December 5, 2018 Edition

This will be the last issue of Regulatory Beat for this year. We will return in early January of 2019.
Have a safe and happy holiday season!!

Feature Focus

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

The Evolving Role of MDS as PDPM Approaches

The Minimum Data Set (MDS) has been a driving force in many areas of the long term care sector of health care for nearly 30 years. Beginning as an assessment tool to drive the care plan process, and evolving into a tool that is now used for reimbursement and for the quality measures/survey processes, the MDS is scrutinized from a multitude of outside agencies for its accuracy.

Amazingly, providers continue to lack multidisciplinary understanding of this vital process. Often the MDS Coordinator is the only person on staff who knows the scheduling and payment guidelines. Many administrators, directors of nursing and even consultants are unaware of the coding rules and what portions drive the Quality Measures. It’s widely noted that a change of staff in the MDS nurse can cause large monetary shifts in reimbursement and also in favorable QMs.

The MDS Coordinator position is as specialized a position as one can have without additional formal training in the LTC industry. There are rules for Medicare, Managed Care, Case Mix, Quality Measures and OBRA/Care Planning that all have to be followed and coordinated. There is an exception to almost every rule and that exception may only apply in one strange instance that only happens every once in a while. There are more than seven different manuals [RAI Manual, Quality Measures Manual, Medicare Benefit Manual, Managed Medicare Benefit Manual, SNF QRP Manual, SNF VBP Manual, Five-Star Manual] for MDS Nurses to adhere to for instructions, interpretations and rules outside of the volumes of general LTC regulations. Some states have Case Mix rules in addition to all of those!

It often takes over six months of training for an MDS nurse to become “independent” in performing their job. It takes over a year for them to comprehend the myriad intertwined rules. Mistakes often occur during this time period that cause negative survey outcomes and/or lessened payment reimbursement. This increases stress and resulting in additional staff turnover more often than not.

Next year, with the implementation of the Patient Driven Payment Model (PDPM) there should be some relief of the MDS workload, yet it will likely be the next evolution of the MDS coordinator role. With payment shifting from therapy focus to clinical acuity focus, where will the documentation and assessment come from to ensure providers continue to be paid at optimal rates?
Providers will need hands-on assessments and detailed documentation to support the medical condition changes that drive reimbursement payment and provide the skilled level of care. Changes of condition and lack of progress towards planned goals will require immediate identification to ensure an interim assessment or significant change is properly identified and documented to continue accurate payment. Many providers will fail to capture these critical assessments and documentation if understaffed direct care nurses are expected to be the sole method by which the assessments and documentation are completed. There is already widespread noncompliance with the current assessments that have been developed as “check the box” forms because of the increased workloads due to higher acuity patients and decreased availability of licensed nurses to employ.

In several social media settings, there is a trending dissatisfaction from MDS nurses because of the high stress from heavy workloads and additional nurse manager duties such as on-call and floor rotations. But the biggest problem is feeling undervalued and under-appreciated by direct supervisors who don’t understand the MDS position themselves. With the shortage we have in licensed nurse staffing nationwide and the ever-shifting rules and workload, experienced MDS nurses are becoming a rare commodity. We cannot afford to squander their talents.

What investment should be made in this position? What support should be given to MDS nurses? If the MDS coordinator is suddenly off work due to medical illness, an emergency, LOA, vacation or (heaven forbid) resignation, what is the backup plan?

Here are some tips to help find ways to reinstate MDS into the clinical team while still preserving the integrity of the MDS position:

1. **On-Call:** If the MDS nurse must be in an on-call rotation, attempt to reduce frequency whenever possible. Always try to prevent on-call assignments during the last week and/or the first week of the month due to the MDS billing process.

2. **Cross Train:** Develop a program to cross train other nurse managers in MDS duties. Possibly divide some of the MDS areas per nurse manager in order to have a backup for scheduling, MDS completion and Care Plan completion (at a minimum). This can help relieve stress from the MDS Nurse who may feel unable to take time off or be away from the building.

3. **QM Programs:** Pick an item per week or per month for the interdisciplinary team to learn about so QMs can be managed proactively. Identifying potential negative triggers during daily clinical reviews will often assist in the prevention of having to capture them on an MDS.

4. **MDS Appreciation:** Recognize the little things every day that add up to the big things! Give kudos for being on top of the schedule, for meeting or exceeding budgets, for catching clinical concerns before negative outcomes occur. [There is a Nurse Assessment Coordinator Day — Make sure to celebrate it!]

5. **Open Communication:** With the changes in the Medicare payment system with PDPM, there is a lot of angst about how providers will implement it and be able to provide staff for the changes. Discuss plans with the IDT and ask for ideas from the MDS nurses. They are the experts today and they will have some great ideas for how to tackle this as a team.

6. **Training:** This is an investment in the MDS nurses and in the entire facility team! Ensure that the training source is vetted so as not to pay for information before the rules are finalized, but have a plan to start training as soon as possible! Start with ICD-10 coding, clinical assessments skills and areas that aren’t based off of the RAI Guidelines or payment rules that are not yet published.

7. **Outside Support:** There are many resources for MDS support from outside agencies. Corporate consultants, consulting firms (private sector and government funded, and Quality Improvement Organizations), associations, certification programs and social media support groups. Find support for the MDS Nurses and the IDT team to ensure compliance and maximization of facility reimbursement.

8. **Encourage Personal Time:** Minimize offsite work from the MDS Nurses. Many feel overwhelmed by their workload and take work home (including care plans, remote MDS completion, etc.). This not only increases the risk for inaccuracies in the medical record and the potential for HR conflicts, it takes away from much needed personal/family time and then often adds to stress and resentment in the work place. Even if the MDS Nurse “volunteers,” discourage offsite work whenever possible in order to foster personal relaxation.
9. **Team Building:** This is probably one of the most important items! Often due to a heavy workload and a lack of understanding of the position, the MDS Nurse becomes an outsider to the nursing team. MDS nurses are not antisocial desk nurses (or at least they shouldn’t be!!). Schedule team building events on a regular basis to encourage interdisciplinary relationships.

10. **Monitor Workload:** Keep an eye on census patterns and overall duties assigned to your MDS Nurse(s). Often census has a rapid rise and fall and while that puts a crunch on everyone, the MDS schedules lag from a few days up to two weeks and then don’t always match up. The reduction of hours for MDS to complete assessments may result in noncompliance and reimbursement issues. Additionally, if there is a large increase in MDS workload, look at duties that might be temporarily reassigned, such as dining room duty, room rounds, etc. These “extra” duties can take away precious MDS time.

This year’s PDPM implementation will be as significant to MDS Coordinators as OBRA 1988 and MDS 3.0 2010!! Invest in your future by learning and supporting the RAI Process and MDS role. Make it one of your Top 10 “To Dos”!

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**Medication Storage and Labeling (Part 7 in the Series – Mandatory LTC Survey Pathways)**

**Medication Storage and Labeling:** The survey team will review half of the med storage rooms, covering different units and review half of the med carts on units where the storage room was not observed. Surveyors, other than the one assigned coordination of the Medication Storage task, who are reviewing medication storage areas, need only answer the CE question if there are “No” responses to observations.

- Medications and biologicals in medication rooms, carts, boxes and refrigerators were maintained within:
  - Secured (locked) locations, accessible only to designated staff;
  - Clean and sanitary conditions; and
  - Maintain temperatures in accordance with manufacturer specifications and monitor according to national guidelines (e.g., see CDC vaccine storage and handling).
- Schedule II controlled medications (excluding single-unit packaging in minimal quantities that can readily be detected if missing) were maintained within a separately locked permanently affixed compartment.
- Sufficiently detailed records of receipt and disposition of controlled medications were maintained to enable an accurate reconciliation.
- All medication records were in order and an account of all controlled medications was maintained and periodically reconciled.
- Medications and biologicals were labeled in accordance with currently accepted professional principles, and include:
  - Appropriate accessory and cautionary instructions; and
  - Expiration date, when applicable.
- Multi-dose vials to be used for more than one resident are kept in a centralized medication area and do not enter the immediate resident treatment area (e.g., resident room). If multi-dose vials enter the immediate resident treatment area they should be dedicated for single-resident use only.
- Multi-dose vials that have been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.
- Multi-dose vials that have not been opened or accessed (e.g., needle-punctured) should be discarded according to the manufacturer’s expiration date.
- Insulin pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person, even when the needle is changed; insulin pens must be clearly labeled with the resident’s name and other identifier(s) to verify that the correct pen is used on the correct resident; insulin pens should be stored in a sanitary manner to prevent cross-contamination.
Disposal methods for controlled medications involve a secure and safe method to prevent diversion and/or accidental exposure.

Surveyors will review the following tags with respect to Medication Storage and Labeling:
- Unit or area where the medication storage task was conducted ______:
- Did the facility provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident? (F755).
- Are all medications and biologicals stored and labeled properly (medication rooms, carts, boxes, refrigerators)? (F755 and/or F761).
- Does the facility have a system to account for the receipt, usage, disposition and reconciliation of all controlled medications? (F755).

Other Tags and Care Areas to consider: Misappropriation of Resident Property/Exploitation Related to Drug Diversion (F602), Infection Prevention and Control (F880)

**Focus F-Tag – F559 Choose/Be Notified of Room/Roommate Change**

This *Regulatory Beat’s* Focus F-tag is **F559 Choose/Be Notified of Room/Roommate Change**. That uncomfortable feeling of having someone you don’t know – or necessarily like – move in with you isn’t reserved just for all the students who have been heading off to college the past few weeks. Residents in a nursing home have several rights related to their room and roommates that providers need to be aware of.

The regulation requires that residents’ preferences should be considered when making a room or roommate change. This is a practice that requires some skill by the responsible staff to match roommates who will be able to cohabitate with minimal issues. Remember, many of your residents lived either with a spouse or alone before coming to your facility, and now we are putting them in a room with a stranger when they arrive at the facility. In an ideal scenario, the two residents get along just fine, but what about situations where one resident stays up all night and wants the TV on and the other is a light sleeper? These types of things need to be considered when we are making room and roommate selections; hopefully we can avoid constant room changes.

It’s also important to note that the regulation requires if a resident is moving at the request of facility staff, written explanation of why the move is necessary needs to be provided to both residents/families/representatives, as one is getting a room change and the other is getting a new roommate. The resident should be given a tour of the new location, have a chance to meet his/her new roommate and express any concerns about the move. Don’t forget that residents who are going to be getting a new room or roommate should be given as much notice as possible. Our responsibility is to facilitate smooth transitions for the residents.

We can get the easy part of the regulation right when a husband and wife wish to share a room and live together. Are we equally as good when there is a request from two residents who want to share a room and consent to the arrangement, but happen to be of opposite sexes? Lastly, it would not hurt to look at your system related to written notification to ensure that you are compliant with F559.

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**Trending Statistics**

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

**United States Census Bureau – A Snapshot of the Fast-Growing U.S. Older Population**

The growth of the U.S. population age 65 and older exceeds that of the total population and the population under age 65.
Lower birth rates and increased longevity have led to this rapid growth not just in the United States but across the world.

So what does it mean to be a part of this increasingly larger segment of American society?

Use this interactive data visualization (click here) to see variations in the characteristics of the older U.S. population among the states.

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

1) The following Federal [CMS Quality, Safety and Oversight Letter](https://www.cms.gov) (formerly known as Survey and Certification (S&C) Letters) was released since the last issue of Regulatory Beat:

- **QSO 19-02 – NH** - Payroll Based Journal (PBJ) Policy Manual Updates, Notification to States and New Minimum Data Set (MDS) Census Reports. Notification to States – CMS will provide CMS Regional Offices (ROs) and State Survey Agencies with a list of facilities with potential staffing issues to support survey activities for evaluating sufficient staffing and improving resident health and safety. Updates in the PBJ Policy Manual and Frequently Asked Questions (FAQs) – We are expanding the guidance on the meal breaks policy to ensure consistency. In addition, we are adding guidance regarding reporting hours for “Universal Care Workers.” Additional Technical Support for Facilities – New MDS-based census reports in the Certification and Survey Provider Enhanced Reporting (CASPER) system.

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

- **NF PPS: New Patient Driven Payment Model Webpage**. On October 1, 2019, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). Visit the new PDPM webpage to prepare for this change:
  - FAQs
  - Fact sheets
  - Presentation
  - Implementation tools

- **CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing**. CMS announced actions that will bolster nursing home oversight and improve transparency in order to ensure that facilities are staffed adequately to provide high-quality care. These actions include sharing data with states when potential issues arise regarding staffing levels and the availability of onsite registered nurses; clarifying how facilities should report hours and deduct time for staff meal breaks; and providing facilities with new tools to help ensure their resident census is accurate.

  “CMS takes very seriously our responsibility to protect the safety and quality of care for our beneficiaries,” said CMS Administrator Seema Verma. “Today CMS is taking important steps to protect nursing home residents based on potential risks revealed by new payroll-based staffing data that our Administration released. We’re deeply concerned about potential inadequacies in staffing, such as low weekend staffing levels or times when registered nurses are not onsite, and the impact that this can have on patient care. The actions announced today strengthen our oversight of resident health and safety, and help ensure accurate public reporting.”

- **Hospice Item Set Manual: New Version**. The [Hospice Item Set (HIS) Manual V2.01](https://www.cms.gov) is updated with refined guidance to clarify HIS coding instructions. Note: No updates were made to HIS items. Visit the HIS webpage for more information.
• **Hospice Comprehensive Assessment Quality Measure Fact Sheet.** A fact sheet on the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235) is now available. Learn about this measure:
  - Background
  - Calculations
  - How to use Quality Measure reports to understand your performance

Visit the [Current Measures](#) webpage for more information.

• **Provider Enrollment Application Fee Amount for CY 2019.** On November 16, CMS issued a notice: Provider Enrollment Application Fee Amount for CY 2019. Effective January 1, 2019, the CY 2019 application fee is $586 for institutional providers that are:
  - Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
  - Revalidating their Medicare, Medicaid, or CHIP enrollment
  - Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2019.

• **Recommend Influenza Vaccination: Each Office Visit is an Opportunity.** People 65 years and older are at greater risk for serious influenza-related complications. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. Your strong vaccine recommendation is a critical factor that affects whether your patients get an influenza vaccine. Take time to recommend and vaccinate your patients, your staff and yourself.

Medicare Part B covers the influenza virus vaccine once per influenza season. Medicare covers additional influenza vaccines if medically necessary.

You may also want to recommend the [pneumococcal vaccine](#) during the same visit. Medicare covers:
  - An initial pneumococcal vaccine for Medicare beneficiaries who never received the vaccine under Medicare Part B
  - A different, second pneumococcal vaccine 1 year after the first vaccine was administered

For More Information:
  - [Preventive Services](#) Educational Tool
  - [Influenza Resources for Health Care Professionals](#) MLN Matters® Article
  - [Influenza Vaccine Payment Allowances](#) MLN Matters Article
  - [CDC Influenza](#) website
  - [CDC Information for Health Professionals](#) webpage
  - [CDC Tools to Prepare Your Practice for Flu Season](#) webpage
  - [CDC Make a Strong Flu Vaccine Recommendation](#) webpage

• **CMS Takes Action to Lower Prescription Drug Costs by Modernizing Medicare.** On November 26, CMS published a proposed rule for Medicare Parts C and D that would strengthen negotiations with prescription drug manufacturers to lower costs and increase transparency for patients. The proposed policies for 2020 would ensure that Medicare Advantage and Part D plans have more tools to negotiate lower drug prices, and CMS is also considering a policy that would require pharmacy rebates to be passed on to seniors to lower their drug costs at the pharmacy counter. Comment on these proposals and other policies under consideration by January 25. For More Information:
  - [Proposed Rule](#)
  - [Press Release](#)
  - [Fact Sheet](#)
- **Nursing Homes: Efforts to Improve Patient Safety, Quality of Care.** On November 20, CMS announced upcoming efforts to support better care and outcomes for nursing home residents under the Civil Money Penalty Reinvestment Program (CMPRP). This three-year initiative aims to improve residents’ quality of life by equipping nursing home staff, administrators and stakeholders with technical tools and assistance to enhance resident care.

As part of the CMPRP, we will develop a variety of work products for nursing home professionals, such as staff competency assessment tools, instructional guides, training webinars and technical assistance seminars. These supports aim to help staff reduce adverse events, improve dementia care and strengthen staffing quality, including by reducing staff turnover and enhancing performance.

We released our first toolkit in the CMPRP series, the Nursing Home Staff Competency Assessment and supporting materials; see the Downloads section of the CMPRP webpage. The competency assessment is designed to help nursing home frontline and management staff evaluate their skills. It includes several questions to gauge staff knowledge about behavioral, technical, and resident-based capabilities.

See the full text of this excerpted CMS Press Release (issued November 20), which describes our other initiatives to strengthen safety and health outcomes for nursing home residents.

- **Improved eCQI Resource Center Website.** Visit the updated and redesigned Electronic Clinical Quality Improvement (eCQI) Resource Center website. The eCQI Resource Center is a one-stop shop for federal eCQI initiatives that includes the most current electronic clinical quality measure (eCQM) specifications, as well as links to the tools, standards, education, and materials critical to support development, testing, implementation and reporting of eCQMs. Send suggestions for improvement, news, events and content to ecqi-resource-center@hhs.gov.

- **Hospital-Based Incident Command Systems: Real Experiences and Practical Applications.** A presentation and recording are available from the November 14 Hospital-Based Incident Command Systems: Real Experiences and Practical Applications webinar hosted by the HHS Office of the Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange. Learn from large health care organizations that recently experienced an emergency.

- **HHS Issues Draft Strategy to Reduce Health IT Burden.** The U.S. Department of Health and Human Services (HHS) issued a draft strategy designed to help reduce administrative and regulatory burden on clinicians caused by the use of health information technology (health IT) such as electronic health records (EHRs).

The draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs was led by the HHS Office of the National Coordinator for Health Information Technology (ONC), in partnership with CMS, and was required in the 21st Century Cures Act. The draft strategy reflects the input and feedback received by ONC and CMS from stakeholders, including clinicians, expressing concerns that EHR burden negatively affects the end user and ultimately the care delivery experience. This draft strategy includes recommendations that will allow physicians and other clinicians to provide effective care to their patients with a renewed sense of satisfaction for them and their patients.

- **CMS Nursing Home Staff Competency Assessment Toolkit Available (click here).** The Civil Money Penalty Reinvestment Program (CMRP) competency assessment poses questions about behavioral, technical and resident-based competencies. Use the assessment to identify areas where your nursing home is doing well, versus where your facility might need support. Toolkit 1 includes:
  - Competency assessments
  - Instruction Manual with resources
  - Answer Sheets
Once you know where you need support, CMPRP can provide funding, technical assistance and learning opportunities to help address some of your facility’s toughest challenges. Visit the CMPRP webpage for more information. Toolkit 1 is available in the Downloads section.

- **Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder.**
  In a recent report, the Office of the Inspector General (OIG) determined that Medicare inappropriately paid acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities, including long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and critical access hospitals. As a result, beneficiaries were unnecessarily charged outpatient deductibles and coinsurance payments. All items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. Use the following resources to bill correctly:
    - Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided To Beneficiaries Who Were Inpatients of Other Facilities. OIG Report, September 2017.
    - MLN Matters® Special Edition Article
    - Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet
    - Acute Care Hospital Inpatient Prospective Payment System Fact Sheet: See payment information on page 3
    - Items and Services Not Covered Under Medicare Booklet, Page 12
    - Medicare Claims Processing Manual, Chapter 3, Section 10.4

- **SNF PPS: New Patient Driven Payment Model Call — Tuesday, December 11 from 1:30 to 3 pm ET.** Register for Medicare Learning Network events. On October 1, 2019, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). Topics:
    - Overview of PDPM, a new case-mix classification system for SNF Part A beneficiaries
    - Changeover from RUG-IV to PDPM

For more information, review the FY 2019 SNF PPS final rule, and visit the PDPM webpage. A question and answer session follows the presentation; however, attendees may email questions in advance to PDPM@cms.hhs.gov with “December 11 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

- **“Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines” Webinar December 13 – Registration Open.** CMS will host our next training event on December 13, 2018, 1-2:30 PM Eastern Time. This will be a two-part webinar covering two different topics. The webinar is entitled “Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines.” During Part One of the training, we will focus on the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235), including the background of this measure, how this measure is calculated and how providers can use their Certification And Survey Provider Enhanced Reporting Quality Measure Reports (CASPER QM Reports) to understand their hospice’s performance on this measure. During Part Two of the training, we will be reviewing the 4.5 Month Data Correction Deadline for Public Reporting policy update that was finalized in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (83 FR 38622, see pages 38638-38640), including explaining how this new policy change will be implemented and the implications of this new policy. It is recommended that providers familiarize themselves with the Hospice Comprehensive Assessment Measure and the new 4.5 Month Data Correction Deadline for Public Reporting prior to the training by reviewing the following two Fact Sheets currently available on the HQRP Web site:
    - 4.5 Month Data Correction Deadline for Public Reporting – available on the Hospice Quality Reporting Program (HQRp) Public Reporting: Key Dates for Providers page.
    - Hospice Comprehensive Assessment QM Background Methodology Fact Sheet – available on the HQRP Current Measures page.
    - For more information, please refer to the Spotlight & Announcements page.
Registration link: https://engage.vevent.com/index.jsp?eid=3536&seid=1296

- **LTCH Provider Preview Reports – Now Available.** Long-term Care Hospital (LTCH) Provider Preview Reports have been updated and are now available. The data contained within the Preview Reports is based on quality data submitted by LTCHs between Quarter 2 – 2017 and Quarter 1 – 2018, and reflects what will be published on LTCH Compare during the March 2019 refresh of the website. Providers have until January 2, 2019 to review their performance data. Corrections to the underlying data will not be permitted during this time; however, providers can request CMS review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate. For more information:
  - LTCH Quality Public Reporting webpage, LTCH Compare and Preview Report Access Instructions

- **Medicare Diabetes Prevention Program: Valid Claims.** For a claim to be valid under the Medicare Diabetes Prevention Program (MDPP), you must have both:
  - Centers for Disease Control and Prevention (CDC) preliminary or full recognition; see the Supplier Fact Sheet and CDC website for more information
  - Separate Medicare enrollment as an MDPP supplier (Specialty D1); see the Enrollment Fact Sheet and Checklist

Important: If you do not have a separate Medicare enrollment as a MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

Medicare enrolled MDPP suppliers: See the Quick Reference Guide to Payment and Billing and the Billing and Claims Fact Sheet for information on valid claims:
  - Submit claims when a performance goal is met, and report codes only once per eligible beneficiary (except G9890 and G9891)
  - List each HCPCS code with the corresponding session date of service and the coach’s National Provider Identifier
  - List all HCPCS codes associated with a performance payment (including non-payable codes) on the same claim
  - Include Demo code 82 in block 19 to identify MDPP services
  - Do not include codes for other, non-MDPP services

For More Information:
  - MDPP Expanded Model
  - MDPP webpage

- **Hospice Compare Quarterly Refresh Available.** The December 2018 quarterly Hospice Compare refresh of quality data is now available. It is based on Hospice Item Set (HIS) quality measure results from data collected Q1 2017 – Q4 2017 and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® results reported Q1 2016 – Q4 2017. We invite you to visit Hospice Compare to view the data. In addition to the Hospice QRP measures that are currently displayed on Hospice Compare, the following new quality measures will be displayed with data collected Q2 2017 – Q4 2017:
  - Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235)

For more information, view the CMS Hospice Quality Public Reporting webpage to view the new Hospice Comprehensive Assessment Measure Fact Sheet and External Questions and Answers Documents, which are available under the Downloads section of the webpage.

Please visit the Hospice Compare website to view the new and updated quality data.
• **Home Health Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the November 13 call on the Home Health Services: Review Choice Demonstration. Find out about the new demonstration that will begin in Illinois.

• **Medicare Basics: Commonly Used Acronyms Educational Tool — Revised.** A revised Medicare Basics: Commonly Used Acronyms Educational Tool is available. Learn about:
  o Acronyms frequently used in Medicare publications
  o Webpage references for certain acronyms
  o Creating a personalized list of the acronyms you use

• **ESRD PPS: CY 2019 Payment for Dialysis Furnished for AKI MLN Matters Article — New.** A new MLN Matters Article MM11021 on Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019 is available. Learn about rate updates, payment updates, and changes to Chapter 11, Section 60 of the Medicare Benefit Policy Manual.

• **Home Health Rural Add-on Payments MLN Matters Article — New.** A new MLN Matters Article MM10782 on Home Health Rural Add-on Payments Based on County of Residence is available. Learn about changes to add-on payments.

• **HH PPS Rate: CY 2019 Update MLN Matters Article — New.** A new MLN Matters Article MM10992 on Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019 is available. Learn about changes to outlier payments.

• **IVIG Demonstration: 2019 Payment Update MLN Matters Article — New.** A new MLN Matters Article MM10896 on Intra venous Immune Globulin (IVIG) Demonstration: Payment Update for 2019 is available. Learn about payment rate changes for demonstration services.

• **RARC, CARC, MREP and PC Print Update MLN Matters Article — New.** A new MLN Matters Article MM11038 on Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update is available. Learn about code list changes and software updates.

• **Uniform Use of CARC, RARC, and CAGC Rule Update MLN Matters Article — New.** A new MLN Matters Article MM11039 on Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council is available. Learn about system updates based on CORE publications.

• **HCPCS Code Updates for Home Health Consolidated Billing Enforcement MLN Matters Article — New.** A new MLN Matters Article MM11040 on Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement is available. Learn about updates to the therapy code list.

• **New Waived Tests MLN Matters Article — Revised.** A revised MLN Matters Article MM10958 on New Waived Tests is available. Learn about the latest tests approved by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments.

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

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

4) The federal HHS Office of the Inspector General (OIG) reports:
OIG recently released their Fall 2018 Semiannual Report to Congress. This fall edition of the Semiannual Report to Congress covers OIG activities from April 2018 through September 2018. Historically, about 80 percent of OIG's resources are directed to work related to Medicare and Medicaid. This is mirrored in the organization and content of the report.

OIG Recovered Nearly $3 Billion in Medicare, Medicaid Fraud in Fiscal Year 2018. The Department of Health and Human Services' Office of the Inspector General (OIG) recently announced it "recovered nearly $3 billion from providers in fiscal 2018, a figure that included more than $18 million in improper payments at nursing homes." In its semiannual report to Congress, the OIG counted "764 criminal actions and the removal of more than 2,700 providers from the approved Medicare and Medicaid rolls." Inspector General Daniel Levinson wrote that his office "continues to fulfill its crucial mission for the American people...by holding those who harm HHS programs accountable."

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

- HFS posted a new public notice regarding Integrated Health Homes Learning Collaborative Webinar. You may view the notice here.
- HFS posted a new provider notice regarding Payment to SMHRFs for Therapeutic Leave of Absence Days. You may view the notice here.
- HFS posted a new provider notice regarding Physician Certification Statement for All Non-Emergency Transportation. You may view the notice here.
- HFS posted a new provider notice regarding Utilization Review Update. You may view the notice here.
- HFS posted a new provider notice regarding Integrated Health Home Implementation. You may view the notice here.
- HFS posted a new provider notice regarding Extension in Due Date for Payment of the December 2018 LTC Assessment. You may view the notice here.

6) The Illinois Department of Public Health reports on:

- The Building Resilience Against Climate Effects (BRACE-Illinois) team at the UIC School of Public Health developed maps to identify health care facilities in or near floodplains. In order to obtain a baseline understanding of what tools and resources emergency preparedness professionals currently use for planning for flood disasters, please complete the survey. The GIS floodplain and healthcare facility mapping tool will be sent a few weeks after the pre-survey for participants to review and utilize.

  Link to the survey: https://uic.ca1.qualtrics.com/jfe/form/SV_4HLgAdiirPAETqJ

  Participation in the online survey will take about 5 minutes to complete, is voluntary and answers will be confidential. As of September 4, 2018, the University of Illinois at Chicago’s Office for the Protection of Research Subjects granted the “Flood preparedness among Illinois healthcare facilities” research project exempt from the federal regulations for the protection of human subjects. However, our project will adhere to the ethical conduct of research and protection of participants’ information.

  Building Resilience Against Climate Effects (BRACE-Illinois) is a CDC-funded project at the University of Illinois at Chicago (UIC). A goal of BRACE is to improve preparedness for the health effects of climate change and extreme weather events. More information about BRACE-Illinois can be found here: https://braceillinois.uic.edu/. BRACE-Illinois works directly with and on behalf of the Illinois Department of Public Health (IDPH).
If you have any questions, please feel free to reach out to Elena Grossman at egross5@uic.edu or 312-996-2085.

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

- CMS has announced that they are taking steps to ensure that skilled nursing facilities are adequately staffed through three actions detailed below.

  First, CMS will utilize Payroll-Based Journal (PBJ) data to identify providers that have a significant drop in staffing levels on weekends or have several days in a quarter without a registered nurse (RN) working. The names of these providers will be shared with state survey agencies so that some weekend surveys can be conducted. If the surveys find insufficient nursing levels, facilities will be cited for non-compliance.

  Second, CMS has published a new update to the PBJ Policy Manual and FAQs, which are available [here](#). Key updates include a more thorough explanation of the Meal Break Policy, reiterating that 30 minutes for every 8 hours worked need to be deducted for a meal break for every shift that exempt, non-exempt or contract employees work regardless of whether the break is paid. If staff takes a meal break that is longer than 30 minutes, the actual time of the break should be excluded. The updates also include instructions for reporting hours for "universal care workers."

  Last, CMS announced the launch of two new PBJ reports. Both reports focus on MDS based resident census. Report 1704S Daily MDS Census Summary displays the daily MDS-based resident census for each day in the quarter. Report 1704D Daily MDS Census Detail displays a list of the residents that the MDS-based census is comprised of in a given timeframe. Detailed information on accessing the reports can be found [here](#). Providers can submit questions on these reports to the QTSO Help Desk at help@qtso.com.

  In the coming days, AHCA will provide members with resources to help prepare for the above-mentioned actions. Additionally, AHCA will continue to provide updates on PBJ as they become available. If you have any questions, please contact the AHCA PBJ team [here](#).

8) Telligen reports on:

- [Telligen Update](#).

9) *Today's Geriatric Medicine* reports on **Challenges of Discontinuing Antidepressants**. Antidepressant discontinuation syndrome describes a cluster of symptoms that can occur following the discontinuation or lowering of an antidepressant dose. Typically these include flulike symptoms, insomnia, nausea, imbalance, sensory disturbances and hyperarousal. These symptoms are generally mild and short-lived. However, for some patients, symptoms can be severe enough to make stopping antidepressants difficult.

  Health care professionals (HCPs) should understand the clinical implications of depression and antidepressant discontinuation syndrome. Furthermore, patients should be educated about the benefits and risks associated with antidepressant medications, including possible discontinuation symptoms. By taking preventive steps, HCPs can help reduce the occurrence and severity of discontinuation symptoms while improving the patient experience.

10) Skilled Nursing News reports:

- **CMS Suggests Increased Prioritization of Telehealth in Skilled Nursing, Long Term Care**. Skilled Nursing News reports that CMS has indicated its continuing interest in expanding the use of telehealth in SNFs, issuing a report (PDF) to Congress stating that the technology "may decrease hospitalizations and readmissions and enable more beneficiaries to remain in the community." CMS cited research suggesting the services could "lead to 15 fewer rehospitalizations per year for specific nursing homes, with an average annual savings to Medicare of $151,000
Experts Discuss How To Avoid CMS Audits Under PBJ. Skilled Nursing News reports that during the American Health Care Association (AHCA) conference and expo in San Diego in October, several speakers discussing the payroll-based journal (PBJ) shared their views on what could cause CMS to launch an audit of a SNF. Experts highlighted the need for providers to maintain accurate staffing information and be wary that "criteria for audits changes each quarter, based on continued analysis of each quarter’s data."

Experts Discuss Data Showing Lower Medicare FFS Reimbursements For SNFs In 2019. Skilled Nursing News reports new data show “73% of SNFs will see lower Medicare fee-for-service reimbursements” in 2019 under the value-based purchasing (VBP) program "after failing to reach mandated readmission benchmarks." According to Vincent Fedele, Director of Analytics at consulting firm Zimmet Health care Services Group, "Until the VBP program makes it more punitive or more incentivizing for the facilities, we’re not going to see too many changes in provider behavior." However, American Health Care Association Director of Research Katherine Almendinger said, "AHCA has been supportive of the SNF VBP program since its inception. ... CMS has released the incentive payment multipliers and rankings, and yesterday they released the 2017 SNFRM [readmission measure] rates. We are pleased to see CMS is rewarding 27% of high performing facilities with an increase in payment of up to 1.65%.”

USA Today reports that a Study Reveals Advances Towards a Successful Alzheimer’s Vaccine. USA Today recently reported that "an experimental vaccine" that could keep Alzheimer’s disease at bay is "showing results in animal testing, according to researchers at the University of Texas Western Medical Center." The researchers "reported this week in the journal Alzheimer’s Research & Therapy testing in mice has shown that the vaccine safely prevents the buildup of substances in the brain associated with the fatal disease." The study’s senior author, Dr. Doris Lambracht-Washington told USA Today if the vaccine proves safe and effective in humans it could slice the number of dementia diagnoses in half.

Provider Magazine reports that Additional Policy Support Necessary to Improve Antipsychotic Prescribing in SNFs. Provider Magazine reports a recent study published in JAMDA concluded that SNF clinicians who have been "more careful than ever about how they use antipsychotics with residents with dementia" nevertheless continue to face challenges with prescribing practices. Furthermore, "study authors concluded that greater policy and institutional support is necessary to encourage and enable better prescribing decisions." Commenting on the study, David Gifford, MD, Senior Vice President of Quality and Regulatory Affairs for the American Health Care Association, said the findings demonstrate "that regulatory efforts alone regarding prescribing antipsychotics among those with dementia do not work." Dr. Gifford added, "As we work on ways to further reduce the use of antipsychotic medications in the U.S., this study reinforces that we should develop strategies beyond just regulatory oversight and focus on changing attitudes and beliefs."

Modern Healthcare reports that CMS Proposes Funding Nursing Home Safety Training With Civil Money Penalties. Modern Healthcare recently reported that CMS announced the Civil Money Penalty Reinvestment Program, a new, three-year initiative "aimed at improving safety at nursing homes" that CMS will use to develop training tools "to help staff reduce adverse events, improve dementia care and strengthen staffing quality, including by reducing staff turnover and enhancing performance." The program will be "funded by federal civil penalties" imposed on nursing homes due to noncompliance. CMS Administrator Seema Verma said in a statement, "We are pleased to offer nursing home staff practical tools and assistance to improve resident care and positively impact the lives of individuals in our nation’s nursing homes." The piece adds that the American Health Care Association has not yet released comments on the announcement.

McKnight’s reports on:

Federal Preparedness Office Urges Providers to Review Active Shooter Training. McKnight’s Long Term Care News reports, the Office of the Assistant Secretary for Preparedness and Response "is encouraging nursing
homes to take a refresher course on preparing for active shooters" following the recent deadly shooting at Chicago, Illinois' Mercy Hospital and Medical Center, where three died. Following these events, the office suggested providers "review its planning and response guide for active shooter incidents, as well as other resources issued by the agency."

- **CMS Data Show Nearly 75 Percent of SNFs Experienced Higher Re-hospitalization Rates Between 2015 and 2017.** *McKnight’s Long Term Care News* reported, CMS released new data on the Nursing Home Compare website revealing "the overall SNF rehospitalization rate rose from 19% in 2015 to 19.4% in 2017," despite "a heavy emphasis on lowering rehospitalization rates in recent years." The data, linked to the SNF Value-Based Purchasing Program, indicate that of about 15,000 facilities, approximately 27 percent received a bonus while 73 percent were penalized. Amy Stewart, RN, curriculum development specialist at the American Association of Directors of Nursing Services, recommended SNF leaders review how the data impact their rankings "because many payers will be curious about this information."

15) **Interesting Fact:** Santa Claus originated in a newspaper ad. Far from being a quaint medieval legend, Santa Claus first appeared as a recognizable entity was in a newspaper ad for toys and "gift books" in the mid-19th century.