April 10, 2019 Edition

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!

Important Letter from IDPH on Reducing Legionella Risk in Healthcare Facility Water Systems
Letter dated 3-26-19 from Debra Bryars, Deputy Director, Office of Health Care Regulations, Illinois Department of Public Health:

It has come to my attention that during recent surveys, entire areas/wings/hallways of facilities are not occupied with some having been vacant for an extended period of time. The Centers for Medicare and Medicaid Services (CMS) expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Further, facilities are required to have water management plans and documentation that, at a minimum, ensures that each facility conducts a risk assessment, develops and implements a water management program, specifies testing protocols and acceptable ranges for control measures, and maintains compliance with other applicable Federal, State and local requirements.

Due to prolonged room vacancies and lack of flowing water through the facility’s potable water system, appropriate measures must be taken in accordance with your water management plan to assure a safe water system for all residents. Healthcare facilities are expected to comply with CMS’ requirements to protect the health and safety of its patients. Those facilities unable to demonstrate measures to minimize the risk of LD are at risk of citations for non-compliance. The most recent CMS policy memorandum dated July 6, 2018, can be found here.

If you have any questions, please do not hesitate to contact Henry Kowalenko, Chief for the Division of Life Safety and Construction, at Henry.Kowalenko@illinois.gov.

Treating Diabetes in Older Adults Requires Simpler Medication Regimens, Looser Glycemic Targets

Endocrine Society’s Clinical Practice Guideline offers diagnosis and treatment recommendations

Simplifying medication regimens and tailoring glycemic targets in older adults with diabetes improves adherence and avoids treatment-related complications, according to a Clinical Practice Guideline issued today by the Endocrine Society. The Society debuted the guideline during a press conference on the opening day of ENDO 2019, its annual meeting in New Orleans, LA.
The guideline, titled “Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline,” was published online and will appear in the May 2019 print issue of The Journal of Clinical Endocrinology & Metabolism (JCEM), a publication of the Endocrine Society. The guideline focuses on treatment strategies that take into consideration the overall health and quality of life of older adults with diabetes, defined as age 65 or older.

Aging plays a major role in the development of diabetes, which currently affects an estimated 33 percent of older adults in the U.S. Older adults with diabetes often have one or more co-existing conditions such as cognitive impairment, cardiovascular disease, impaired vision, and rheumatoid arthritis, which affect diabetes self-management.

“The guideline encourages clinicians to consider available evidence and a patient’s overall health, likelihood to benefit from interventions and personal values when considering treatment goals such as glucose, blood pressure, and cholesterol,” said Derek LeRoith, M.D., Ph.D., of Mount Sinai School of Medicine in New York, N.Y. LeRoith chaired the writing committee that developed the guideline. “Our framework prioritizes blood glucose targets over the hemoglobin A1c test when managing diabetes in older adults.”

Recommendations from the guideline include:

- Simplifying medication regimens and tailoring glycemic targets in older adults with diabetes and cognitive impairment (e.g. dementia) to improve compliance and prevent treatment-related complications
- Designing outpatient diabetes regimens specifically to minimize hypoglycemia
- Targeting blood pressure levels of 140/90 mmHg to decrease the risk of cardiovascular disease outcomes, stroke, and progressive chronic kidney disease in older adults with diabetes aged 65 to 85 years
- Using an annual lipid profile to reduce the amount of “bad cholesterol” in the blood
- Administering annual comprehensive eye exams to detect retinal disease
- Establishing clear blood sugar targets for older adults with diabetes in hospitals or nursing homes at 100-140 mg/dL (5.55-7.77 mmol/L) fasting and 140-180 mg/dL (7.77-10 mmol/L) after meals while avoiding hypoglycemia

**Focus F-Tag – F801 Qualified Dietary Staff**

This *Regulatory Beat*’s Focus F-Tag is **F801 Qualified Dietary Staff**, which is part of the Food and Nutrition Services Regulatory Group. This regulation has been in effect since Phase 1 (November 28, 2016) with some of the education requirements waived until five years from that date. The Requirements of Participation (RoPs) state that a nursing facility needs to employ sufficient staff with the appropriate competencies and skill sets to carry out food and nutrition services functions. The care and services provided needs to take into account resident assessments and individual plans of care as well as the facility’s population based on the Facility Assessment. The regulation at F801 specifically states the requirement for having a qualified dietitian (or other clinically qualified nutrition professional) on staff on a full or part-time basis or as a consultant. The regulation further states that if this qualified staff member is not employed full-time, the facility must designate a person who will serve as the Director of Food and Nutrition.

**Qualified Dietitian/Clinically Qualified Nutritional Professional**

The requirements for qualification include:

- Bachelor’s degree or higher from an accredited US college/university with completion of the academic requirements for a program in nutrition or dietetics
- Completion of a minimum of 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional
- Licensed or certified as a dietitian or nutrition professional in the state where services are being performed;
- *Dietitians hired or contracted with prior to November 28, 2016 have five (5) years from that date to meet these requirements or as required by state law*

If the qualified person listed above is not a full-time staff member (35+ hours/week), the facility must designate someone to serve as the Director of Food and Nutrition Services. To be qualified for this role, the individual must:
• Meet the requirements mentioned above within five (5) years after November 28, 2016 or no later than 1 year after November 28, 2016 for staff members designated after November 28, 2016
• The individual must be a certified dietary manager, certified food service manager or has a similar national certification from a national certifying body for food service management and safety
• Associate’s degree or higher in food service management or in hospitality, if the course study from an accredited institution includes food service or restaurant management
• Meets state requirements for food service managers or dietary managers in States that have such established requirements
• Receives “frequently scheduled consultations” from a qualified dietitian/nutritional professional

On survey, F801 can be cited because surveyors identify concerns with the qualifications of the facility’s dietitian, clinical nutrition personnel or the food services director, including carrying out the food and nutrition services functions appropriately. This includes nutritional assessments of residents, developing and evaluating regular and therapeutic diets, participating in the QAPI Committee related to food and nutrition services, ensuring all facility staff receive person-centered food and nutrition services education and overseeing budgeting and procurement. Under the LTCSP, this F-Tag has been cited multiple times across the country related to staff not being properly designated for the role and/or not having the appropriate education and credentials.

If you have not already conducted an assessment of your Dietary Staff against the requirements of F801, the sooner you take a hard look the better as this is an “avoidable” deficiency. Also keep in mind that a compliance investigation related to this F-tag can lead to an investigation of compliance with other regulations such as F686 Pressure Injury, F692 Nutrition/Hydration Status or F693 Tube Feeding Management.

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**Trending Statistics**

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

**NCHS Publishes New Data on LTC**


**Key Findings:**

In 2016, about 65,600 paid, regulated long term care services providers in five major sectors served over 8.3 million people in the United States.

- Long term care services were provided by 4,600 adult day services centers, 12,200 home health agencies, 4,300 hospices, 15,600 nursing homes and 28,900 assisted living and similar residential care communities (Appendix III, Table V).
- In 2016, there were an estimated 286,300 current participants enrolled in adult day services centers, 1,347,600 current residents in nursing homes and 811,500 current residents living in residential care communities. In 2015, about 4,455,700 patients were discharged from home health agencies and 1,426,000 patients received services from hospices (Appendix III, Table VIII).

**Sectors differed in ownership and chain status, and supply varied by region.**

- The majority of home health agencies, hospices, nursing homes and residential care communities were for profit, while a minority of adult day services centers were for profit (Figure 4). The majority of nursing homes and residential care communities and a minority of adult day services centers were chain-affiliated (Figure 5).
- The supply of residential care beds per 1,000 persons aged 65 and over was higher in the Midwest and West than in the Northeast and the South, and the capacity of adult day services centers was higher in the West than in the other regions (Figure 3).
Almost 1.5 million nursing employee full-time equivalents (FTEs)—including registered nurses (RNs), licensed practical or vocational nurses (LPNs or LVNs), and aides—and about 35,000 social work employee FTEs worked in the five sectors.

- The relative distribution of nursing and social work employee FTEs varied across sectors; the most common employee FTEs were aides in adult day services centers, nursing homes, and residential care communities, while RNs were the most common employee FTEs in home health agencies and hospices (Figure 9).

Sectors differed in their average staffing levels for nursing, social work, and activities employees.

- Among the three sectors where nursing staff levels (RNs, LPNs or LVNs, and aides) could be examined, the average total nursing staff hours per resident or participant day was higher in nursing homes than in residential care communities and adult day services centers (Figure 11).
- In contrast, the average social work staffing level was higher in adult day services centers than in nursing homes or residential care communities, and the average activities staffing level in adult day services centers was more than twice that of nursing homes and residential care communities.

Daily-use rates among individuals aged 65 and over per 1,000 persons aged 65 and over varied by sector.

- The highest daily-use rate was for nursing home residents, followed by residential care residents, and the lowest daily use rate was for adult day services center participants.

Long-term care services users varied by sector in their demographic and health characteristics and functional status.

- Adult day services center participants tended to be younger than services users in other sectors (Figure 20). Adult day services center participants were the most racially and ethnically diverse among the five sectors (Figure 22).
- At least one-quarter of services users in each of the five sectors had Alzheimer disease or other dementias, arthritis, heart disease, or hypertension (Figure 24). However, the prevalence of these and six other reported diagnosed chronic conditions varied widely between sectors.
- Fewer adult day services center participants needed assistance with four of six activities of daily living (ADLs; bathing, dressing, toileting, and walking or locomotion) than services users in other sectors (Figure 25).

Adverse events among long-term care services users varied by sector.

- Compared with adult day participants and residential care residents, more home health patients had overnight hospital stays and emergency department visits (Figure 26).
- More residential care residents had falls compared with adult day participants and nursing home residents.

Short- and long-stay current nursing home residents varied on a variety of characteristics.

Short-stay (less than 100 days) residents differed from long-stay (100 days or more) residents by age and sex, and in the prevalence of numerous diagnosed conditions, overnight hospital stays, and falls (Appendix III, Table IX).

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

1) There was one federal CMS Quality, Safety and Oversight Letter (formerly known as Survey and Certification [S&C] Letters) released since the last issue of Regulatory Beat.

- **QSO 19-11 – Transplant.** All survey activity for approval and re-approval of Medicare transplant programs was transitioned back to the State Survey Agencies (SAs) as of January 1, 2019. These surveys were conducted by a federal contractor from 2013 until September 2018. The SAs also assumed responsibility for communications between the approved transplant programs and CMS, to include recommendations to the CMS Regional Offices (ROs) regarding denials/approvals of new applicants, re-approval of approved
programs, and/or termination of approvals. Funds were added to the State Agency budgets for FY 2019 for the additional survey activity.

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

- **SNF QRP Review and Correct Reports Now Available.** The enhanced Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) review and correct reports are now available on demand in the Certification and Survey Provider Enhanced Reporting (CASPER) application. In addition to enhanced sorting functionality, this report now includes patient level data and automated CSV file creation functionality that contains patient level results. Providers can access these reports by selecting the CASPER Reporting link on the “Welcome to the CMS QIES Systems for Providers” webpage.

  NOTE: You must log into the CMS Network using your CMSNet user ID and password in order to access the “Welcome to the CMS QIES Systems for Providers” webpage.

  In addition to the sorting enhancements and inclusion of patient level data, these reports:
  - Contain quality measure information at the facility level
  - Allow providers to obtain aggregate performance for the past four quarters (when data are available)
  - Include data submitted prior to the applicable quarterly data submission deadlines
  - Display whether the data correction period for a given CY quarter is “open” or “close

- **CMS Updates PDPM Materials, Including Fresh FAQs.** In its latest guidance on the ongoing transition to the Patient-Driven Payment Model (PDPM) set to occur October 1, CMS has released a number of materials (click here) for stakeholders to review, including updates to its PDPM-related frequently asked questions (FAQs).

  Of these updates is a new version of the PDPM FAQs covering the basics, like Payment Overview and Billing and What is PDPM?, as well as more technical issues, like coding.

  CMS, for instance, spells out how the new payment model for skilled nursing facility (SNF) patients in a Medicare Part A covered stay will have a new case-mix classification system come this fall, with PDPM replacing the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV). On the subject of how SNF patients are classified into payment groups under PDPM, the FAQ said PDPM classification methodology use a combination of six payment components to derive payment. Of these, five are case-mix adjusted to cover utilization of SNF resources that vary according to patient characteristics. There is, however, an additional non-case-mix adjusted component to address utilization of SNF resources that do not vary by patient, CMS said. Different patient characteristics are used to determine a patient’s classification into a case-mix group (CMG) within each of the case-mix adjusted payment components. CMS said the PDPM classification methodology differs from RUG-IV because under the current system payment is found via a combination of two case-mix adjusted payment components and two non-case mix adjusted components.

  “The RUG-IV payment methodology assigns patients to payment classification groups, called RUGs, within the payment components, based on various patient characteristics and the type and intensity of therapy services provided to the patient,” CMS said.

  But, the new PDPM and its six payment components use clinically relevant factors, rather than volume-based service for determining Medicare payment.

  “Under the PDPM, patient characteristics are used to assign patients into CMGs across the payment components to derive payment. Additionally, the PDPM adjusts per-diem payments to reflect varying costs throughout the stay,” CMS said.
Other areas the FAQs discuss include the topics of how providers bill for services under PDPM, what health insurance prospective payment system codes represent under PDPM, what the default code is under PDPM, and, how ICD-10 coding will work with the new model.

In addition to the FAQs, CMS also released additional updated resources relevant to PDPM implementation, including various coding crosswalks and classification logic.

- **New Part D Policies Address Opioid Epidemic.** As part of our prevention efforts, CMS introduced new Medicare Part D opioid safety policies to reduce prescription opioid misuse while preserving medically necessary access to these medications. It’s important to note that these new policies are not “one size fits all,” and are deliberately tailored to address distinct populations of Medicare Part D prescription opioid users. These interventions do not apply to residents of long-term care facilities, beneficiaries in hospice, palliative, or end-of-life care, and beneficiaries being treated for active cancer-related pain.

The new Medicare Part D opioid policies encourage collaboration and care coordination among Medicare drug plans, pharmacies, prescribers, and patients in order to improve opioid management, prevent opioid misuse, and promote safer prescribing practices.

For More Information:
- Roadmap
- Prescriber’s Guide to New Medicare Part D Opioid Overutilization Policies for 2019 MLN Matters Article
- Training materials for prescribers, pharmacists and patients

See the full text of this excerpted CMS Blog (issued March 28).

- **PEPPERs for Hospices, LTCHs, SNFs, IRFs, IPFs and CAHs.** Fourth quarter FY 2018 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for hospices, Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs) and Critical Access Hospitals (CAHs). These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Use your data to support internal auditing and monitoring activities.
  - Hospices, LTCHs and free-standing SNFs and IRFs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide
  - IPFs and SNF and IRF units of hospitals: PEPPER was distributed via the QualityNet secure portal
  - CAHs: Your PEPPER delivery method is changed; see the CAH section of the PEPPER Resources website

For More Information:
  - Visit the PEPPER Resources website for guides, recorded training sessions, QualityNet account information, frequently asked questions and examples of how other hospitals are using the report
  - Visit the Help Desk if you have questions or need help obtaining your report
  - Send us your feedback or suggestions

- **Hospice Visits when Death is Imminent Measure Pair.** The Hospice Visits when Death is Imminent measure pair assess whether a hospice patient and caregiver’s needs were addressed by hospice staff in the last three and seven days of life:
  - 3-day measure will be publicly reported on Hospice Compare in summer 2019, as planned
  - 7-day measure will not be publicly reported at this time because it does not meet readiness standards for public reporting

For More Information:
  - Fact Sheet
• **Mapping Medicare Disparities Tool: New Enhancements.** CMS expanded the [Mapping Medicare Disparities (MMD) Tool](https://www.cms.gov/Medicare/Medicare-Payment/Mapping-Medicare-Disparities) Population View to include several new enhancements:
  - Data by rural and urban areas: View and compare health outcome, spending and utilization rates across rural and urban counties
  - Four opioid use disorder indicators: View prevalence, cost, and utilization rates
  - 2017 data

Why use our MMD Tool? You can view and download maps and data files to learn more about health outcomes in your community. The web-based tool provides health outcome measures for disease prevalence, costs and hospitalization for 55 specific chronic conditions, emergency department utilization, readmissions rates, mortality rates and preventable hospitalizations. View your hospital’s metric and performance score across more than 50 quality measures and compare hospitals based on geography, hospital type and/or hospital size. If you have questions, email HealthEquityTA@cms.hhs.gov.

• **Medicare-Medicaid Crossover Bad Debt Accounting Classification.** Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the [Provider Reimbursement Manual](https://www.cms.gov/Medicare/Provider-Participation/ProviderReimbursementManual). Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:
  - Do not write off to a contractual allowance account
  - Charge to an expense account for uncollectible accounts (bad debt)

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

• **Qualified Medicare Beneficiary Billing Requirements.** Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions.

Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:
  - Use Medicare 270/271 [HIPAA Eligibility Transaction System (HETS)](https://www.cms.gov/Medicare/Provider-Participation/HIPAA-Eligibility-Transaction-System) data; see [MLN Matters Article SE1128](https://www.cms.gov/Medicare/Payer-Regulations-and-Guidance/Medicare-Payment/MLNMattersArticles/MLNMattersArticleSE1128)
  - Check your Medicare Remittance Advices (RAs); see [MLN Matters Article MM10433](https://www.cms.gov/Medicare/Payer-Regulations-and-Guidance/Medicare-Payment/MLNMattersArticles/MLNMattersArticleMM10433)
  - Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing and issuance of Medicaid RAs for payment of Medicare cost-sharing. [Check with the states](https://www.cms.gov/Medicare/Payer-Regulations-and-Guidance/Medicare-Payment/MLNMattersArticles/MLNMattersArticleSE1128) where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

For More Information:
  - [QMB Program](https://www.cms.gov/Medicare/Medicaid-Federal-State-Medicaid-Coordination/Medicaid-Coordinated-Medicare-Services/QMBProgram) webpage
  - [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](https://www.cms.gov/Medicare/Medicaid-Federal-State-Medicaid-Coordination/Medicaid-Coordinated-Medicare-Services/QMBProgram) MLN Matters Article
  - [QMB Program Billing Requirements FAQs](https://www.cms.gov/Medicare/Medicaid-Federal-State-Medicaid-Coordination/Medicaid-Coordinated-Medicare-Services/QMBProgram)
  - [Dual Eligible Beneficiaries under the Medicare and Medicaid Programs](https://www.cms.gov/Medicare/Medicaid-Federal-State-Medicaid-Coordination/Medicaid-Coordinated-Medicare-Services/QMBProgram) Booklet
• **Looking for Educational Materials?** Visit the [Medicare Learning Network](https://www.medicare.gov) and see how we can support your educational needs. Learn about publications; calls and webcasts; continuing education credits; Web-Based Training; newsletters; and other resources.

• **New Medicare Card and MBI Adoption: How Do You Compare?** Use Medicare Beneficiary Identifiers (MBIs) for all Medicare transactions – the transition period ends December 31, 2019. For the week ending March 22, here is how you are using the MBI on claims:
  - National: 68 percent
  - Institutional: 68 percent
  - Professional: 69 percent
  - Durable Medical Equipment: 52 percent

  **3 Ways to Get the MBI:**
  - Ask your patients for the card. If your Medicare patients say they did not get a card, instruct them to call 1-800-MEDICARE (1-800-633-4227), so we can help them get their new cards.
  - Use your Medicare Administrative Contractor’s look up tool. [Sign up](https://www.medicare.gov) for the Portal to use the tool.
  - Check the remittance advice. Until the end of the transition period, we return the MBI on the remittance advice for claims with a valid and active Health Insurance Claim Number. Contact your vendor if you do not see the MBI.

• **SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1.** On October 1, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has resources to help you prepare.

  For More Information:
  - [PDPM webpage](https://www.medicare.gov), including fact sheets, FAQs, presentation and coding crosswalks/classification logic
  - [Materials](https://www.medicare.gov) from the Medicare Learning Network call in December
  - [New Medicare Webpage on PDPM MLN Matters Article](https://www.medicare.gov)
  - [Implementation of the SNF PDPM MLN Matters Article](https://www.medicare.gov)

• **Important Updates on the Hospice Quality Reporting Program (HQR)**. CORMAC sends informational messages to hospices related to the Quality Reporting Program (QRP) on a quarterly basis. Their latest outreach communication can be found on the [HQR Requirements and Best Practices webpage](https://www.medicare.gov). If you want to receive CORMAC’s quarterly emails, then add or update the email addresses to which these messages are sent by sending an email to QRPHelp@cormac-corp.com. Be sure to include your facility name and CMS Certification Number (CCN) along with any requested updates.

• **CMS Artificial Intelligence Health Outcomes Challenge**. The CMS Artificial Intelligence Health Outcomes Challenge is a three-stage competition to accelerate artificial intelligence solutions to better predict health outcomes such as unplanned hospital and skilled nursing facility admissions and adverse events for potential use by the Innovation Center in testing innovative payment and service delivery models under the authority of section 1115A of the Social Security Act (42 U.S.C. 1315a). CMS is partnering with the American Academy of Family Physicians (AAFP) and the Laura and John Arnold Foundation to award up to $1.65 million to selected participants during the three stages of the Challenge.

• **CMS Home and Community-Based Settings (HCBS)**. On March 22, CMS issued a new set of guidance responses to Frequently Asked Questions (FAQs) on implementation activities associated with the January 2014 home and community-based settings final rule, based in part on collaboration with states, state associations, and other stakeholders. Promoting community integration for older adults and people with disabilities remains a high priority for CMS.

• **Hospice Provider Preview Reports Now Available**. Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey ® provider preview reports have been
updated and are now available. These two separate reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from Quarter 3, 2017 to Quarter 2, 2018 and their facility-level CAHPS® survey results from Quarter 3, 2016 to Quarter 2, 2018.

Providers have 30-days to review their HIS and CAHPS® results (March 1, 2019 through March 31, 2019) prior to the May 2019 Hospice Compare site refresh, during which this data will be publicly displayed.

Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data webpage and the Public Reporting: CAHPS® Preview Reports and Requests for CMS Review of CAHPS® Data webpage.

For more information on how to access these reports, view the HIS Preview Report Access Instructions and the Hospice CAHPS® Provider Preview Reports Access Instructions.

- **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 3 – 2017 and Quarter 2 – 2018, and reflects what will be published on LTCH Compare during the June 2019 refresh of the website. Providers have until April 3, 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

- **MedPAC Submits March Report to Congress.** The Medicare Payment Advisory Commission has published its March report to Congress on the state of the Medicare Program. The report includes recommendation on changes to payment rates for specific Medicare programs. As has become its custom, it recommends no increase in SNF payments for the FY 2020 year.

  - See Full Report
  - Summary
  - Skilled Nursing Facility Services
  - Medicare Part D Status Report


- **Medicare Secondary Payer — Revised.** A revised Medicare Secondary Payer Medicare Learning Network Booklet is available. Learn:

  - When Medicare pays first
  - How to gather accurate data from the beneficiary
  - What happens if you fail to file correct and accurate claims

- **Safeguard Your Identity and Privacy Using PECOS — Revised.** A revised Safeguard Your Identity and Privacy Using PECOS Medicare Learning Network Booklet is available. Learn:

  - How to use the Provider Enrollment, Chain, and Ownership System (PECOS)
  - Privacy tips
  - How to keep, review, and protect enrollment information
• **Dementia Care Call: Audio Recording and Transcript.** An audio recording and transcript are available for the [March 12](#) Medicare Learning Network call on the Dementia Care & Psychotropic Medication Tracking Tool. Learn about the tool, updates on the Phase 3 Requirements for Participation, and the progress of the National Partnership to Improve Dementia Care in Nursing Homes.

• **Open Payments Call: Audio Recording and Transcript.** An audio recording and transcript are available for the [March 13](#) Medicare Learning Network call on Open Payments: Transparency and You. Find out how to access the Open Payments system to review the accuracy of the data submitted about you before it is published on the CMS website.

• **Medicare Secondary Payer Provisions Web-Based Training Course — Revised.** With Continuing Education Credit. A revised Medicare Secondary Payer Provisions Web-Based Training (WBT) course is available through the Medicare Learning Network [Learning Management System](#). Learn about:
  - Identifying provisions
  - Recognizing when Medicare is primary and secondary
  - Responsibilities to comply

• **ASP Medicare Part B Drug Pricing Files and Revisions: July 2019.** A new MLN Matters Article MM11225 on [July 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files](#) is available. Learn about the drug pricing files used to determine the payment limit for claims.

• **FY 2017 SSI/Medicare Beneficiary Data for IPPS Hospitals, IRFs, LTCHs.** A new MLN Matters Article MM11187 on [The Supplemental Security Income/Medicare Beneficiary Data for Fiscal Year 2017 for Inpatient Prospective Payment System Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals](#) is available. Learn about changes and adjustments to Supplemental Security Income (SSI)/Medicare beneficiary data for Inpatient Prospective Payment System (IPPS) hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs).

• **Understanding the Medicare Beneficiary Identifier.** A new [Understanding the Medicare Beneficiary Identifier](#) Medicare Learning Network Educational Tool is available. Post this one pager on your desk for easy reference. Learn about:
  - Alpha and numeric characters
  - Letters never used to avoid confusion

• **Hospice Payment System — Revised.** A revised [Hospice Payment System](#) Medicare Learning Network Booklet is available. Learn about:
  - Coverage and certification requirements
  - Election periods and statements
  - Caps on payments

• **Medicare Preventive Services — Revised.** A revised [Medicare Preventive Services](#) Medicare Learning Network Educational Tool is available. Learn about:
  - Codes
  - Coverage information

• **Reducing Opioid Misuse Call: Audio Recording and Transcript.** An audio recording, transcript and clarification are available for the [February 14](#) Medicare Learning Network call on the New Part D Opioid Overutilization Policies. Learn about the new policies for Medicare drug plans effective January 1.

• **Promoting Interoperability Call: Audio Recording and Transcript.** An audio recording and transcript are available for the [March 19](#) Medicare Learning Network call on Data Interoperability across the Continuum. Learn about the recently released CMS Data Element Library, a database of post-acute care patient assessment content.
• **SNF Value-Based Purchasing Program Call: Audio Recording and Transcript.** An audio recording and transcript are available for the March 20 Medicare Learning Network call on Skilled Nursing Facility (SNF) Value-Based Purchasing Program Phase One Review and Corrections. Learn about the process and get answers to frequently asked questions.

3) The federal Centers for Disease Control and Prevention (CDC) reports on:

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

• **Upcoming 2019-2020 Seasonal Influenza Vaccine.** The composition of U.S. flu vaccines is reviewed annually and updated as needed to match circulating flu viruses. After some delay, members of the World Health Organization (WHO) and FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) concluded their recommendations for the 2019-2020 northern hemisphere seasonal influenza vaccine.

• **CDC Study Shows Potential to Improve Flu Vaccine Strain Selection.** A recent study describes CDC’s development and use of a new lab test that can more quickly and accurately characterize circulating flu A(H3N2) viruses, which evolve more rapidly than other flu subtypes. This new method is a major step forward in overcoming the challenges of vaccine strain selection and how well flu vaccines work against flu viruses.

• **New CDC Health Advisory Alerts Clinicians to Treat Flu with Antivirals.** CDC Health Advisory: Clinicians are encouraged to treat all severely ill and high-risk patients with suspected or confirmed flu with antiviral drugs as early as possible. Flu antiviral medications are most effective in treating flu and reducing complications when treatment is started within 48 hours of illness onset, although later treatment can still be beneficial for some patients.

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

• **States with Opioid Treatment Policies See Higher Hospital Readmission Rates.** States that made the opioid overdose drug naloxone more accessible had a higher likelihood of opioid-related hospital readmissions than states that restricted availability of the drug, according to an AHRQ-funded study in BMC Health Services Research. Researchers used data from more than 383,000 initial opioid hospitalizations in 13 states from AHRQ’s Healthcare Cost and Utilization Project to examine the relationship between opioid-related readmissions and three policies: expanding availability of naloxone, enacting Good Samaritan laws to protect individuals who obtain emergency services for someone undergoing an overdose and expanding Medicaid coverage of medication-assisted treatment (MAT). States that made naloxone more available had higher odds of opioid-related hospital readmissions, which could be due to patients’ surviving the initial overdose and getting follow-up hospital care. States that expanded MAT programs had higher odds of hospital readmissions among patients insured by Medicaid. Readmission odds were lower for patients covered by Medicare and private insurance, possibly because of additional benefits for opioid treatment, such as outpatient treatment, available in Medicare and private insurance. Researchers did not find any relationships between Good Samaritan laws and opioid-related readmissions. Access the abstract.

• **Adverse Effects of Pharmacological Treatments of Major Depression in Older Adults.** Assessing the adverse events of antidepressants in the treatment of major depressive disorder in adults 65 years of age or older.

5) The federal National Institutes of Health (NIH) reports **The Beginning of the First-In-Human Trial of a Universal Influenza Vaccine Candidate.** The first clinical trial of an innovative universal influenza vaccine candidate is examining the vaccine’s safety and tolerability as well as its ability to induce an immune response in healthy volunteers. Scientists at the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health, developed the experimental vaccine, known as H1ssF_3928.

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:
• HFS posted updated **Fee Schedules for 2019**. You may view the updated fee schedules [here](#).

• HFS posted a new Provider Notice regarding **LTC Extension for January 2019**. You may view this notice [here](#).

• HFS posted a new Provider Notice regarding **Promoting Interoperability Program Attestation Extension**. You may view the new notice [here](#).

• HFS posted a new Provider Notice regarding **Proposed changes in methods and standards for establishing medical assistance payment rates**. You may view the notice [here](#).

• HFS posted a new Provider Notice regarding **Reimbursement and Billing for Services Effective April 1, 2019**. You may view the new notice [here](#).

• HFS posted a new Provider Notice regarding **Rate Year 2020 Determination for Disproportionate Share, Medicaid Percentage Adjustment, and County Trauma Center Adjustment Payments**. You may view the notice [here](#).

• HFS posted a new Provider Notice regarding **Critical Access Pharmacies (CAP) Attestation Period Closure**. You may view the new notice [here](#).

7) The **Illinois Department of Public Health (IDPH)** reports:

• **Schedule for IDPH Town Hall Meetings** will be out shortly.

• **IDPH Letter on QSO 19-10.** Attached please find the recently released CMS Memo *Infection Prevention and Control Training*. CMS and the CDC have collaborated to offer this free online training course in infection prevention and control for nursing home staff in the long term care setting. The "Nursing Home Infection Preventionist Training Course" is located on CDC’s TRAIN website ([click here](#)) and provides approximately 19 hours of continuing education credits.

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

• **Resource - Active Shooter Video for SNFs**

• **AHCA/NCAL Social Media Update.** Welcome to the AHCA/NCAL Social Media Digest, a biweekly newsletter detailing social media efforts and offering guidance to members on how to get more involved in social media and digital advocacy.

• **Webinar Recording on Five-Star Changes Now Available.** AHCA hosted a webinar summarizing the new Centers for Medicare & Medicaid Services (CMS) *Five-Star Rating System changes* that will be updated on Nursing Home Compare later this month. For those who were unable to participate, the recording of the webinar is now available for viewing [here](#).

A member toolkit that includes talking points, a letter to families and a letter to payors will be available to download on ahcancaLED [here](#) on Friday, April 12.

As a reminder, you can view the CMS announcement on the changes [here](#) and the updated Technical Users’ Guide [here](#).

If you have additional questions on the upcoming changes to your ratings, please email research@ahca.org. AHCA will continue to keep you informed.
The latest Your Top-Line publication for skilled nursing centers in Illinois is now available. Your Top-Line is a LTC Trend Tracker℠ publication that includes metrics and graphics outlining skilled nursing center’s progress on Five Star performance, the AHCA/NCAL Quality Initiative, their journey through the Quality Awards program, and other necessary data to help skilled nursing centers achieve their desired goals. Log into LTC Trend Tracker.

AHCA/NCAL Quality Initiative Quarterly Update.

9) Telligen reports:

This Month at Telligen

10) Today’s Geriatric Medicine reports that Alzheimer’s Screenings Often Left Out of Senior’s Wellness Exams. According to the Alzheimer’s Association, more than one-half of primary care providers fail to routinely test patients 65 and older to detect issues related to cognition and memory. NPR reports on the reasons physicians may be reluctant to perform these assessments.

Skilled Nursing News reports that the OIG Recovers $48M in Fraudulent Medicaid Payments. Skilled Nursing News reports the HHS Office of the Inspector General (OIG) revealed this week it has recouped "$48.7 million from nursing providers accused of fraud, with about $36.4 million coming from 15 civil settlements and judgments – and the remaining $12.3 million stemming from eight criminal convictions." The piece says those figures are "a significant rise from fiscal 2017, when the total fraud recoveries sat at about $1.4 million." The sums also "came amid overall declines in both the total dollar value of Medicaid recoveries and the number of settlements." The OIG wrote in its report, "The occurrence of large monetary settlements in certain years and the timing of these settlements contributes to this variability."

11) Skilled Nursing News reports that AHCA Partners with AHIMA to Develop Training for PDPM Coding. The Electronic Health Reporter reports that in a new collaboration, the American Health Care Association and the American Health Information Management Association (AHIMA) have developed "in-depth coding and CDI education courses to help prepare SNF providers" for the transition to the Patient Driven Payment Model (PDPM), which "will require CDI skillsets and knowledge of ICD-10-CM diagnosis codes in order to accurately support the qualifying stay and demonstrate the need for care and treatment best suited for each patient." Jennifer Shimer, AHCA/NCAL COO and Senior Vice President of Member Services, said, "ICD-10 is a driving force behind the new PDPM payment system for skilled nursing care. ... AHCA partnered with AHIMA to develop the best ICD-10 curriculum possible to prepare our members for this massive Medicare payment change."

12) The Electronic Health Reporter reports that CDC Funds $8M Effort to Stop Superbugs in Hospitals, Nursing Homes. NPR recently reported that hospitals and nursing homes in California and Illinois "are using the antimicrobial soap chlorhexidine" as part of an $8 million, CDC-backed effort "to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year." In the program, 14 facilities in Chicago "are screening people for the CRE [carbapenem-resistant Enterobacteriaceae] bacteria at admission and bathing them daily with chlorhexidine," and 36 facilities in Southern California "are using the antiseptic wash along with an iodine-based nose swab...to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections." The collaboration "recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community," said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research. He added, "No health care facility is an island. ... We all are in this complicated network."

13) Provider Magazine reports, AHCA Associate Vice President Discusses Changes to Therapy Services Under PDPM. Dan Ciolek, Associate Vice President of Therapy Advocacy for the American Health Care Association, writes in Provider Magazine to outline some of the expectations SNFs should have as the implementation of PDPM approaches, particularly given that changes to how SNFs are paid for through Medicare Part A services will shift "how physical and occupational therapy and speech-language pathology services (PT, OT, SLP) will be reimbursed and could impact how providers furnish therapy." Ciolek writes, "Under PDPM, therapy minutes and days will continue to be reported on the
five-day SNF PPS assessment for CMS analysis purposes but will no longer impact payment." Ciolek adds that "PDPM offers providers more flexibility to provide the right therapy care at the right time."

15) Neurology Advisor reports that Researchers Examine Resident-to Resident Aggression in Patients with Dementia Living in Long-Term Care Facilities. Neurology Advisor recently reported that researchers examined resident-to-resident aggression in patients with dementia living in long-term care facilities. The findings were published in the Journal of Bioethical Inquiry.

16) McKnight’s reports:

- Study Finds About 10 Percent of Patients Discharged from Hospital to SNF Were Not Visited by a Physician. McKnight’s Long Term Care News reports on a study published in Health Affairs finding that "about 10% of patients discharged from a hospital to a skilled nursing facility are not getting a visit from a doctor for a medical assessment," and of those that did not, "almost 28%...were readmitted to a hospital within 30 days and more than 14% died – both twice the rate of those who did have at least one visit." The study included "almost 2.4 million fee-for-service Medicare beneficiaries."

- Group of 17 LT/PAC Associations Join Workforce Website Launched by IHCA. McKnight’s Long Term Care News reports that a group of 17 "long-term and post-acute care associations announced they had joined CareForTheAging.org, a workforce website originally launched in 2017 by the Indiana Health Care Association/Indiana Center for Assisted Living." The website aims "to increase awareness of career pathways and boost workforce retention." Mark Parkinson, President and CEO of the AHCA/NCAL, said, "This collective effort will bring great value to our members, job seekers, students and the long-term and post-acute care profession as a whole. ... We’re excited to see this partnership come together and give our support to help providers attract and retain qualified, dedicated caregivers."

- Advice Offered on Preparing for “Involuntary Transfer” of Resident. McKnight’s Senior Living offers advice on how to prepare for an "involuntary transfer" of a resident. First, it says, "try to initiate communication with the resident or, if applicable, his or her family member, about a voluntary discharge before escalating the matter." Still, it adds, "If you fail to involuntarily discharge a resident, when appropriate, it creates a risk or harm to that resident as well as to other residents of the facility, its staff and visitors." McKnight’s also reminds readers to "check your local statutes, regulations and policies."

17) Interesting Fact: The United States walks the least of any industrialized nation. The average Australian takes 9,695 steps per day (just a few short of the ideal 10,000), the average Japanese takes 7,168; the average Swiss: 9,650; and the average American just 5,117.