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!

Use of Medical Cannabis in LTC Facilities – What is the Current Status?

IHCA has received many questions with regard to the use of medical marijuana/cannabis in LTC facilities. There is no prohibition to LTC facilities admitting residents who use or want to use medical cannabis...HOWEVER, there are no regulations or guidance from either federal CMS or the Illinois Department of Public Health (IDPH) with respect to the use of medical cannabis in LTC facilities. It is one of those “travel at your own risk” scenarios.

Illinois, along with over 30 other states, allow for the use of medical cannabis. However, cannabis is still federally classified as a schedule 1 substance under the Controlled Substances Act of 1970. There is no indication that the federal government would punish an LTC facility for appropriately using medical cannabis. But, without rulemaking or guidance, the LTC facility is entering ‘no man’s land’ and opening itself up for anything that goes wrong with the use of medical cannabis. There will be the policy of strict liability for anything that goes wrong with the use of medical cannabis. Even if it is not the fault of anything the facility did, if something goes wrong, the facility will be held totally accountable. Entering this arena without any federal or state guidance will require LTC facilities to develop in-depth policies and procedures on their own and they will have no federal or state protections.

As stated earlier, medical cannabis is legal in Illinois, and its use was expanded in August 2018 by making it an alternative to opioid painkillers. Since their inception in November 2015, the state’s 55 licensed medical cannabis dispensaries have sold more than $220 million worth of cannabis. That number is growing quickly: In the first nine months of 2018, medical cannabis brought $100 million of revenue to the state.

The recent expansion of medical marijuana use is likely to bring another massive wave of users and income. As of October 2018, only 46,000 Illinois residents qualified for the program, as only some conditions qualify patients for it, but that number is bound to increase dramatically even if a tiny fraction of patients switch from opioids to marijuana.

The state of Illinois has worked very hard to develop a medical cannabis patient registry program, a cannabis patient application process and a process and a procedure for growing and selling the product. What they haven’t done is developed any regulations for the use of medical cannabis in health care facilities. IHCA has asked numerous times for regulations or guidance on how LTC facilities can appropriately allow the use of medical cannabis. To date, the Department has been silent.

Real difficulties exist in discussing the medicinal benefits of cannabis in clinical settings. Since medical cannabis is considered a Schedule 1 substance under the Controlled Substances Act of 1970, this contributes to the lack of scientific
evidence on cannabis that could inform clinicians about dosing, clinical efficacy, routes of administration and contraindications. There is insufficient data to provide evidence-based clinical guidance for cannabis based medicine. Clinicians are unable to move forward without clinically relevant guidelines. Clinicians need tools to communicate effectively with patients/residents about perceived benefits and risks of cannabis use.

On a related topic of medical cannabis, there is also discussion around the use of Cannabidiol (CBD) oil. The non-intoxicating marijuana extract is being credited with helping treat a host of medical problems -- everything from epileptic seizures to anxiety to inflammation to sleeplessness. But experts say the evidence is scant for most of these touted benefits. Worse, CBD is being produced without any regulation, resulting in products vary widely in quality. Cannabidiol is extracted from the flowers and buds of marijuana or hemp plants. It does not produce intoxication; marijuana’s “high” is caused by the chemical tetrahydrocannabinol (THC). Only one purported use for cannabidiol, to treat epilepsy, has significant scientific evidence supporting it. Studies on CBD also have raised concerns about possible interactions with other drugs. For the rest of CBD’s potential uses, there is simply too little evidence to make a firm conclusion. There also are concerns about both the quality of CBD oil being produced and its potential side effects. Because of the legally murky nature of marijuana, the FDA has not stepped in to regulate products like CBD oil. States are struggling to put regulations in place, but they don't have the deep pockets of the federal government.

Meanwhile, a 2017 study led by Bonn-Miller found that nearly 7 of 10 CBD products didn't contain the amount of marijuana extract promised on the label. Nearly 43 percent of the products contained too little CBD, while about 26 percent contained too much, Bonn-Miller said. "CBD is kind of a tricky drug because it's not very well absorbed orally," Welty explained. "Less than 20 percent of the drug is absorbed orally. If it isn't made in the right way, you may not be getting much drug into your systemic circulation.” Worse, about 1 in 5 CBD products contained the intoxicating pot chemical THC, Bonn-Miller and his colleagues found.

The bottom line is to proceed with caution. If your facility is going to allow the use of medical cannabis or CBD Oil, you will need to involve your Medical Director, other attending physicians, consulting pharmacist, facility nursing and clinical staff and the facility’s legal counsel to develop in-depth and comprehensive policies and procedures to protect both the residents and the facility.

**Over-The-Counter Hearing Aids Will Mean Nursing Homes Must Step Up Their Audiology Game**

Nursing homes and other eldercare providers will need to bolster their offerings in audiology due to a recent federal law, an expert recommended this week.

The Over-the-Counter Hearing Aid Act of 2017 will soon allow seniors to purchase hearing aids without an audiologist serving as middleman. But there will be no guarantee that older adults will have access to the corresponding hearing care services needed to optimize the use of such devices, Johns Hopkins Bloomberg School of Public Health researchers noted in a *Health Affairs* study published Monday.

Those who are dually eligible for both Medicare and Medicaid have about 41% lower odds of using hearing care services, and were twice as likely to report having trouble hearing with their aids when compared to high-income Medicare beneficiaries. Those barriers are only likely to be exacerbated once obtaining hearing aids is separated from a healthcare encounter, the authors wrote.

The takeaway for nursing homes is to be ready for this care gap, and diversify their hearing care services, whether by adding an audiologist on staff or another hearing specialist, lead researcher Amber Willink, Ph.D., told *McKnight’s*. Without that help, hearing aids can sometimes end up in a drawer, rather than in one’s ears.

“My big message to leaders at nursing homes is that this is a very prevalent issue, even more so in their facilities, because of the older age of the population that tends to be there,” said Willink, an assistant scientist in both the Department of Health Policy and Management and Cochlear Center for Hearing and Public Health. “If people aren’t able to understand and communicate, then they’re less likely to adhere to their medications and follow instructions from doctors and staff.”
Johns Hopkins researchers reached their conclusions by examining 2013 data from the Medicare Current Beneficiary Survey, looking for existing barriers to hearing care. The Hearing Aid Act of 2017 requires the FDA to establish a regulatory framework and processes to allow for the over-the-counter sale of these devices by 2020.

Willink said they’re embarking on further studies to look specifically at use of hearing aids in the nursing home population.

“Are [beneficiaries] going to the hospital more often?” she asked. “Are they having some of these adverse events like falls? Or are they experiencing high rates of depression? These are things that we know to be true in the community-dwelling population, but considering that those in nursing homes are more likely to have hearing loss, do we see even higher rates there?”

Another recent study found that treating hearing loss might help to reduce depression for older adults.

Article authored by Marty Stempniak with McKnight’s.

Focus F-Tag – F837 Governing Body

This Regulatory Beat’s Focus F-Tag is F837 Governing Body, which is part of the Administration regulatory group. The governing body is the group of people who are legally responsible for establishing and implementing policies related to the operations/management of the facility. The Governing Body also has responsibility for appointing the administrator, who is licensed if required by the state, has responsibility for managing the facility as well as being responsible for reporting and accountability to the Governing Body.

The purpose of this regulation is to ensure that the Governing Body is active, engaged and involved in establishing the policies noted above. The facility needs to have determined the frequency that the administrator reports to the Governing Body, how this communication will be done, how the Governing Body is to respond, as well as what kind of information is to be reported. Think about what your owners would like to know – survey results, of course, but does administration advise them of other areas of concern that they should be aware of related to management and operational issues regarding such areas as compliance audits, staffing or budgetary concerns?

If your facility has ever been in an Immediate Jeopardy situation, you know that the Governing Body may be cited with a deficiency if there are operational and/or management concerns identified.

The requirements for the Governing Body are relatively straightforward, but the regulation sets out the Governing Body’s role related to two key regulatory requirements as well – the Facility Assessment and Quality Assurance and Performance Improvement (QAPI). The facility is required to determine how the administration and Governing Body are involved in the Facility Assessment (F838). In Phase 3, effective November 28 of this year, the regulation at F837 also states that the governing body “is responsible and accountable for the QAPI program.”

Lastly, surveyors are to request the names and contact information of the members of the Governing Body during the Entrance Conference. When concerns are identified, surveyors are instructed to interview the administrator and if possible one or more members of the Governing Body. The facility needs to ensure that members of the Governing Body are well informed regarding the management and operations of the facility.

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Trending Statistics

Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.
Factors Associated With Geriatric Frequent Users of Emergency Departments

Frequent users of the emergency department (ED) are often associated with increased health care costs. Limited research is devoted to frequent ED use within the increasing senior population, which accounts for the highest use of health care resources. We evaluate patient characteristics and patterns of ED use among geriatric patients.

Health care spending in the United States continues to increase, with a 5.3 percent increase to $3.0 trillion from 2013 to 2014. Although the emergency department (ED) is often portrayed as a significant and costly portion of this spending, much of this is attributed to the increasing trend of community-based providers’ relying on EDs to evaluate patients with complex disease who were previously admitted to the hospital, as evidenced by an increase in high-intensity ED visits. As a result, the ED’s role in delivering care for a large proportion of the population is expanding, especially for older and sicker patients.

The increasing senior population, estimated to double by 2050, currently represents 15 percent of the population, yet contributed to 21 percent of total health care expenditures in 2012 and is among almost half of the top 1 percent of health care spenders. Additionally, annual ED visits by seniors increased by 24.5 percent between 2001 and 2009. In comparison to other age groups, older adults use the ED at a higher rate, have longer stays in the ED and require more resources and medical interventions during their visit. Although frequent users of the ED have been well studied, there is limited research examining the frequent users within the increasing geriatric population.

The purpose of this study (click here) was to evaluate patient characteristics and patterns of ED use among geriatric patients to inform interventions to improve health care delivery in and out of the ED for this population.

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Important Regulations, Notices & News Items of Interest

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

- QSO 19–05 – Transplant - Survey and Approval of Pancreas and Intestine Transplant Centers. Pancreas Transplant Centers - An adult or pediatric pancreas transplant center may be Medicare approved, with no independent survey activity, if the program operates as a component of a Medicare approved kidney transplant center. Intestine Transplant Centers - An adult or pediatric intestine transplant center may be Medicare approved, with no independent survey activity, if the program operates as a component of a Medicare approved liver transplant center. Pancreas and intestine transplant patients will be incorporated into the kidney and liver program survey reviews. Noncompliance with the care or services to pancreas or intestine transplant patients will result in noncompliance by the associated kidney or liver programs, respectively.

- QSO 19–06 – All - Emergency Preparedness- Updates to Appendix Z of the State Operations Manual (SOM). Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers: On September 16, 2016, the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (Emergency Preparedness Rule) final rule was published in the Federal Register. Health care providers and suppliers affected by the rule were required comply and implement all regulations by November 15, 2017. CMS is updating Appendix Z of the SOM to reflect changes to add emerging infectious diseases to the definition of all-hazards approach, new Home Health Agency (HHA) citations and clarifications under alternate source power and emergency standby systems.

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

- CMS Releases New Data Specifications for MDS Under PDPM. CMS posted links to new MDS 3.0 data specifications that will take effect October 1. That’s when the Patient-Driven Payment Model goes into effect, the biggest overhaul of the nursing home reimbursement system in a generation. The MDS becomes more
influential than ever for provider reimbursements under the new system. Officials noted the “many significant changes, including the removal of eight item sets” and the addition of two new item sets included in the new specifications, as well tweaks to various sections. Providers expected many of the data specification changes and now are more eagerly awaiting the release of the new RAI Manual so that training for the new system can begin in earnest. A new version of the MDS 3.0 CAT Specifications, which also starts on Oct. 1, was additionally posted Tuesday. The CMS website announcement on the changes can be found here. The MDS data specifications reside at this link.

- **SNF Provider Preview Reports – Now Available.** Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. Providers have until March 4, 2019 to review their performance data prior to the April 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time; however, providers can request 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. The data contained within the Preview Reports is based on quality data submitted by SNFs during the following quarterly timeframes:
  - **Quarter 3 – 2017 to Quarter 2 – 2018 data**
    - Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (#0674)
    - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
    - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (#2631).
  - **Quarter 4 – 2016 to Quarter 3 – 2017 data**
    - Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure
    - Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

As a reminder, CMS announced in October 2018 that it will not publish a 6th previously posted quality measure, Potentially Preventable 30-Day Post-Discharge Readmissions, at this time. Additional time will allow for more testing to determine if modifications to the measure and method of displaying it are needed. This additional testing will ensure that the future publicly reported measure is thoroughly evaluated so Compare users have an accurate picture of provider quality. While we conduct this additional testing, CMS will not post reportable data for this measure, including each SNF’s performance, as well as the national rate.

For more information:

- **PDPM Website Offers Answers.** CMS has launched a new website to help providers and other stakeholders navigate preparations for the Patient Driven Payment Model (PDPM). The site includes fact sheets, frequently asked questions, training presentations and implementation tools to help providers prepare for PDPM, which launches October 1, 2019. It can be found here. The new case mix model is the biggest overhaul to nursing home payments in at least a generation. PDPM will focus on resident condition and care needs, rather than the amount of care provided, to determine reimbursements. It replaces Resource Utilization Group system, or RUG-IV, used to categorize Medicare Part A residents into various payment levels based on their degree of need.

- **Skilled Nursing Facilities/Long Term Care Open Door Forum Agenda.** The proposed agenda for the next Skilled Nursing Facilities/Long Term Care Open Door Forum scheduled for Thursday, February 14, 2019, 1 – 2 pm CST is as follows below. If you wish to participate, dial 1-800-837-1935. Conference ID: 3693669. Please see the full participation announcement in the Downloads section. Thank you for your continued interest in the CMS Open Door Forums.

  Announcements & Updates:
  - SNF QRP Updates
HHS Proposes New Rules to Improve the Interoperability of Health Information. The U.S. Department of Health and Human Services (HHS) proposed new rules to support seamless and secure access, exchange and use of electronic health information. The rules, issued by CMS and the Office of the National Coordinator for Health Information Technology (ONC), would increase choice and competition while fostering innovation that promotes patient access to and control over their health information. The proposed ONC rule would require that patient electronic access to this electronic health information (EHI) be made available at no cost.

- For a fact sheet on the CMS proposed rule (CMS-9115-P), please click here
- For fact sheets on the ONC proposed rule, please visit: https://healthit.gov/nprm
- To receive more information about CMS's interoperability efforts, sign-up for listserv notifications, click here
- To view the CMS proposed rule (CMS-9115-P), please click here

New Medicare Card: Are You Using the MBI? Many providers are using the new Medicare Beneficiary Identifier (MBI) for Medicare transactions. For the week ending January 25, providers submitted 62 percent of fee-for-service claims with the MBI. We encourage you to use MBIs now for all Medicare transactions. Don't have an MBI?

- Ask your patient for their card. If they have not received a new card, ask them to look for a plain white envelope from the Department of Health and Human Services; sign into MyMedicare.gov to get their new number or print an official card; or call 1-800-Medicare (1-800-633-4227).
- Use your Medicare Administrative Contractor’s look up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number.

For more information, see the MLN Matters® Article.

Nursing Home Compare Refresh. The January 2019 Nursing Home Compare refresh is available, including quality measure results based on Skilled Nursing Facility (SNF) Quality Reporting Program data. Visit Nursing Home Compare to view the data. For more information, visit the SNF Quality Public Reporting webpage.

DMEPOS: Strategies to Support Access for Dually Eligible Individuals. CMS released an Informational Bulletin for state Medicaid agencies with strategies to support timely access to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for people dually eligible for Medicaid and Medicare. The bulletin clarifies that states do not need to obtain a Medicare denial for DMEPOS items that are not covered by Medicare. If you are not sure which program will cover a DMEPOS item or how to bill for an item that Medicare does not cover, check with your state Medicaid agency. Some states may create a list of Medicare non-covered items, so you can identify claims that can be submitted directly to your state Medicaid agency.

New App Displays What Original Medicare Covers. The new CMS “What’s Covered” app lets people with original Medicare, caregivers, providers, and others quickly see whether Medicare covers a specific medical item or service. You can now use your mobile device to more easily get accurate, consistent original Medicare coverage information in your office, the hospital or anywhere. The free app is available in Google Play and the Apple App Store. See the full text of this excerpted CMS Press Release (issued January 28), which discusses other eMedicare tools for people with Medicare.

Hospice Quality Reporting Program: FY 2021 Data Collection Began January 1. The Hospice Item Set (HIS) and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data collection period for the FY 2021 reporting year is January 1 through December 31, 2019.
For more information, visit the Requirements and Best Practices webpage.

- **Hospice Training: Updates to Public Reporting in FY 2019.** Information is available from the two-part webinar on Updates to Public Reporting in FY 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines. Visit the Training and Education Library webpage for more information:
  - Materials, including presentation, speaker notes and transcript
  - Video

- **Prevent Legionnaires' Disease: Water Management Program Training.** Did you know? The number of people with Legionnaires’ disease grew 5.5 times from 2000 to 2017 and is deadly for 25% of people who get it from a health care facility. Ninety percent of the problems that cause Legionnaires’ disease outbreaks could have been prevented with more effective water management. Help prevent outbreaks by taking the Centers for Disease Control and Prevention’s (CDC’s) new online training: Preventing Legionnaires' Disease: A Training on Legionella Water Management Programs:
  - Learn how to align with ASHRAE 188 risk management requirements for building water systems (e.g., potable water, cooling towers, hot tubs, decorative water features)
  - Earn continuing education units from the National Environmental Health Association

Learn more about Legionnaires’ disease on the CDC Environmental Health Services webpage.

- **Home Health Compare Quarterly Refresh – January 2019.** The January 2019 quarterly Home Health (HH) Compare refresh, including new quality measure results based on data submitted to CMS, is now available on the HH Compare Site. In addition to the HH QRP measures that have displayed on Home Health Compare previously, the following four new quality measures are newly reported on HH Compare:
  - Assessment-based measures:
    1. Percent of Residents or Patients with a Pressure Ulcers that Are New or Worsened (Short Stay) (NQF#0678)
    2. Drug Regimen Review Conducted with Follow-Up for identified Issues
  - Claims-based measures:
    1. Medicare Spending Per Beneficiary-PAC HH QRP
    2. Discharge to Community-PAC HH QRP

CMS has decided not to publish a 5th quality measure, Potentially Preventable 30-Day Post-Discharge Readmissions, at this time. Additional time would allow for more testing to determine if there are modifications that may be needed both to the measure and to the method for displaying the measure. The additional testing will ensure that the future publicly reported measure is thoroughly evaluated so that Compare users can depend upon an accurate picture of provider quality. While we conduct this additional testing, CMS will not post reportable data for this measure, including each agency’s performance, as well as the national rate.

Please visit the Home Health Compare website to view the new and updated quality data.

For more information visit the CMS HH QRP Website.

- **DME Proof of Delivery Documentation Requirements.** CMS simplified and clarified documentation requirements for proof of delivery of Durable Medical Equipment (DME) and related services. If you are a
physician, provider or supplier who bills a DME Medicare Administrative Contractor, read the MLN Matters Article on Proof of Delivery Documentation Requirements for details. Learn about updates to support compliance and the impact on your payment. More resources to help you bill correctly and avoid overpayment recoveries:

- Medicare Program Integrity Manual, Chapter 4, Section 26
- 42 CFR Section 424.57(c)(12)

- **New Part D Opioid Overutilization Policies Call — Thursday, February 14 from 12:30 to 2 pm CST.** 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. Note: This content was previously presented during a Regional Office event on December 27.

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

- **Quality Payment Program: Overview of APMs for Year 3 Webinar — Thursday, February 21 from 1 to 2 pm CST.** Register for this webinar. This webinar provides a basic overview of Alternative Payment Models (APMs) for the 2019 Performance Year of the Quality Payment Program. Learn how to get started in an APM. Topics:
  - Advanced APMs, Merit-Based Incentive Payment System APMs and all-payer other payer combination options
  - Qualifying APM participant determination and performance period
  - Scoring standard
  - Support


- **Coding and Billing Date of Service on Professional Claims MLN Matters Article — Revised.** A revised MLN Matters Article SE17023 on Guidance on Coding and Billing Date of Service on Professional Claims is available. Learn how to identify correct dates of service.

- **CWF Provider Queries NPI and Submitter ID Verification MLN Matters Article — Revised.** A revised MLN Matters Article MM10983 on Common Working File (CWF) Provider Queries National Provider Identifier (NPI) and Submitter Identification (ID) Verification is available. Learn about modifying each Part A eligibility inquiry and establishing verification processes.

- **LCDs MLN Matters Article — Revised.** A revised MLN Matters Article MM10901 on Local Coverage Determinations (LCDs) is available. Learn about detailed changes to the LCD process.

- **Skilled Nursing Facility Prospective Payment System Booklet — Revised.** A revised Skilled Nursing Facility Prospective Payment System Booklet is available. Learn about:
  - Payment rates
  - Quality reporting program
  - Value-based purchasing program
• **Quality Payment Program in 2018: Transitioning to an Advanced APM Web-Based Training — New.** With Continuing Medical Education Credit. A new Quality Payment Program in 2018: Transitioning to an Advanced APM Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  o Steps for joining an Advanced Alternative Payment Model (APM)
  o Benefits and risks of participation
  o Resources

• **Lenses Provider Compliance Tips Fact Sheet — New.** A new Provider Compliance Tips for Lenses Fact Sheet is available. Learn about:
  o Coverage guidelines
  o Reasons for denials
  o How to prevent claim denials

• **Parenteral Nutrition Provider Compliance Tips Fact Sheet — New.** A new Provider Compliance Tips for Parenteral Nutrition Fact Sheet is available. Learn about:
  o Reasonable and necessary requirements
  o Qualifying conditions
  o How to prevent claim denials

• **Patient Lifts Provider Compliance Tips Fact Sheet — New.** A new Provider Compliance Tips for Patient Lifts Fact Sheet is available. Learn about:
  o Supplier requirements
  o Coverage criteria
  o Common reasons for claim denials
  o How to prevent denials

• **Pressure Reducing Support Surfaces Provider Compliance Tips Fact Sheet — New.** A new Provider Compliance Tips for Pressure Reducing Support Surfaces Fact Sheet is available. Learn about:
  o Three groups/classifications of pressure reducing support surfaces
  o Coverage criteria
  o Common reasons for claim denials
  o How to prevent denials

• **ESRD Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the January 15 call on the End-Stage Renal Disease (ESRD) Quality Incentive Program. Learn about provisions in the CY 2019 final rule.

• **DMEPOS Fee Schedule: CY 2019 Update MLN Matters Article — Revised.** A revised MLN Matters Article MM11064 on Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule is available. Learn about data files and update factors.

• **Diabetic Shoes Provider Compliance Tips Fact Sheet — Revised.** A revised Provider Compliance Tips for Diabetic Shoes Fact Sheet is available. Learn about:
  o Reasons for denials
  o How to prevent claim denials
  o Type of order needed to submit a claim

• **Coding and Billing Date of Service on Professional Claims MLN Matters Article — Reissued.** A reissued MLN Matters Article SE17023 on Guidance on Coding and Billing Date of Service on Professional Claims is available. Learn how to identify correct dates of service.

• **TKA Removal from IPO List and 2-Midnight Rule MLN Matters Article — Reissued.** A reissued MLN Matters Article SE19002 on Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and
Application of the 2-Midnight Rule is available. Learn about TKA procedures performed on an inpatient or outpatient basis.

3) The federal HHS Office of the Inspector General (OIG) posted CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs to be Improved to Help Ensure the Health and Safety of Nursing Home Residents (A-09-18-02000). State survey agencies (state agencies) must verify that nursing homes corrected identified deficiencies, such as the failure to provide necessary care and services, before certifying whether the nursing homes are in substantial compliance with Federal participation requirements for Medicare and Medicaid.

- Read the Full Summary https://go.usa.gov/xEnkv
- Read the Report https://go.usa.gov/xEn8X

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

- Weekly U.S. Influenza Surveillance Report

5) The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE) released their February 2019 issue of The Express.

6) 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 Due Date for Payment of the Monthly Occupied Bed Provider Assessment. You may view the notice here.

7) The Illinois Department of Public Health reports:

- Information Sheet for LTC Facilities on ePOC. IDPH sent out an email and attachment to facilities that have submitted their attestation for watching the CMS Provider Training. Some providers we have spoken to either haven’t yet taken the time to register or have been waiting for more information to come from the Department. The attachment is the same one sent to you and facilities on 1/22/19. Please let me know if you have questions. Please remember to follow the attached instructions to register for ePOC. To register, you will need access to the CMSNet system. Through CMSNet you will get your username and password. Each person who uses ePOC will need their own username and password. If you have already registered, please disregard. If you have questions, please call or email Pam Winsel at 217-782-5180 or Pamela.Winsel@ILLINOIS.GOV.

- ePOC FAQ #2. The second ePOC Frequently Asked Question document can be seen here.

- SIREN (State of Illinois Rapid Electronic Notification), has a new self-registration process at siren.illinois.gov to receive important notifications from The Illinois Department of Public Health. We have attached quick tips on how to register along with a new user guide.

  1. When selecting your organization, filter using HCC – Health Care Coalition, then click on the Organization Selection button. All Long Term Care Facilities will need to register within EMS Regions and IDPH Regions.

    a. On the popup screen expand DPH Long Term Care Facilities – EMS Regions. Please select which region your facility resides in by placing a checkmark in the box to the left. You can also expand your region and select from the positions listed if possible. Please Collapse EMS Regions.

    i. If unsure what EMS Region you are in, please see the IDPH EMS Region Map here.
b. Expand IDPH Regions and select your region by placing a checkmark in the box to the left. You can also expand your region and select from the positions listed if possible. You will now be able to click Select in the lower right.

i. If unsure what IDPH Region you are in, please see the IDPH Region Map here

2. Please make sure that you use your Firstname.Lastname as your Username. The password can be anything you would like and it will never expire. Please adhere to the password requirements.

3. Ensure that you have your work email, work phone, and an alternate phone (mobile phone or home phone) listed in your Profile under Contacts to where SIREN can reach you in the event of an emergency. Please add a text message if you wish using this option SMS Text MSG with your mobile phone number.

4. Please add the SIREN phone number (866-998-3678) to your mobile contacts. This will help you determine when you are getting a SIREN alert notification. You can also add the SIREN text message number (246-39 and 542-92) to your mobile contacts as well. Your mobile device will put the dash in for you.

Please let us know if you have any questions and we would be happy to assist (dph.siren@illinois.gov).

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

- **An Update from The AHCA Chair – February 2019.** It's hard to believe that it is already February! We are off and running, focusing on our 2019 goals. The Board recently held its first meeting of the year in conjunction with the Council for Post-Acute Care (CPAC) Partners Event, which is summarized below. I hope you find this helpful and that it demonstrates the Board's commitment to supporting your continued efforts to improve lives by delivering solutions for quality care.

- **AHCA VP Reviews Upcoming Transition from RUGs to PDPM.** In the February 2019 issue of Provider Magazine, Dan Ciolek, associate vice president, therapy advocacy, for the American Health Care Association, explains how the transition from Resource Utilization Groups (RUGs) to Patient Driven Payment Model (PDPM) will impact providers when implemented on October 1. He says "this represents the most significant change in Medicare Part A payments since the SNF PPS was first implemented in 1998 and will require preparation across the entire SNF organization to assure a smooth transition," especially considering CMS did not include a transition period. Ciolek goes on to explain specific aspects of PDPM for which providers should prepare.

9) **Provider Magazine** reports Law Expert Offers Advice for Professional Social Media Practices. In its February 2019 issue, Provider Magazine carries an advice piece by Timothy Ford, member of the Employment Law, Commercial Litigation, and Closely Held Business Law Departments, Einhorn Harris in Denville, New Jersey on best practices for providers in social media. Ford writes that social media can positively impact long-term care businesses, but caveats that internal policies are legally required. However, it is unlawful for providers to "prohibit employees from posting information related to work and working conditions," as are "blanket restrictions from using social media." Ford urges providers to include confidentiality provisions including clearly defining HIPAA-protected information in internal policies. Lastly, Ford notes "the relationship between a facility and the resident is governed by an admission agreement," including whether a resident can be contacted via social media.

10) **ModernHealthcare** reports that Health Care Personnel in LTCs Have Lowest Influenza Vaccine Rates. ModernHealthcare reported that influenza vaccine "coverage rates among health care personnel only started increasing steadily over the past five years as the industry more forcefully stressed the importance of prevention among its workforce." But, while "the highest vaccination rates can be found among hospital workers, at above 80% since 2010, according to the Centers for Disease Control and Prevention," the lowest rates are found among "health care personnel in long-term care facilities such as nursing homes, where staff vaccination rates" hover "under 70%." Some LTCs are now embracing "the concept of flu vaccination requirements...seeking to reverse the trend of low flu vaccination among their workforce."
11) McKnight’s reports on:

- **New Guide Lay Out Path For SNFs to Use Telemedicine to Evaluate Change of Status.** McKnight’s Long Term Care News reports a new analysis published in the Journal of Post-Acute and Long-Term Care Medicine offers skilled nursing leaders a resource outlining how to best use "telemedicine for the evaluation and management of resident changes" in an SNF. In the guide, researchers "emphasize that telemedicine should be integrated into residents’ primary care, and delivered by clinicians with competency in skilled care." They also note that, when integrated properly, "telemedicine can contribute to the delivery of timely, high-quality care in SNFs that reduces unnecessary hospitalizations," the piece adds.

- **Survey Lists Nation’s Best, Worst States for Nursing Home Care.** A new analysis of Medicare data ranks the nation’s best states for nursing home care, according to organizers, and the last one to the party appears to have won the race. Hawaii ranks No. 1 on the list with an average quality ranking of 3.93, Care.com wrote in its analysis, which was published last week. On the flip side, Texas — a state in which experts have frequently complained about the reimbursement climate — ranks at the bottom of the list, with an average overall quality rating of 2.68. Illinois ranks 40th.

- **CMS Chief: Providers Should Expect New Set of Quality Measures, More Sophisticated Enforcement Strategies.** In a fiery speech recently, CMS’ top official issued a “call to action” to providers and said the health care industry’s status quo is no longer acceptable. Administrator Seema Verma highlighted the industry’s new Patient-Driven Payment Model — along with similar reimbursement changes for home health and labs — as ways to transform the payment system, but said further reform is needed. She noted during the CMS Quality Conference that these are first steps to move SNFs and other providers toward a more “outcomes-based system.” Only 14 percent of all healthcare providers are in value-based agreements, which needs to “speed up,” she said.

- **12) Interesting Fact:** February 14th is the second largest card giving day of the year, just after Christmas.