)
  - Pad of 50 You’re Getting a New Medicare Card! tear-off sheets, 4”x 5.25” (Product #12006)
  - New Medicare Cards Are Coming video for your waiting room

Fraud resources for all states:
  - Guard Your Medicare Card video
  - Drop-in article (also in Spanish), print only
  - Flyer (also in Spanish), print only

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

Visit the Provider webpage for the latest information.

- **Updated Ranking File.** CMS thanks all skilled nursing facilities (SNFs) that participated in Phase Two of the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program’s Review and Corrections process. As a result, CMS is providing updated rankings for all SNFs included in the Fiscal Year (FY) 2019 program year. A list of each SNF’s
incentive payment multiplier and updated ranking can be found on the SNF VBP website. The incentive payment multiplier applicable to each SNF is unchanged from the multiplier that CMS previously included in the SNF’s FY 2019 Annual Performance Score Report. That multiplier will be used to adjust the Federal per diem rate otherwise applicable to the SNF for services furnished from October 1, 2018 through September 30, 2019. A more detailed file containing facility level performance will be made publicly available later this year on Nursing Home Compare.

The Review and Corrections process provides SNFs with the opportunity to review the information that will be made public for the applicable SNF VBP program year and to submit correction requests to CMS. As a reminder, Phase One Review and Correction requests are due no later than March 31, 2019 for Calendar Year 2017 measure data. To submit a complete request, SNFs must submit the following information to the SNFVBPinquiries@cms.hhs.gov mailbox:

- The SNF’s CMS Certification Number (CCN)
- The SNF’s Name
- The correction requested and the reason for requesting the correction. SNFs must also submit evidence, if available, supporting the request.

Please do not include any protected health information or other patient-level data in correction requests submitted to the SNF VBP mailbox.

For more information on how to review the FY 2019 Annual Performance Score Report, view this tutorial. Click this link to access the FY 2019 Annual Performance Score Report. For questions about accessing CASPER, please contact the QIES Technical Support Office (QTSO) Help Desk: help@qtso.com.

For more information about the SNF VBP Program, please review the Frequently Asked Questions document and refer to the FY 2019 SNF PPS final rule.

If you have additional questions, please email them to SNFVBPinquiries@cms.hhs.gov.

- **Omnibus on Burden Reductions Proposed Rule.** Join the Centers for Medicare & Medicaid Services (CMS) for national webinars hosted by the chief medical officer of regions V, VI & VII. Both webinars will discuss changes proposed in the Omnibus proposed rule, each followed by a question and answer session. Registration is required.
  - Omnibus on Burden Reduction NPRM Option 1
    - Mon, October 29
    - 12:00 p.m. – 12:30 p.m. CT
  - Omnibus on Burden Reduction NPRM Option 2
    - Thu, November 8
    - 1:00 p.m. – 1:30 p.m. CT

For more information on the proposed rule, visit Press Release and Fact Sheet.

Note: The same material will be presented during both webinars.

Once your registration is processed, you will receive a confirmation email with instructions for joining the session. Note: You will need to register for each webinar individually. If you have already registered for a session, you do not need to register again.

- **CMS Takes Action to Modernize Medicare Home Health.** On October 31, CMS finalized significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare. Specifically, CMS made changes to improve access to solutions via remote patient monitoring technology, updated payments for home health care with a new case-mix system, begin the new home infusion therapy benefit and reduce burden.

  “This home health final rule focuses on patient needs and not on the volume of care,” said CMS Administrator Seema Verma. “This rule also innovates and modernizes home health care by allowing remote patient monitoring. We are also proud to offer new home infusion therapy services. Using new technology and reducing unnecessary reporting measures for certifying physicians will result in an annual cost savings and provide Home
Health Agencies (HHAs) and doctors what they need to give patients a personalized treatment plan that will result in better health outcomes.”

Beginning with CY 2020, CMS is implementing changes required by law, including a new case-mix system called the Patient-Driven Groupings Model (PDGM) that puts the focus on patient needs rather than volume of care. The PDGM relies more heavily on patient characteristics to more accurately pay for home health services.

CMS is promoting innovation and modernization of home health care by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data are shared among patients, their caregivers and their providers. The use of such technology can allow for greater patient independence and empowerment. Supporting patients in sharing their data will advance the MyHealthEData initiative.

This final rule implements the temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, as required by the Bipartisan Budget Act of 2018, until the new permanent home infusion therapy services benefit begins on January 1, 2021. In addition, the final rule establishes the health and safety standards for qualified home infusion therapy suppliers of the new permanent home infusion therapy service benefit. The final rule also establishes the approval and oversight process for accrediting organizations of these suppliers as required by the 21st Century Cures Act. We are finalizing our proposal and also seeking further comments on our interpretation of “infusion drug administration calendar day” and on its potential effects on access to care.

CMS is eliminating the requirement that the certifying physician estimate how much longer home health services are needed when recertifying the need for continued home health care. This results in an estimated reduction in burden for physicians of $14.2 million, annually, and would allow physicians to spend more time with patients rather than on unnecessary paperwork.

The final rule helps advance the Comprehensive Meaningful Measures Initiative. CMS is removing seven Home Health Quality Reporting Program measures. Changes in data collection under the new case-mix system, coupled with the changes from these seven measure removals will reduce burden for HHAs by approximately $60 million annually, beginning in CY 2020. For More Information:

- Final Rule
- Fact Sheet
- Home Health PPS website
- HHA Center website
- Home Health Quality Reporting Requirements webpage

- **Home Health, Hospice and DME Open Door Forum – Wednesday, November 14, 2018 – 1:00 – 2:30 pm CST.**
  
  This call will be Conference Call Only. To participate by phone:
  - Dial: 1-800-837-1935 & Reference Conference ID: 35539695
  - Persons participating by phone do not need to RSVP. TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.
  - Encore: 1-855-859-2056; Conference ID: 35539695
  - Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 beginning 1 hour after the call has ended. The recording expires after 2 business days.

- **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
- **Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims** OIG Report, December 2014
- **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

- **MRI MLN Matters Article — New.** A new MLN Matters Article MM10877 on Magnetic Resonance Imaging (MRI) is available.


- **ASP Medicare Part B Drug Pricing Files and Revisions: January 2019 MLN Matters Article — New.** A new MLN Matters Article MM11016 on January 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files is available. Learn about the drug pricing files used to determine the payment limit for claims.

- **MCRef System Webcast: Audio Recording and Transcript — New.** An audio recording and transcript are available for the October 15 webcast on Submitting Your Medicare Part A Cost Report Electronically. Learn how to use the new Medicare Cost Report e-Filing (MCRef) system.

- **Medicare Podiatry Services Fact Sheet — Revised.** A revised Medicare Podiatry Services Fact Sheet is available. Learn covered foot care service requirements, exclusions from coverage, and foot care for patients with chronic disease.

- **Medicare and Medicaid Basics Booklet — Revised.** A revised Medicare and Medicaid Basics Booklet is available. Learn quick facts, covered services and other types of common coverage.

- **Updating CY 2019 MDPP Payment Rates MLN Matters Article — New.** A new MLN Matters Article MM10970 on Updating Calendar Year (CY) 2019 Medicare Diabetes Prevention Program (MDPP) Payment Rates is available. Learn about updated payment rates for CY 2019.

- **Quality Payment Program 2018 Advanced APMs Web-Based Training Course — Revised.** - With Continuing Education Credit. A revised Quality Payment Program in 2018: Advanced Alternative Payment Models (APMs) Web-Based Training Course is available through the Learning Management System. Learn:
  - How to identify Advanced APMs
  - How to participate in QPP via an Advanced APM

- **Items and Services Not Covered under Medicare Booklet — Revised.** A revised Items and Services Not Covered under Medicare Booklet is available. Learn about:
Four categories not covered under Medicare

3) The federal Centers for Disease Control and Prevention (CDC) provided updates on the 2018-2019 Flu Season:

- **Weekly U.S. Influenza Surveillance Report.**

- **Long Term Care and Flu.** Health care providers in long term care (LTC) facilities have contact with residents, who often are older adults, people with disabilities and people with chronic medical conditions receiving care. In addition to vaccinating residents to protect them from flu, it is very important for health care workers to get vaccinated against flu also.

- **MMWR: Influenza Activity – U.S. and Worldwide.** New MMWR reports: During the summer, the U.S. experienced low levels of flu activity. Seasonal flu activity in the Southern Hemisphere was low overall, with influenza A(H1N1)pdm09 dominating in many regions. While flu activity is currently still low in the U.S., health care providers should urge their patients to get vaccinated by the end of October, if they have not already been vaccinated, to ensure they are protected before flu begins to spread in their community.

4) The federal Agency for Healthcare Research and Quality (AHRQ) reports on:

- **Long Term Care Facilities Invited to Join Free Antibiotic Stewardship Program.** Register now to attend a one-hour webinar that explains how long term care facilities can 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 prevent harms associated with antibiotics, such as *Clostridium difficile*. Participants also have the opportunity to earn continuing education credits. Learn more about the project by registering for one of three upcoming webinars: Oct. 30, 12:30 p.m. ET; Nov. 1, 10:30 a.m. ET; or Nov. 7, 3:30 p.m. ET. Contact antibioticsafety@norc.org for questions.

- **New AHRQ Views Blog Post – A Fresh Look at the Data Shows Patient Safety Improving Overall, With Improvement Still Needed in Many Areas.** Jeffrey Brady, M.D., M.P.H., director of AHRQ’s Center for Quality Improvement and Patient Safety and Karen Chaves, M.H.S, Director of AHRQ’s National Healthcare Quality and Disparities Report Program, highlight data in the newly released Chartbook on Patient Safety. The Chartbook, based on AHRQ’s recently released National Healthcare Quality and Disparities Report, shows that the nation’s efforts to improve the safety of health care resulted in some encouraging overall gains between 2000 and 2016. However, there is much room for improvement, particularly for people of color and people in poor households. The Chartbook findings also identify ongoing safety concerns. Quantifying these challenges provides essential information to inform future quality improvement efforts. Access the blog post.

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

- HFS posted an updated **Podiatry Fee Schedule.** You may view the updated fee schedule here.

- HFS posted a new provider notice regarding **Notice of Informational Webinars on Provisional Eligibility – Follow Up Issues.** You may view the notice here.

- HFS posted a new provider notice regarding **Posting of Admission Transaction Audit Numbers (TANs) and Status Codes.** You may view the notice here.

- HFS posted a new provider notice regarding **Approved and Authorized Representative Forms.** You may view the notice here.
• HFS issued the **Provider Handbook Supplement** that will replace Provider Handbook appendix documents from 21 different Provider Handbooks, eliminating much duplication. As the Provider Handbooks are re-issued, the individual handbook appendices will be eliminated and providers will be directed to the Handbook Supplement.

• HFS posted a new provider notice regarding **Hepatitis C Direct Acting Antiviral Criteria Update.** You may view the notice [here](#).

6) The **Illinois Department of Public Health (IDPH)** has one remaining **Town Hall Meeting** scheduled 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 final date and location is:

• November 14, 2018 – Oak Trace in Downers Grove 1-3pm

7) The **Illinois Health Care Association (IHCA)** and the **American Health Care Association (AHCA)** report on:

• **Abuse/Neglect Citations.** AHCA received questions from a few different states related to comments from state agency staff that all cases of abuse will result in a deficiency citation and all resident-to-resident incidents will be cited as abuse. We have discussed this with CMS and will continue to do so.

CMS has affirmed that there are no automatic citations. Whether an incident is self-reported by the facility or comes to light through a complaint or standard survey, surveyors always have to investigate and make determinations based on the findings of each situation. In order to cite F600 for abuse, surveyors must determine based on the evidence collected whether the incident meets the regulatory definition of abuse. We expect the principle of "no automatic citations" to be reinforced in the revisions to Appendix Q when released; however, CMS stated they will continue to remind surveyors of this principle. Should you receive any further communications from state agencies about automatic citations of abuse or neglect, or citations of abuse and neglect that clearly do not meet the regulatory definitions, please share that information and any documentation with us.

The Interpretive Guidelines for F600 state, "if the survey team has investigated and collected evidence that abuse has occurred, it is appropriate for the survey team to cite the current or past noncompliance at F600-Free from Abuse and Neglect." According to these guidelines, it is appropriate to cite abuse or neglect if there is evidence it has occurred, even if the facility properly assessed residents and risks, reported appropriately, developed and implemented policies and procedures to prohibit abuse and trained staff as required.

AHCA has strongly argued in the past and will continue to argue against this "strict liability" approach. A big challenge to the success of this argument is that ALJs have made decisions both supporting and opposing "strict liability." Despite this, we will continue to oppose strict liability and attempt to achieve a more reasonable perspective from CMS on this issue.

Note that the guidelines at F600 also state that if the noncompliance has occurred in the past, but the facility corrects the deficiency and is in substantial compliance by the time of the current survey, the deficiency should be cited as past non-compliance.

CMS has indicated it is working on some revisions to the guidelines for F609 to better clarify the types of incidents that must be reported as allegations of abuse or neglect-for example, when an argument between two residents meets the definition of an alleged violation and when it does not. Although these revisions will not change the regulatory definitions of abuse and neglect, clarifying the parameters of what types of incidents fall in the realm of potential abuse and neglect for reporting purposes may help in some measure with interpretations of F600 as well.
8) **Telligen** reports:

- The latest **Telligen** report can be found [here](#).

9) The **National Consensus Project for Quality Palliative Care** recently issued **New Clinical Practice Guidelines for Quality Palliative Care**. New guidelines are calling for a “seismic” shift in treatment for serious illnesses, with long term care and other providers taking on a bigger role. The National Consensus Project for Quality Palliative Care, which issued the [new guidelines](#), says they are endorsed by more than 80 national organizations. They include tools, resources and practice examples that skilled nursing facilities can use to bolster the delivery of care. NCP experts noted that, given the limited availability of palliative care specialists to pitch in at nursing homes, providers must become experts themselves to ensure that all residents receive the relief from physical and mental stress that can come with serious illness.

10) **Today’s Geriatric Medicine** reports on **Malnutrition in the Older Adult**. Malnutrition prevalence in the older adult is well recognized, and awareness of the condition continues to grow. Despite increased awareness, malnutrition remains a significant issue for older adults across the care continuum and also in the community. Malnutrition is a leading cause of morbidity and mortality in the older adult. Health care–acquired infections, pressure injuries, falls, worsening lung and heart function, longer hospital stays and higher overall mortality are known to occur more frequently in malnourished individuals. Preventing or minimizing malnutrition is of key importance to the older adult and must not be overlooked. Malnutrition, to any degree, can affect older adults’ independent living and their aging process, and can worsen the severity of their chronic conditions and disabilities.

11) **News Medical** reports that **Many Primary Care Doctors are Still Prescribing Sedative Drugs for Older Adults**. Despite years of warnings that older adults shouldn’t take sedative drugs that put them at risk of injury and death, a new study reveals how many primary care doctors are still prescribing them, how often and exactly where. Mapped out county by county, the study shows wide variation in prescriptions of the drugs, called benzodiazepines. Some counties, especially in the deep south and rural western states, had three times the level of sedative prescribing as others. The study also highlights gaps at the level of individual prescribers; some primary care providers prescribed sedatives more than six times more often than their peers. These high-intensity prescribers of drugs such as Xanax, Ativan and Valium also tended to be high-intensity prescribers of opioid painkillers.

12) **Becker's Hospital Review** reports on **Trump Administration's New Insurance Guidelines for States, Employers: 10 Things to Know**. The Trump administration issued new guidelines and proposals aimed at giving states and employers more flexibility to waive ACA regulations.

13) **Modern Healthcare** reports that CMS Nursing Home Compare Lacks Metrics Accurately Reflecting Patient Safety Measures. **ModernHealthcare** reported that according to a new analysis published in *Health Affairs*, patient safety measures are not “weighted strongly enough to sway the star ratings nursing homes receive on CMS' Nursing Home Compare website.” Researchers determined the six measures considered by CMS "don't have a strong influence on the overall rating a nursing home is assigned," but "did find the nursing homes categorized as the worst and best – or those with one or five stars – had a stronger correlation with patient safety." Dr. David Gifford, Vice President of Quality and Regulatory Affairs at the AHCA, "said he agrees that Nursing Home Compare ‘needs to provide information in a format that allows consumers to prioritize what information is more important to them.’" Regarding the resource’s limitations, Gifford said the "rating system should not be used as the sole judge of a center’s quality."

14) **Skilled Nursing News** reports on:

- **Initial Assessment Key to PDPM Success**. Of all the changes coming to the skilled nursing industry when a new payment model takes effect next fall, the most pressing may be one of the most basic: starting in October 2019, providers will have a single opportunity to set themselves up for financial success with a patient’s initial assessment. The Patient-Driven Payment Model, set to take effect in October 2019, will shift payment incentives away from billable therapy hours and toward general treatment of the patients’ overall health issues, with CMS specifically citing a desire to reduce the possibility of fraud among providers. Under the new system, all reimbursements will be based on a patient’s initial assessment for the duration of his or her stay in a skilled
nursing facility, with further revisions not having a significant impact in the amount of money that a provider can capture for the course of the episode.

- **OHCA EVP Shares Recommendations on Succeeding Under New RoP Rules.** [Skilled Nursing News](https://www.skillednursingnews.com) reports that during the American Health Care Association’s annual conference and expo in San Diego, California, Gwen Dayton, Executive Vice President and General Counsel at the Oregon Health Care Association, discussed how providers should approach the new Requirements of Participation, "repeatedly [emphasizing] the importance of the facility assessment." Dayton said, "This assessment is at the hub of so many other compliance efforts. ... If you don’t get the facility assessment done right, you’re going to be subject to other tags and other enforcement problems." Dayton recommended providers "routinely update their facility assessments every time there’s a triggering event that substantially changes the kind of care that an individual skilled nursing facility providers" among other suggestions, the piece says.

15) **McKnight’s** reports on:

- **Cap On Immigrant Visas Would Hurt Nursing Homes, Provider Group Says.** According to [McKnight’s Long Term Care News](https://www.mcknights.com), the American Hospital Association and LeadingAge are voicing opposition to "an amendment included in the Department of Homeland Security’s appropriations bill" which "would limit the per-county cap for immigrant visas." Health care leaders worry the change would worsen staffing shortages. The amendment’s provisions include "rigid standards of equivalent education, English fluency and state licensure" for immigrants.

- **Proper Wound Documentation Saves Lives, Prevents Added Injury, Costs.** David Navazio, Chief Operating Officer and Founder of advanced wound care products and services provider Gentell, writes for [McKnight’s Long Term Care News](https://www.mcknights.com) to discuss the cost of "poor documentation" in health care settings, saying a recent survey of "wound care professionals who work in nursing homes" found that "almost half reported observing wound documentation that was inaccurate and led to adverse patient outcomes including sepsis, gangrene, prolonged pain, transfer to ICU, amputations and even death." Navazio adds that costs and risks will increase as even "greater demands on nurses" have emphasized "the need for more thorough wound documentation." He adds that appropriately tracking wounds can speed the healing process, "reduce pain and suffering, and demonstrate to families, insurance companies, and courts that facilities have provided a diligent and attentive course of wound care."

- **Specialized Dementia Units In Nursing Homes Outperform Others, Data Suggest.** [McKnight’s Long Term Care News](https://www.mcknights.com) reports an analysis of claims data from nursing homes published by Harvard Medical School researchers suggest that "admission into a dementia special care unit (SCU) brought measurable drops on several quality indicators." These "included reductions in inappropriate use of antipsychotics, physical restraints, pressure ulcers, feeding tubes and hospitalizations." Researchers wrote that the facilities with SCUs "provide better quality of care as measured by several validated quality indicators."

- **C. Diff Sticks Around on Bedsheets, Even After Washing.** The potentially life-threatening bacteria *Clostridium difficile* can cling to hospital bedsheets even after a thorough washing. That’s according to a new [study](https://www.jiceonline.com) by British researchers, published in the journal of [Infection Control and Hospital Epidemiology](https://www.journals.lww.com). Investigators believe their findings may provide insight into why flare-ups of the bacteria can occur out of the blue. “The findings of this study may explain some sporadic outbreaks of *C. difficile* infections in hospitals from unknown sources,” Katie Laird, Ph.D., lead author of the study and head of the Infectious Disease Research Group, School of Pharmacy, De Montfort University, Leicester, United Kingdom, said in a [press release](https://www.mcknights.com). “However, further research is required in order to establish the true burden of hospital bedsheets in such outbreaks.” Researchers reached their conclusions by washing *C. diff*-contaminated cotton sheets at high temperatures using industrial detergent. They found that traces of the bacteria lingered afterward. Plus, traces of the disease were also transferred to uncontaminated sheets. Laird said that future research will explore ways to better remove contaminants from linens in the cleaning process.
• **Upcoming HIPAA Audits to Use Harsher Investigative Tools.** Providers need to start tightening the screws on their privacy and security programs because scrutiny is about to get a little harsher. Typically, the Health and Human Services Office for Civil Rights has conducted audits as a way to educate providers. But now, the agency says it will begin focusing more on enforcement, using harsher investigative tools to “hold bad actors accountable,” Bloomberg reports, citing OCR Director Roger Severino. Tools could include everything from subpoenas to legal action, being forced to pay victims, having to put corrective plans in place and even statutory penalties, the report says. OCR in general has been toughening its enforcement actions the last three years, forcing providers to better prepare themselves. “You want to be able to demonstrate that you’re taking privacy and security seriously and that your HIPAA compliance plan is being used and not just sitting on the shelf,” Deborah Gersh, an attorney with Ropes & Gray in Chicago, told Bloomberg. Penalties for violating the Health Insurance Portability and Accountability Act can range from $100 to $50,000. The OCR receives about 20,000 complaints of violations each year. In one example of the tone being set by the agency, insurer Aetna recently agreed to pay a $17 million settlement following a data breach in 2017. Experts urge providers to perform a risk analysis and study the [OCR’s audit protocols](https://www.hhs.gov/privacy) to help prepare for future reviews by the agency.

• **CMS Releases Physician Fee Schedule, But Leaves Out Skilled Nursing Field From Merit-Based Incentive Payment System.** *McKnight’s Long Term Care News* reports that “the Centers for Medicare & Medicaid Services released its Physician Fee Schedule,” which indicates that “the skilled nursing field will not be a part of the Merit-Based Incentive Payment system... leaving some advocates perplexed.” Cynthia Morton, Executive Vice President of the National Association for the Support of Long Term Care, said she was dismayed that nursing homes were not included in the incentive program. Their omission "makes no sense" and would prevent the field from getting a Part B payment update ever year, she said. For its part, "An official with the American Health Care Association expressed similar concerns tied to MIPS back in July, but did not have a comment on the final rule as of late Friday."

16) **Interesting Fact:** World War I formally ended on November 11th, at the 11th hour. It is also the 11th month. Originally, when known as Armistice Day, it was meant to honor those who died in World War I, but when it was amended in the early 1940s, it was changed to honor all the veterans who have served in the U.S. military.

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

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