Summary of the CMS Region 5 LTC Provider Association Meeting
On December 13 and 14, federal CMS hosted their annual Region 5 LTC Provider Association Meeting in Chicago. CMS invites State Surveyor Agency representatives, State LTC Nursing Home Provider Association representatives and State LTC Ombudsman of each of the six CMS Region 5 States to this meeting. CMS uses this meeting to give updates on various programs/issues impacting Nursing Homes and allows for question and answers. Each LTC Provider Association is limited to two members. For IHCA, Mike Bibo and Bill Bell were our representatives. The following are the key highlights and important information from the meeting:

- In past meetings, CMS started out the meeting by providing and discussing various LTC trends and data. This year, due to the new CMS QCOR website, CMS did not provide any information on this. They stated that providers can access the QCOR website and get a plethora of information and statistics/data there.

- CMS provided the latest CMS Regions 5 Org Chart and contact information

- CMS did a presentation of LTC Certification and Enforcement – Provider Communication (click here). Highlights included:
  - CMS stated that they are working to remove the backlog of enforcement cases and to streamline their process
  - Updating and clarifying their enforcement letters
  - Beginning in January, CMS RO will send initial enforcement notices soon after cases are transferred by the State Agency for Immediate Imposition of Remedy cases
  - CMP COLA adjustment (increase) expected soon
  - CMS is working towards a new database system
  - Note that almost all enforcement and certification notices are being sent electronically
  - Embrace the RO waiver mailbox for submitting hearing waiver requests
  - Ensure that all the facility contact information is up-to-date and accurate

- A question was asked about transfer and discharge notices. For all facility initiated involuntary transfers or discharges, the resident, the resident’s representative and ombudsman must be given immediate notice. For facility initiated transfers to the hospital or other (with the expectation for the resident returning) the notice must be given to the resident and resident representative immediately, but such notices can be batched and given to the ombudsman once a month. Facilities need to have documentation somewhere in the medical record of who was notified and when.
A presentation was made on KEPRO (click here). KEPRO is the Beneficiary and Family Centered Care QIO (BFCC-QIO) for more than 30 states. They offer no cost information and assistance to providers, patients and families regarding beneficiary complaints, discharge appeals, Immediate Advocacy and Patient Navigation.

The next agenda item was labeled – Staffing. Included in this document are several charts related to staffing deficiencies. CMS wanted to have discussions around the various scenarios that are presented at the end of this document. There was very little consensus among the various groups represented. This issue is very complex and there are so many variables. CMS and the ombudsman were leaning more towards numbers of staff and the providers were pushing the quality of care provided. No definitive guidance was given and CMS ended the discussion stating that they will closely monitor this issue and address the concerns/problems accordingly. This issue will be a key component of the federal monitoring and look-behind surveys this coming year.

A presentation was made by the Lake Superior QIN discussing their ‘Reducing Healthcare-Acquired Conditions in Nursing Homes’ initiative (click here). The LSQIN developed several tools with regard to infection control and QAPI that you may want to consider using.

Another presentation was made describing the Quality Improvement Contractors – 12th Statement of Work – to begin the summer of 2019 (click here). CMS goals and priorities include:

- Workforce burden reduction
- Improve behavioral health, including opioid abuse
- Improve Public Health through improved chronic disease management
- Increase patient safety
- Increase quality of care transitions
- Long term care

CMS did a presentation on ‘Region 5 Financial Alignment Demonstrations’ (click here).

CMS did a presentation of ‘Managed Long Term Services and Supports’ (click here).

CMS ended the meeting with a discussion on F608 – Reporting of Crimes and F609 – Facility Reported Incidents.

- F608- Reporting of Crimes
  - confusion with regard to alleged allegations and crimes
  - serious crimes need to be reported within 2 hours, non-serious crimes within 24 hours
  - facilities need to have a policy, post information and educate their staff – education is key
  - facilities need to work with their local law enforcement agency to help define crime

- F609 – Reporting of allegations of abuse, neglect, exploitation or mistreatment
  - Ensure all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but not later than 2 hours
  - Confusion on the reporting of resident on resident abuse
  - CMS stated that draft guidance for comment will be coming out soon with regard to F609
  - Remember there in an initial report and an investigation report to follow
  - Facilities need to documents actions and tracking of incidents

As you can see, there were more questions raised then there were answers or guidance. IHCA and AHCA will continue to take your issues/concerns to CMS or IDPH to try to get issues addressed.
Updated List of Required Postings for Illinois Long Term Care Facilities

After receiving several recent inquiries on what needs to be posted in long term care facilities with regard to state and federal mandatory labor-related requirements, Illinois Department of Public Health requirements, Department of Healthcare and Family Services requirements and Department on Aging requirements, we did some research on this issue and have accumulated a list of required postings.

The Illinois Department of Labor website lists out the required postings (state and federal labor and labor-related), gives information on each of them and tells how to get a copy of each of them. There are also several other required postings as determined by various state agencies and federal CMS.

Federal Posting Requirements
1. Family Medical Leave Act
2. Equal Employment Opportunity is the Law
3. Federal Minimum Wage
4. Uniformed Services Employment and Re-employment Rights Act
5. OHSA – Job Safety and Health Protection
6. Employee Polygraph Protection Act
7. Veteran’s Employment and Training Service and VA Hotline (if your facility has a VA contract)
8. Employee Rights Under the National Labor Relations Act (NLRA)
9. Elder Justice Act Requirements (poster available on AHCA website)

Illinois State Posting Requirements
1. Illinois No Smoking
2. Emergency Care/Choking
3. Unemployment Insurance
4. Worker’s Compensation
5. Day and Temporary Labor Service Act
6. Illinois Employment Laws/Minimum Wage
7. Pregnancy Accommodation
8. Equal Pay
9. Payday Notice
10. Victim’s Economic Security and Safety Act
11. Workplace Safety and Health
12. Unemployment Insurance Benefits Notice
13. Illinois Service Member Employment and Re-employment Rights Act (ISERRA) – NEW (effective 1-1-2019)
14. Discrimination and Sexual Harassment NEW (effective 9-18)

The above noted mandatory posters must be displayed in a conspicuous location where employees and applicants for employment can see them. Posting of these notices in other languages is not required.

There are several other required postings as determined by various state agencies and federal CMS. They are as follows:

Illinois Department of Public Health (IDPH)
Every facility shall conspicuously post for display in an area of its offices accessible to residents, employees and visitors, the following:

1. Its current license;
2. A description, provided by the Department of Public Health, of complaint procedures established under the Nursing home Care Act, ID/DD Community Care Act or MC/DD Act (Hotline Poster);
3. A copy of any order pertaining to the facility issued by IDPH or a court;
4. A list of the material available for public inspection under Section 3-210 of the Nursing Home Care Act (click here), ID/DD Community Care Act or MC/DD Act;
5. Every licensed facility shall post a notice advising the residents, guardians or employees of their right to ask whether any residents of the facility are identified offenders;

6. A notice that advises residents and their families of the availability of interpreters, the procedure for obtaining an interpreter and the telephone numbers to call for filing complaints concerning interpreter service problems, including, but not limited to, a TTY number for persons who are deaf or hard of hearing. The notices shall be posted, at a minimum, near the facility entrance and the admission area. Notices shall inform residents that interpreter services are available on request, shall list the languages most commonly encountered at the facility for which interpreter services are available and shall instruct residents to direct complaints regarding interpreter services to IDPH, including the telephone number to call for that purpose;

7. Visiting hours and the facility visitation policy;

8. Pursuant to Section 30 the Authorized Electronic Monitoring in Long-Term Care Facilities Act (click here) there must be posting if a resident of the facility conducts authorized electronic monitoring; and

9. Pursuant to Section 65 of the Firearm Conceal Carry Act (click here), signs stating that the carrying of firearms is prohibited shall be clearly and conspicuously posted at the entrance of the facility.

**Federal Centers for Medicare and Medicaid Services (CMS)**

Every facility shall conspicuously post for display in an area of its offices, accessible to residents, employees and visitors, the following:

1. A list of names, addresses (mailing and email), and telephone numbers of all pertinent state agencies and advocacy groups, such as the State Survey Agency, the state licensure office, adult protective services where state law provides for jurisdiction in long term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based services programs and the Medicaid Fraud Unit.

2. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including by not limited to, resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directive requirements (42 CFR Part 489 – Subpart I) and requests for information regarding returning to the community;

3. Post notice of reports with respect to any surveys (including the most recent survey of the facility), certifications and complaint investigations made during the three (3) preceding years, and any plans of correction in effect with respect to the facility available to any individual to review upon request;

4. A posting that provides residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered under such benefits;

5. A posting, on a daily basis at the beginning of each shift, that contains the facility name, the current date, the resident census and the total number of and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: registered nurses, licensed professional nurses and certified nurse aides.

6. A posting for the facility employees specifying the employee’s rights, including the right to file a complaint under Section 1150B of the Social Security Act, which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. The notice must also include a statement that an employee may file a complaint with the State Survey Agency against a LTC facility that retaliates against an employee as well as include information with respect to the manner of filing such a complaint.

**Illinois Department of Healthcare and Family Services (HFS)**

HFS stated that there was nothing in their requirements that required facility posting.

**Illinois Department of Aging**

Every facility shall conspicuously post in each wing on each floor of the facility, in each of the facility’s activity rooms/areas, and at the main entrance/exit of the facility, the following:

1. The [Ombudsman Poster](#) provided by the Illinois Department on Aging.
Please note that the listings above were our best effort in trying to acknowledge all of the various requirements for postings in Illinois long term care facilities. If you think we have missed something or if you have any questions, please contact Bill Bell at bbell@ihca.com or call our office at 800-252-8988.

Focus F-Tag – F659 Qualified Persons

This Regulatory Beat’s Focus F-Tag is F659 Qualified Persons, which is part of the Comprehensive Resident Centered Care Plans regulatory group. This requirement is part of the care planning group because it requires that the services that have been set out in the comprehensive care plan (CCP) to be provided by the facility are provided by qualified staff in accordance with the individual resident’s plan of care. Staff are required, per the Interpretive Guidance (IG) to have “the skills, experience and knowledge to do a particular task or activity,” including licensure/certifications as necessary. It also states that non-compliance with this regulation creates a situation where a resident is at risk for more than minimum harm, so Level 1 severity is not applicable if F659 is to be cited.

F659 can be cited for a wide range of deficient practices related to staff not doing what they were supposed to do in order to follow the plan of care. This includes things such as med administration, not ensuring residents are wearing TEDs, not providing pressure-relieving devices as ordered, or assistance with transfers. There is a great example of a Level 2 deficiency under this tag related to an observation of a staff member taking and reporting abnormal BPs. It was determined that the staff member was using the wrong size BP cuff so incorrect BP readings were being reported. It is as simple as that – using the wrong piece of equipment can result in a deficient practice being identified. You can see how it all ties together with skills and competencies that your staff should have been trained to do based on their assigned job duties.

This tag is being cited twice as frequently on standard surveys under the LTCSP as it is on complaint surveys. It has also been cited at an immediate jeopardy level several times, with about an even mix of citations between standard and complaint surveys. What you also need to keep in mind is that beginning 11/28/19 (Phase 3) the culturally-competent and trauma-informed component of this F-tag will be assessed. So start educating your staff now!

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Trending Statistics

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

Opioid Use Among Seniors

More than 19 percent of seniors filled at least one outpatient opioid prescription per year, on average, in 2015-16. More than 7 percent obtained four or more (click here).

Currently in the United States, prescription opioids are commonly used to treat both chronic and acute pain. These drugs can help manage some types of pain, but due to serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use—opioids are not recommended as the first-line treatment for most types of pain.¹

Examine patterns of use of prescribed opioids can contribute to efforts to make appropriate use of these drugs.

This Statistical Brief presents estimates from the 2015 and 2016 Medical Expenditure Panel Survey Household Component (MEPS-HC) of fills of prescriptions for opioid medications that are commonly used to treat pain. Only prescriptions purchased or obtained in an outpatient setting are included in these estimates. Prescription medicines administered in an inpatient setting or in a clinic or physician’s office are excluded.

The sample includes all elderly adults (ages 65 and older) in the U.S. civilian noninstitutionalized population. (Statistical Brief #516 presents estimates of opioid use for non-elderly adults ages 18 to 64.) We examine the average annual percentages of elderly adults in 2015–2016 with any opioid use (1 or more prescription fills during year) and with
frequent opioid use, which we define as having 4 or more prescription fills or refills during the year.\textsuperscript{2} We present overall estimates for the full population of elderly adults and for subgroups defined by sex, race/ethnicity, poverty status, insurance coverage, perceived health status, Census region, and MSA status. All differences mentioned in the text are significant at the \(p<0.05\) level, or better.

### Highlights

- In 2015–2016, 19.3 percent of elderly adults, on average, filled at least 1 outpatient opioid prescription, and 7.1 percent obtained 4 or more prescription fills during the year.
- Elderly adults who were poor (9.5 percent) or low income (11.3 percent) were more likely than middle-income (6.8 percent) and high-income (4.5 percent) elderly adults to obtain 4 or more opioid prescription fills during the year.
- In 2015–2016, the average annual rates of any outpatient opioid use increased as health status declined, ranging from 8.8 percent for those in excellent health to 39.4 percent for those in poor health. Similarly, rates of frequent use increased from 1.6 percent to 21.8 percent as health status declined from excellent to poor.
- Elderly adults with Medicare and other public insurance coverage were more likely to fill at least 1 opioid prescription (24.4 percent) and to have 4 or more opioid prescription fills (11.2 percent) than those with Medicare only (18.8 and 7.6 percent) and those with Medicare and private insurance coverage (18.9 and 6.1 percent).

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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 19-03 – Hospice** – Extension of the Designation of the Current Nursing Shortage as an “Extraordinary Circumstance” per 42 CFR 418.64 Core Services. CMS has extended its designation of the national nursing shortage as an extraordinary circumstance for an additional two (2) years. This designation enables those hospice agencies, which are unable to provide a sufficient number of nursing staff directly to meet the needs of its patients due to the national shortage, to utilize contracted staff in addition to their full time nursing staff.  

   **Compliance Determination:** CMS is eliminating the previous requirement that the hospice agency must notify CMS of its use of contacted staff during extraordinary circumstances and submit justification for such use to its State Survey Agency. This notification/justification is not required by 42 CFR 418.64. Compliance with the regulation for use of contracted staff will be reviewed as a part of the routine survey process.  

   **Hospice Responsibility:** When contract services are utilized, the hospice agency maintains all professional, financial and administrative responsibility for the services. This policy memorandum serves as an extension and supersedes previously issued SC17-01-Hospice.

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

   - CMS has released the [Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program](https://www.cms.gov/) year public reporting files for Calendar Year 2017 performance. The files contain scoring and measure performance for the SNF 30-Day All-Cause Readmission Measure as well as associated payment incentives for all SNFs. This information is available on the [Nursing Home Compare](https://www.cms.gov/) website. For more information about the SNF VBP Program, please review the [Frequently Asked Questions](https://www.cms.gov/) document and refer to the [FY 2019 SNF PPS final rule](https://www.cms.gov/).  

   - An updated errata (V2.02.4) was posted for the FINAL version (v2.02.1) of the [MDS 3.0 Data Specifications](https://www.cms.gov/), which went into effect on October 1, 2018. Several additional items were mapped to edit -3897, and edit -3907 was discontinued. Note that these changes are already in production for ASAP, jRAVEN, and the VUT (click here).
CMS released this document (click here) to describe the policies for waivers of the Skilled Nursing Facility (SNF) 3-Day Rule under the Shared Savings Program and the Medicare ACO Track 1+ Model. Specifically, this document provides background on the SNF 3-Day Rule, waiver-eligibility criteria for ACOs and SNF affiliates, as well as information on how to apply for a SNF 3-Day Rule Waiver.

CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing. On November 30, 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. Read CMS Press Release.

New Medicare Webpage on Patient Driven Payment Model MLN Matters Article — New. A new MLN Matters Special Edition Article SE18026 on New Medicare Webpage on Patient Driven Payment Model is available. Learn about educational and training resources.

HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised. A revised HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet is available. Learn:
- Who must comply with HIPAA rules
- Covered entities
- Enforcement

New Medicare Card: Transition Period Ends December 31. We are halfway through the transition period that began April 1, 2018:
- To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31
- Beginning January 1, 2020, you must use the MBI on all Medicare transactions with a few exceptions

About the MBI:
- MBIs are random and use numbers 0-9 and uppercase letters, except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating between these letters and numbers (e.g., between “0” and “O”). Read MLN Matters® Article New MBI Get It, Use It for helpful information, including what to do if an MBI changes.
- Learn about Getting MBIs.
- Learn about Using MBIs.

If your patients accidentally threw away their new Medicare card, ask them to call 1-800-MEDICARE and request a replacement. Your patients can also sign into MyMedicare.gov to print an official card. They must create an account if they do not already have one.

For More Information:
- Transition to New Medicare Numbers and Cards Fact Sheet
- Frequently Asked Questions
- Provider and Office Manager webpage

New Electronic System for Provider Reimbursement Review Board Appeals Call — Tuesday, February 5, 12:30—2 pm CST. Register for Medicare Learning Network events. Do you want to file or manage a Provider Reimbursement Review Board (PRRB) appeal? Learn how to use the new Office of Hearings Case and Document Management System (OH CDMS) to submit new appeals, transfer issues, file position papers and manage all aspects of your PRRB appeals. For more information, visit the PRRB OH CDMS webpage.

During this call, PRRB staff discuss:
How to access the system
Detailed overview of the system and its capabilities
Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to PRRB@cms.hhs.gov with “Office of Hearings Case and Document Management System Conference Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

- **Home Health Patient-Driven Groupings Model Call** — Tuesday, February 12, 12:30—2 pm CST. Register for Medicare Learning Network events. During this call, learn about the Patient-Driven Groupings Model (PDGM) that will be implemented on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:
  - Overview of PDGM model
  - Walkthrough of payment adjustments, including low utilization payment adjustments, partial payment adjustments, and outliers payments

A question and answer session follows the presentation. For more information, visit the Home Health Prospective Payment System webpage; review the CY 2019 final rule and Overview of the PDGM.

- **New Part D Opioid Overutilization Policies Call** — Thursday, February 14, 1:30—3 pm ET. Register for Medicare Learning Network events. CMS implemented new opioid policies for Medicare drug plans effective January 1. The new policies include:
  - Improved safety alerts when patients fill opioid prescriptions at the pharmacy
  - Drug management programs for patients at-risk for misuse or abuse of opioids or other drugs

During this call, CMS experts discuss the new policies and answer questions. Prior to the call, participants should review the following materials:
  - Training materials, including slide decks and tip sheets for prescribers, pharmacists and patients
  - Reducing Opioid Misuse webpage for more information on the CMS strategy

- **Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training Course** — Revised. With Continuing Education Credit. A revised Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  - Key aspects and requirements for electronic and paper claims
  - Information required when submitting claims
  - Important claims processing actions

- **Quality Payment Program: 2019 Resources.** CMS posted new resources to help you prepare for the 2019 performance year of the Merit-based Incentive Payment System (MIPS):
  - Medicare Part B Claims Measure Specifications and Supporting Documents: Descriptions of the claims measures for the Quality performance category
  - Clinical Quality Measure Specifications and Supporting Documents: Descriptions of the clinical quality measures for the Quality performance category
  - CMS Web Interface Measure Specifications and Supporting Documents: Descriptions of the CMS Web Interface measures for the Quality performance category
  - Cross-Cutting Quality Measures: List of cross-cutting Quality measures that are broadly applicable to all clinicians regardless of their specialty
  - Quality Measure Benchmarks: Lists and explains benchmarks used to assess performance in the Quality performance category
  - Promoting Interoperability Measure Specifications: Overview of the requirements for the Promoting Interoperability performance category objectives and measures
- **Cost Measure Code Lists**: Details the cost measure code lists for each of the 8 episode-based cost measures that are new for the Cost performance category
- **Cost Measure Information Forms**: Details the methodology for each episode-based measure for the Cost performance category
- **MIPS: Summary of Cost Measures**: Summary of cost measures
- **Improvement Activities Inventory**: List of the improvement activities and descriptions
- **Qualified Clinical Data Registries (QCDRs) and Qualified Registries**: Qualified Postings: List of CMS-approved QCDRs and Qualified Registries and the performance categories and measures they support
- **MIPS Participation and Eligibility Fact Sheet**: Overview of the eligibility criteria
- **Quality Performance Category Fact Sheet**: Includes an overview of quality measures and how to collect and submit quality data
- **Cost Performance Category Fact Sheet**: Includes details on the episode-based measures

For More Information:
- [Resource Library](#) webpage
- [Quality Payment Program](#) website
- Reach out to your local [technical assistance organization](#)
- Contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

**eCQM Resource: The Collaborative Measure Development Workspace.** CMS expanded the Electronic Clinical Quality Improvement Resource Center to include a Collaborative Measure Development (CMD) Workspace. The CMD Workspace brings together a set of interconnected resources, tools, and processes to promote clarity, transparency, and better interaction across stakeholder communities that develop, implement, and report Electronic Clinical Quality Measures (eCQMs).

**Medicare Enrollment Application Fee for CY 2019.** On November 18, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2019 [CMS–6079–N](#). Effective January 1, 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.

**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 Booklet
- MDPP webpage

- Claim Status Category and Codes Update MLN Matters Article — New. A new MLN Matters Article MM11073 on Claim Status Category and Claim Status Codes Update is available. Learn about updates for ASC X12 276/277 transactions.

- Ensuring Only the Active Billing Hospice Can Submit a Revocation MLN Matters Article — New. A new MLN Matters Article MM11049 on Ensuring Only the Active Billing Hospice Can Submit a Revocation is available. Learn about the new Common Working File edit in Medicare Systems.

- Quality Payment Program in 2018: Group Participation Web-Based Training — New. With Continuing Education Credit. A new Quality Payment Program in 2018: Group Participation Web-Based Training course is available through the Learning Management System. Learn about:
  - Difference between a group and a virtual group
  - Different reporting mechanisms
  - Reporting requirements for groups for each performance category
  - How scoring and payment adjustments work for groups

- SNF PPS Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the December 11 call on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). On October 1, 2019, the new Patient Driven Payment Model is replacing Resource Utilization Group, Version IV. Learn about this new case-mix classification system for SNF Part A beneficiaries.

- LTCH Compare Refresh. The December 2018 quarterly Long-term Care Hospital (LTCH) Compare refresh is available, including quality measure results based on data from the first to fourth quarter of 2017. Visit LTCH Compare to view the data. For more information, visit the LTCH Quality Public Reporting webpage.


- Physician Supervision of Diagnostic Procedures, Telehealth Services MLN Matters Article — New. A new MLN Matters Article MM11043 on Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke is available. Learn about updated policies.

- 2019 Medicare Part D Opioid Policies: Training Materials. CMS will implement new opioid policies for Medicare drug plans on January 1. The new policies include:
  - Improved safety alerts when patients fill opioid prescriptions at the pharmacy
  - Drug management programs for patients at-risk for misuse or abuse of opioids or other drugs

CMS posted new training materials, including slide decks and tip sheets for:
- Prescribers
- Pharmacists
- Patients

- **MLN Catalog: December 2018 – Revised.** A revised MLN Catalog – December 2018 is available. Learn about free:
  - Products and services that can be downloaded
  - Web-based training courses; some offer continuing education credits
  - Helpful links, tools, and tips

- **CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing.** On November 30, 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.”

  Research shows the ratio of nurses to residents impacts quality of care and health outcomes. For example, facilities with higher nurse staffing levels tend to have fewer resident hospitalizations. In general, the new payroll-based staffing data shows most facilities have somewhat fewer staff on weekends, but some facilities have significantly lower weekend staffing. Additionally, some facilities have reported days with no registered nurse onsite, although nursing homes are generally required by law to have a registered nurse onsite eight hours a day, seven days a week.

  To help address these risks, CMS will use frequently-updated payroll-based data to identify and provide state survey agencies with a list of nursing homes that have a significant drop in staffing levels on weekends or that have several days in a quarter without a registered nurse onsite. State survey agencies will then be required to conduct surveys on some weekends based on this list. If surveyors identify insufficient nurse staffing levels, the facility will be cited for noncompliance and required to implement a plan of correction.

  See the full text of this excerpted CMS Press Release (issued November 30).

- **Nursing Home Staff Competency Assessment Toolkit.** 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, CMRP can provide funding, technical assistance, and learning opportunities to help address some of your facility’s toughest challenges. Visit the CMRP webpage for more information. Toolkit 1 is available in the Downloads section.

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 U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response released their ASPR TRACIE Express: December 2018 Updates.

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 provider notice regarding Extension in Due Date for Payment of the December 2018 LTC Assessment. You may view the notice here.

- HFS posted a new public notice regarding Critical Clinic Provider Encounter Rates. You may view the notice here.

- HFS posted a new provider notice regarding 1115 Waiver Pilot Program: Intensive In-Home Billing and Service Delivery Requirements. You may view the notice here.

- HFS posted new Integrated Health Home Staffing Ratios - Updated December 10, 2018. You may view the new rates from the following link – click here.

- HFS posted a new provider notice regarding Handbook for Practitioners Rendering Medical Services Re-issue. You may view the notice here.

- HFS posted a new provider notice regarding Exondys 51 and Spinraza Prior Authorization Criteria Update. You may view the notice here.

- HFS posted a new provider notice regarding Handbook for Providers of Transportation Services Re-issue. You may view the notice here.

- HFS posted a new provider notice regarding Ordering, Referring, Prescribing - National Provider Identifier (NPI) Requirements - Delay in Implementation. You may view the notice here.

- HFS posted a new Public Notice regarding New Service Definition for CMHCs and BHCs. You may view the notice here.


- HFS posted updated Nursing Facility Rate Lists for 2019. You may view the new rate lists from the following link: click here.

- HFS posted a new Provider Notice regarding Due Date for Payment of the Fiscal Year 2019 2nd Quarter Licensed Bed Assessment. You may view the notice here.

- HFS posted a new Public Notice regarding Integrated Assessment and Treatment Planning. You may view the notice here.

- HFS posted a new Provider Notice regarding Current Dental Terminology (CDT) Codes – Update. You may view the new notice here.
6) The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) report on:

- **What's New in LTC Trend Tracker?**
- AHCA/NCAL recently unveiled its new online **Workforce Resource Center** to help members address the mounting challenges to effective staffing recruitment and retention.

7) **Telligen** reports on:

- **Telligen Update**.

8) **Today’s Geriatric Medicine** reports that **IFAP Launches Advanced Wound Care Certification**. Healthcare Facilities Accreditation Program (HFAP), founded in 1945, is launching an Advanced Wound Care Certification program, enabling wound care centers to showcase their specialty services to patients and payers.

9) **HealthDay** reports that **Attending Cultural Activities Every Few Months May Reduce Risk for Depression in Older People**. **HealthDay** reported that research indicates that "older folks can cut their depression risk by 32 percent simply by going to cultural activities every few months." According to HealthDay, the "results are based on a decade-long tracking analysis that stacked cultural engagement – plays, movies, concerts and museum exhibits – against depression risk among approximately 2,000 men and women over the age of 50," all of whom were "participants in the English Longitudinal Study of Ageing (ELSA)."

10) **FierceHealthCare** reports, **Almost Half of Medicare Patients in Long Term Care Facilities Have Experienced Harm, HHS-OIG Finds**. **FierceHealthcare** reports that almost 50 percent "of Medicare patients in long-term care facilities have experienced some type of harm as the result of their care, endangering their health and increasing Medicare costs, according to" an analysis conducted by the HHS-OIG. Data show "more than 20% of Medicare patients who have received treatment in long-term care facilities have experienced serious harm resulting from medical care or lack thereof." The analysis also revealed that "27% of Medicare patients in hospitals, 33% of Medicare patients in skilled nursing facilities and 29% of Medicare patients in rehab hospitals experienced...harm." Therefore, the OIG is recommending that CMS "and Agency for Health care Research and Quality (AHRQ) take steps to raise awareness in several inpatient settings, specifically tailoring their ongoing efforts to improve patient safety to address the specific needs of LTCHs."

11) **Provider Magazine** reports:

- **HHS OIG Work Plan Includes Nursing Home Staffing Audits**. In its January issue, **Provider Magazine** reports on updates to the HHS Office of Inspector General’s (OIG) Work Plan that add scrutiny over nursing home staffing levels in OIG audits. In an effort to monitor the Medicare Requirements of Participation rules, "OIG will be examining nursing staffing levels that are reported by facilities electronically to CMS’ Payroll-Based Journal (PBJ)," and "will address the efforts by CMS to ensure data accuracy and improve quality of care by examining the enforcement of minimum requirements and encouraging the hire of high-quality staff above required levels."

- **AHCA’s Mike Cheek Discusses Steps to Comply with PDPM**. Mike Cheek, Senior Vice President of Reimbursement Policy at the American Health Care Association, writes in the January issue of **Provider Magazine** that CMS’ new Patient-Driven Payment Model (PDPM) marks a "significant departure" from the existing Resource Utilization Group (RUGs) prospective payment system (PPS). In contrast to RUGs, which "has struggled with a payment bias toward the delivery of therapy," PDPM is expected to "refocus SNF care to medically complex patients and away from therapy." Cheek adds that as the PDPM deadline approaches, SNFs can consult the "four key PDPM Core Competencies© developed by the American Health Care Association:" learning about the new system; developing "accurate diagnostic and MDS coding capabilities;" evaluating and strengthening the "ability to manage complex patients’" and configuring resources within an SNF.
New Regulations Demand More Staff Training, Competency. *Provider Magazine* reported in its December issue on increasing requirements for staff training under CMS rules. In the first phase of the latest wave of regulations, training requirements covered "abuse and neglect for all staff, in-service training for nurse assistants on dementia management and abuse prevention, care of those with cognitive impairments, and training of feeding assistants." In Phase 3, which begins next year, training must also address "communication, resident rights, infection control, compliance, and ethics—especially in regard to person-centered care, behavioral health, and Quality Assurance and Performance Improvement." Furthermore, nurses will not only need to complete training but also demonstrate competency.

12) **Skilled Nursing News** reports:

- CMS Explains New Expectations for Transition From RUG to PDPM. *Skilled Nursing News* reports that during a Medicare Learning Network call, CMS officials said there will be no transition period between the existing Resource Utilization Group, Version IV (RUG-IV) and the new Patient-Driven Payment Model (PDPM), which takes effect October 1, 2019. A spokesman said the "hard switch from one system to the other" is "due to the potential for significant administrative burden that could arise from running the RUG-IV and PDPM systems concurrently." CMS also addressed issues such as the "lack of clarity" surrounding therapy, noting that providers "have to complete an interim payment assessment (IPA)...in order to receive a Health Insurance Prospective Payment System (HIPPS) code" to be used for billing under PDPM.

- CMS Finalizes New Set of Rules for ACOs. *Skilled Nursing News* reported that on December 21, "the Centers for Medicare & Medicaid Services (CMS)...finalized its new set of rules for accountable care organizations (ACOs), removing the no-risk tracks that represented financial drains on Medicare and expanding three-day stay waivers for nursing homes." Now, "under the new 'Pathways to Success' model, most new ACOs will only have two years to operate without assuming risk, with incremental increases in the potential for both risk and reward as the program progresses."

- Top Cabinet Officials Urge States to Eliminate Certificate of Need Laws. *Skilled Nursing News* reports Health and Human Services Secretary Alex Azar, Treasury Secretary Steven Mnuchin, and Labor Secretary Alexander Acosta have "called on individual states to eliminate Certificate of Need (CON) laws regarding the development of new health care facilities...characterizing the statues as anti-competitive and detrimental to consumers." In a 120-page report, the secretaries said, "States should consider repeal of Certificate of Need (CON) statutes or, at a minimum, significantly scale back the scope of their CON regimes, for example by ensuring that competitors of CON applicants cannot weigh in on these applications."

13) **Interesting Fact:** January is named after the Roman god Janus, who was always shown as having two heads. He looked back to the last year and forward to the new one.

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!