May 22, 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!

Summary of the May 16, 2019 LTC Advisory Board Meeting

On Thursday, May 16, 2019, the Illinois Department of Public Health (IDPH) conducted the Long Term Care Advisory Board Meeting. A summary of the issues discussed is as follows:

- **Update of LTC rulemaking in process or already published:**
  - Section 300 National Fire Protection Association (NFPA) – This set of updates will bring the state’s life safety requirements up-to-date with the 2012 Life Safety Code. These updates were discussed, some changes were made and they were approved by the LTC Advisory Board. They will soon be published in the *Illinois Register* for public comment. Expect final adoption in late 2019.
  - Section 300.660 Nursing Assistants – Changes were made to this Section to update the Code due to recent legislative changes. The LTC Advisory Board agreed with the suggested changes and approved this set of revisions. They will soon be published in the *Illinois Register* for public comment. Expect final adoption in late 2019.
  - Section 300.661 Health Care Worker Background Check – This Section was also amended due to recent legislative action. The LTC Advisory Board agreed with the suggested changes and approved this set of revisions. They will soon be published in the *Illinois Register* for public comment. Expect final adoption in late 2019.
  - Section 300.663 Registry of Certified Nursing Assistants - The LTC Advisory Board agreed with the suggested changes and approved this set of revisions. They will soon be published in the *Illinois Register* for public comment. Expect final adoption in late 2019.
  - P.A. 099-822 New Dementia Requirements – This set of requirements was due to recent legislation. The rules have been through the rulemaking process and will soon be published as final rules. As soon as the rules are adopted, we will send notice to our members.
  - Section 300.120 Application for Licensure (facility specific email address) – This rule change is in process internally within IDPH and will be brought to the LTC Advisory Board for review at the next LTC Advisory Board meeting.
  - P.A. 100-217 Nurse Waivers – IDPH is currently drafting rules to implement this legislative change. IDPH stated that they hope to have the rules ready for Board review at the next LTC Advisory Board meeting.
  - Part 395 LTC Assistants and Aides Training Program Code – This set of rule changes has been in the works for several years. This set of rules allows for an [Advanced Nursing Assistant Training Program](#) or ANATP. The Board reviewed this set of new regulations and approved them. IDPH will soon publish this

- Status of Distressed Facility Rules and Proposed Legislative Revision – The legislation to make this provision of distressed facilities workable was stalled in committee and did not move forward. IHCA will continue to work with IDPH and the advocates to address the problems with this provision and develop language that will make the concept of distressed facilities workable.

- Status of Informed Consent for Psychotropic Medication Form and Website Development – There was also legislation proposed during this current legislative session to address and clarify the concept of informed consent. This legislation also stalled in committee. IHCA will continue to work with IDPH and the advocates to address the provision of informed consent.

- Discussion of a change to the Emergency/Convenience Medication Kits Requirement – This issue was postponed until the next meeting due to the presenter not being available for this meeting.

- Drug Regimen Review – change state requirement to federal requirement to address “onsite” issue – IDPH agrees and will draft language to allow for “offsite” review for Drug Regiment Reviews. IDPH will have the language for review for the Board at the next LTC Advisory Board meeting.

- Electronic Monitoring Devices – There was considerable Board discussion on this issue. The Board asked IDPH to discuss this issue internally with their legal department and provide some clear guidance to LTC facilities.
  1. Any rulemaking being considered to the original legislation
  2. Thoughts on Residents wanting to use Amazon Echo or Google Home – similar issues with resident rights and privacy as with other electronic monitoring devices

- Medical Marijuana Use in LTC Facilities – any progress on rulemaking – more and more pressure from residents wanting to use in LTC facilities – There was also considerable discussion on this issue. LTC facilities need guidance from IDPH if medical marijuana is going to be allowed/used in LTC facilities.

- IDPH gave a short summary on the New ePOC Initiative – IDPH stated that all but about 60 LTC facilities are now using the new ePOC process. There are some glitches that IDPH is working on. IDPH noted that if all of the four allowed users are corporate, the facility is not aware of any actions. IDPH suggested that at least one of the four allowed users be someone at the facility. If the facility allowed user leaves, make sure the new facility user gets registered. If a facility has any questions on this process, they should contact their IDPH reviewer.

The next LTC Advisory Board Meeting is scheduled for August 15, 2019.

**The End and the New Beginning, October 1, 2019**

On August 31, 2019 the SNF Prospective Payment System (PPS) that was in place for over 21 years, RUGs, with a long array of legislative fixes and regulatory changes culminating with RUG IV, comes to an end – perhaps somewhat abruptly, given the fact that there is no transition period.

For much of those years, experts such as the GAO and OIG/HHS researchers, MedPAC, leading health analytic entities such as the Urban Institute researchers, and an infinite variety of university health care payment researchers and institutes, all warned that something was very wrong with the basic RUG model. They demonstrated that the incentives built into the RUGs enabled SNFs to provide care based on quantity and not need. They argued that such an incorrect impetus led to provider overpayment, basically driven by rehabilitation therapy.

On October 1, 2019, PDPM commences. CMS has issued the proposed rule for FY 2020. Comments are due on June 18. Even though CMS offers no transition period, it did offer a rather long gestation period for PDPM with innumerable Technical Expert Panel (TEP) Meetings – starting in 2016. The TEPs involved SNF representatives and experts in all the
various services involved in SNF care. CMS also issued a possible new payment model, Resident Classification System, Version 1 (RCS-1) on May 4, 2017. Based on public reaction and extensive comments to RCS-1, CMS went back to the drawing board and came up with the PDPM which it showcased in the proposed rule of FY 2019, but scheduled to start on October 1, 2019, the fiscal year for 2020.

We have kept you apprised on all these developments, perhaps to the point of seeming redundancy. But the illusion of redundancy was indeed due in part to the extensive outreach efforts of CMS, outlined above, to examine and analyze the extensive professional input in the modeling. CMS kept revising and modifying.

What next? No more iteration of models. Despite the comment period provided, the PDPM model is essentially locked in. And no more major changes in the PDPM model – at least for now. Thus, we provide below a brief accounting of the proposed payments for FY 2020, a few changes that CMS did make to the PDPM in the FY 2020 proposed rule, and CMS’ updating of the value-based purchasing program (VBP) and the quality reporting program (QRP).

The PDPM Proposed Rule Published in the Federal Register on April 25, 2019

1. Update for SNF Aggregate Payments

CMS projects aggregate payments to SNFs will increase by $887 million, or 2.5 percent, for FY 2020 compared to FY 2019. This estimated increase is attributable to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment. CMS estimates that estimates that in FY 2020 under PDPM, SNFs in urban and rural areas will experience, on average, a 1.8 percent increase and 6.4 percent increase, respectively, in estimated payments compared with FY 2019. Providers in the urban outlying regions will experience the largest estimated increase in payments of approximately 61.3 percent. Providers in the urban Middle Atlantic region will experience the largest estimated decrease in payments of 0.8 percent.

As discussed in the SNF Proposed rule for FY 2019 and the March 2019 LTC Pharmacy Newsletter, CMS finalized the implementation of PDPM in a budget neutral manner. The total estimated payments under PDPM would be adjusted to be equal to what the total actual payments under RUG-IV would have been.

2. Align SNF PPS Group Therapy Definitions with Other PAC Settings

Various PAC settings permit therapists to furnish therapy to their patients in three different modes: individual, concurrent, and group. Under the current SNF PPS, group therapy is defined as consisting of exactly four patients. Other payment systems, such as the IRF PPS, define group therapy as including as few as two patients. For more fair and consistent therapy definitions across care settings, CMS is proposing to adopt the definition of group therapy that is used in the IRF PPS: group therapy consists of two to six patients doing the same or similar activities. CMS believes aligning the group therapy definition serves to improve the agency’s consistency in payment policies across PAC settings, and to create opportunities for site neutral payments.

3. Sub-Regulatory Process for International Classification of Diseases, Tenth Version (ICD-10) Codes Revisions:

PDPM utilizes ICD-10 codes to classify SNF patients into certain payment groups. Each year, the ICD-10 codes and guidelines are revised in a variety of so-called non-substantive ways, such as a single code being split into two more specific codes. To help ensure SNFs have the most up-to-date ICD-10 code information as soon as possible, in the clearest and most useful format, CMS proposes a sub-regulatory process for making what it refers to as non-substantive changes to the list of ICD-10 codes used to classify patients into clinical categories under the PDPM.

CMS makes the point that this sub-regulatory process aligns with similar policies in the SNF PPS and the Inpatient Rehabilitation Facility (IRF) PPS. For example, the SNF PPS already uses a sub-regulatory process to make non-substantive updates to the list of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to consolidated billing. And, the IRF PPS uses a similar sub-regulatory updating process for the IRF tier comorbidities list and for updating the ICD-10 code lists used for the IRF presumptive compliance methodology.
CMS makes all this sound painless and eminently reasonable. And so, it may be, but an endless list of federal court cases attest to the fact that there has been disagreement over the years as to what is or isn’t a “substantive change” in policy, one which requires notice and comment (e.g. a proposed rule followed by a final rule); as opposed to a non-substantive change which does not require this process.

Why is this so crucial? It is crucial because a sub-regulatory process is one which forgoes notice and comment in the issuance of policy changes. So the industry, e.g. health provider category such as SNFs or hospitals or IRFs etc. gets no say in the “sub-regulatory” change. I am not asserting that this process for the ICD-10 changes discussed in this proposed rule is questionable. That is for SNFs to weigh in on or not. But it bears watching.

4. **Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)**

SNF QRP is authorized by legislation and applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Under the SNF QRP, CMS must reduce by 2 percentage points the annual market basket percentage update in the case of a SNF that does not submit required quality data.

CMS proposes to adopt two new quality measures in FY 2020 to assess how health information is shared. The two proposed measures are:

1. Transfer of Health Information from the SNF to another Provider, and
2. Transfer of Health Information from the SNF to the Patient.

In addition, CMS proposes to adopt a number of standardized patient assessment data elements that assess cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, or social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, or social isolation). Finally, CMS proposes updates to specifications for the Discharge to Community PAC SNF QRP measure to exclude baseline nursing home residents.

5. **SNF Value-Based Purchasing Program (VBP)**

The SNF VBP Program began rewarding SNFs with incentive payments based on their quality measure performance on October 1, 2018. The program currently scores SNFs on an all-cause measure of hospital readmissions, and in the future, will transition to a measure of potentially preventable hospital readmissions. As required by statute, the program reduces SNFs’ Medicare payments by two percentage points, then redistributes 60% of those funds as incentive payments.

In the FY 2020 SNF PPS proposed rule, the SNF VBP Program is changing the name of the program’s measure to the “Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge” measure. The measure will retain the same abbreviation (SNFPPR). The proposed rule also includes an update to the public reporting requirements to ensure that CMS publishes accurate performance information for low-volume SNFs.

*Article authored by Elise Smith and featured in the May 2019 issue of LTC Pharmacy News.*

**Focus F-Tag – F865 QAPI Program/Plan, Disclosure/Good Faith Attempt – Parts 1 and 2**

This Regulatory Beat’s Focus F-Tag is F865 QAPI Program/Plan, Disclosure/Good Faith Attempt. We begin our look at Part 1 of the Quality Assurance and Performance Improvement regulatory group, which is comprised of 4 F-Tags. F865 QAPI Program/Plan, Disclosure/ Good Faith Attempt is a large regulation that was partially effective in Phase 2, but will be fully implemented in Phase 3 – November 28, 2019 – so it’s important to review ahead of this year’s effective date.

**QAPI Program Scope & Design**

The regulation at F865 requires that facilities develop, implement and maintain and effective, comprehensive and data-driven QAPI Program that focuses on indicators of care outcomes and quality of life. Each facility’s QAPI Program must address the full scope of care and services being provided. The QAPI Program must address all systems of care and
management practices, include clinical care, quality of life and resident choice, reflect the complexities, unique care/services being provided and utilize best available evidence to define and measure indicators of quality and the facility’s goals. These indicators and goals must be predictive of desired outcomes for residents.

**Ongoing QAPI Efforts**

Facilities are required to maintain documentation and be able to demonstrate evidence that their QAPI Programs are ongoing. The regulation at F865 states that this may be shown through systems and reports that demonstrate:

- Systematic identification, reporting, investigation, analysis and prevention of adverse events
- Documentation that demonstrates the development, implementation and evaluation of corrective actions or performance improvement activities (PIPs)

**What to Expect on Survey**

Effective with Phase 2 of the RoPs (November 28, 2017), facilities were required to present their written QAPI plans to surveyors. The expectation is that facilities will present their QAPI plans to surveyors during recertification surveys, when requested during any other survey type or when the Centers for Medicare & Medicaid Services (CMS) requests it at any time. Facilities are expected to present documentation/evidence that their QAPI Program is ongoing whenever surveyors or CMS requests this information.

Under the LTCSP, the QAPI Plan/QAA review task is expected to occur towards the end of the survey, according to the Interpretive Guidance (IG). Surveyors should have completed their investigations into all the other requirements to ensure that these findings are independent of what is reviewed in the QAPI Plan/QAA review. This helps to ensure that QAA Committee documents are not used by surveyors to identify additional concerns and to encourage facilities to feel as though they can openly conduct QA investigations and PI efforts without worrying it will have a negative outcome.

You might want to consider reviewing your QAPI Plan to ensure that it includes everything that it should, including how you identify and correct quality deficiencies. Guidance related to the QAPI Plan, per CMS, notes that key components to the process should include: “tracking and measuring performance, establishing goals and thresholds for performance measurement, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of system quality deficiencies, developing and implementing corrective action or performance improvement activities and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.” Once you finish your review, ask yourself if your QAPI Plan is robust enough to be scrutinized and if your QAPI Committee is “looking at” issues that really affect your resident population.

In **Part 2 of our Focus F-Tag related to F865**, we will look at who is responsible for the QAPI program and what type of QAA information needs to be provided to surveyors, as well as defining “good faith attempts” to correct. In Part 1, we reviewed the scope and design of a QAPI Program, the regulatory expectation that QAPI is continuous and ongoing, and also reviewed what will happen during survey related to QAPI. So, how does a facility ensure that all these things are happening and make proactive attempts to correct identified issues? Let’s find out.

**Governance and Leadership**

The governing body and/or executive leadership team are responsible for the facility’s QAPI program (view F837 Governing Body). They are responsible for ensuring that the QAPI Program:

- Is on-going, defined, implemented, maintained and addressed identified priorities
- Does not encounter issues during leadership/staffing transitions
- Has adequate resources (staff time/equipment/technical training)
- Identifies and prioritizes issues and opportunities that reflect the facility’s process, functions and services provided to residents. This should be based on performance indicator data, resident input, staff input and other data sources available.
- Has clearly set expectations regarding safety, quality, rights, choices and respect
- Addresses gaps in systems through corrective actions that are evaluated for effectiveness
**Good Faith Attempts**

The regulation at F865 clearly discusses the idea of “good faith attempts to correct.” The Interpretive Guidance (IG) states that if a facility has identified and made a good faith attempt (through its QAA Committee) to correct an issue that has been identified by surveyors on the current survey, the facility will not be cited for QAA. However, the facility can still be cited under other relevant tags. The expectation is that the surveyor will determine if:

- The facility became aware of the issue as soon as it should have
- The issue was one the facility should have been tracking because it was high-risk/high-volume/problem-prone
- There was a negative outcome to a resident that should have alerted the facility to the issue
- There has been sufficient time to address the issue by implementing changes and evaluating their effectiveness
- The efforts made show an honest, diligent attempt to correct the issue

**Other Things to be Aware of**

- Surveyors can only require a facility to disclose QAA Committee records if they are used to determine the extent to which the facility is compliant with the QAA provisions.
- If documents contain information necessary to determine compliance with QAA or QAPI regulations, the facility must allow the surveyors to review and copy them.
- Information from these records will not be used to cite new issues or expand the scope/severity of issues the surveyors have already identified. (This is why the QAPI/QAA review occurs towards the end of survey during the LTCSP.)
- Reports and logs such as Incident/Accident reports, wound logs and other records used to track adverse events are not protected from disclosure.
- If a facility refuses to provide evidence of compliance with QAA, the IG is very clear – the facility will be cited for noncompliance at F865, will be required to submit a Plan of Correction, and may be penalized with enforcement remedies that can include termination of the provider agreement. This is because the QAA Committee’s records may be needed to determine a facility’s compliance with Medicare requirements at 483.75, and access is denied to surveyors, this creates a risk of terminating the provider agreement.

In closing, if you have not wrapped your arms around the need to be compliant with all aspects of this regulation put some time aside for you and your team to review your QAPI Program/Plan and how you can demonstrate compliance.

In upcoming issues of *Regulatory Beat*, we will review the other three remaining F-Tags (F866, F867 and F868) under the Quality Assurance and Performance Improvement regulatory group.

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**Trending Statistics**

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

**HHS OIG - Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed to Ensure the Health and Safety of Residents**

In this data brief [click here](#), HHS OIG analyzed nursing home deficiencies that were identified by state survey agencies (state agencies) across the Nation for calendar years (CYs) 2013 through 2017 (review period). This data brief offers the Centers for Medicare & Medicaid Services (CMS) and other stakeholders (e.g., state agencies and nursing home management) insight into deficiency trends at nursing homes nation-wide. It also complements our previous report on state agencies’ verification of correction of nursing home deficiencies.

The OIG’S objective was to analyze trends in the deficiencies that State agencies identified in nursing home surveys across the Nation.
Key Takeaways:

- The number of nursing home surveys and deficiencies slightly increased each year from 2013 through 2016, then slightly decreased in 2017.
- Ninety-four percent of deficiencies had “less serious” ratings, and 6 percent of deficiencies had “more serious” ratings.
- About 31 percent of nursing homes had a deficiency type that was cited at least five times during our review period.
- Ten states accounted for half of the deficiencies identified.
- The top 10 of 340 deficiency types accounted for more than 40 percent of deficiencies.
- The results of our analysis do not clearly indicate whether the quality of care and the safety of nursing home residents improved during our review period.

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

1) There were no new Federal CMS Quality, Safety and Oversight Letters (formerly known as Survey and Certification (S&C) Letters) released since the last issue of Regulatory Beat.

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

- **CMS Post Early Release of New RAI Manual for PDPM Training.** CMS has posted an early release of the MDS 3.0 RAI Manual v1.17. The much-anticipated draft document spells out many requirements that nursing home operators will need to follow when the Patient-Driven Payment Model (PDPM) takes effect on October 1, 2019. The 1,299 page manual appeared on the MDS 3.0 RAI Manual web page. The posting will allow providers to actively prepare for the most notable payment and resident classification changes in more than a generation. Although the released document is called a “Draft,” it includes many key elements that will help providers and trainers prepare.

- **SNF Provider Preview Reports are Now Available.** Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. The data contained within the Preview Reports is based on quality data submitted by SNFs between Quarter 4 – 2017 and Quarter 3 – 2018, for assessment-based quality measures, and between Quarter 1 – 2017 to Quarter 4 – 2017, for claims-based quality measures. Providers have until **May 30, 2019** to review their performance data prior to the July 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. For more information see CMS SNF Quality Public Reporting webpage, NH Compare website and Preview Report Access Instructions.

- Recently CMS published a final rule in the Federal Register, which clarifies Changes to the Appeals Process in the Medicare Program for Providers. The final rule revises the regulations for appealing adverse determinations regarding claims for benefits under Medicare Part A and Part B or determinations for prescription drug coverage under Part D. Provider Magazine has the story HERE. In addition, the most recent Skilled Nursing Facility Provider Preview Reports are available. CMS recommends that providers review their performance data by May 30, prior to public display on Nursing Home Compare in July 2019. Corrections to the underlying data are not permitted during this time, but you can request a CMS review if you believe your data is inaccurate. For more information:
  - SNF Quality Public Reporting webpage
  - Access Instructions
CMS Streamlines Medicaid Review Process and Reduces Approval Times so States Can More Effectively Manage Their Programs [click here]. At CMS, we are making great progress to transform Medicaid, which CMS’ largest program serving 72.5 million beneficiaries. We are working to reset the federal-state relationship and restore the partnership between the states and the federal government, while at the same time modernizing the program to deliver better outcomes for the people we serve.

CMS has made significant improvements in administering the Medicaid program in partnership with states. Identified early as a priority for both the Trump Administration and the National Association of Medicaid Directors (NAMD), I charged a CMS team to collaborate with states to make the state plan amendment (SPA) and 1915 waiver review process more transparent, efficient, and less burdensome so we can reduce processing times. This is particularly important as these represent the bulk of approvals states need to receive to make even routine changes to program benefits, rates, and eligibility requirements. When this process doesn’t work, it can create bureaucratic headaches that hinder their ability to effectively manage their program.

REGISTRATION OPEN – Hospice Quality Reporting Program: Review and Correct Report Overview Webinar. The Centers for Medicare & Medicaid Services (CMS) will be hosting a webinar on Tuesday, June 11, 2019, from 2:00 to 3:30 p.m. ET. The purpose of the webinar is to increase providers’ awareness of how to use the new Review and Correct Report to verify the data displayed on the Hospice Compare website for their facility is accurate. See the Hospice Quality Reporting Program Spotlight & Announcements webpage for details.

Recovery Audits: Improvements to Protect Taxpayer Dollars and Put Patients over Paperwork. The Medicare Fee-For-Service (FFS) Recovery Audit Contractor (RAC) Program is one of many tools CMS uses to prevent and reduce improper payments. RACs identify and correct overpayments made on claims for health care services provided to beneficiaries, identify underpayments and provide information that allows us to prevent future improper payments. We reduced RAC-related provider burden to an all-time low, as evidenced by the significant decrease in the number of RAC-reviewed claim determinations that are appealed and the corresponding reduction in the appeals backlog. Examples of key improvements and enhancements:

- Better oversight
- Holding RACs accountable for performance by requiring them to maintain a 95% accuracy score
- Requiring RACs to maintain an overturn rate of less than 10%
- RACs will not receive a contingency fee until after the second level of appeal is exhausted
- Reducing provider burden and appeals
- Making RAC audits more fair to providers
- Changing how we identify who to audit
- Giving providers more time to submit additional documentation before needing to repay a claim
- Increasing program transparency
- Regularly seeking public comment on newly proposed RAC areas for review, before the reviews begin
- Requiring RACs to enhance their provider portals to make it easier to understand the status of claim.

For more information visit the Medicare FFS Recovery Audit Program website. See the full text of this excerpted CMS Blog (issued May 2).

New Part D Opioid Overutilization Policies: Myths and Facts. CMS implemented new opioid policies for Medicare drug plans effective January 1. This is the final message in our series on common myths about these new policies and the facts for providers.

Myth: “There is nothing I can do to help my patients who need more opioids.”
Fact:

- If a pharmacy cannot fill the prescription as written because of an opioid safety edit and the issue is not resolved at the pharmacy, the prescriber can contact the Medicare drug plan to ask for a coverage determination on their patient’s behalf
- A coverage determination can also be requested before prescribing an opioid
Prescribers can attest to the Medicare drug plan that the cumulative level or day supply is the intended and medically necessary amount.

Additionally, to resolve opioid safety alerts expeditiously, CMS encourages prescribers to respond to pharmacist outreach in a timely manner.

Medicare Part D opioid policies are not prescribing limits and generally do not apply to enrollees who have cancer, get hospice, palliative, or end-of-life care, or who live in a long-term care facility. The new policies encourage collaboration and care coordination among Medicare drug plans, pharmacies, prescribers, and patients to improve opioid management, prevent opioid misuse and promote safer prescribing practices.

For More Information:
- Roadmap
- Letter to providers about reducing opioid misuse
- Prescriber’s Guide to New Medicare Part D Opioid Overutilization Policies for 2019
- MLN Matters Article
- Training Materials for prescribers, pharmacists and patients
- YouTube video from February 14 Medicare Learning Network call

**Comprehensive Strategy to Foster Innovation for Transformative Medical Technologies.** On May 2, CMS Administrator Seema Verma for the first time walked through the agency’s comprehensive strategy to improve patients’ access to emerging technologies. The Administrator highlighted two specific actions.

First, for issuing HCPCS codes, CMS is changing the current process of allowing only one opportunity per year to apply for new Level II codes. The agency is moving to a process with quarterly opportunities to apply for drugs and semi-annual opportunities to apply for devices. CMS anticipates this will greatly improve the ability for technologies to move through the adoption curve.

Second, for technologies with CPT Category III codes (which are temporary codes used for emerging technologies), CMS is clarifying that for technologies that do not fall under an existing Local Coverage Determination (LCD), Medicare contractors are required to follow the transparent new LCD process for every local coverage decision, including reviewing the evidence with respect to the technology.

For More Information:
- Speech: Remarks by Administrator Seema Verma at the Medical Device Manufacturers Association Annual Meeting
- LCD Modernization Process Qs & As

See the full text of this excerpted CMS Press Release (issued May 2).

**Part D Prescriber PUF and Opioid Prescribing Mapping Tools Updated with 2017 Data.** CMS released an update to the Medicare Part D Prescriber Public Use File (PUF), the Medicare Part D Opioid Prescribing Mapping Tool, and the Medicaid Opioid Prescribing Mapping Tool with data for 2017:
- Medicare Part D Prescriber PUF: Summarized information on prescription drugs that were prescribed by individual physicians and other health care providers and paid for under the Medicare Part D Prescription Drug Program
- Medicare Part D Opioid Prescribing Mapping Tool: An interactive, web-based resource that presents geographic comparisons at the state, county, and ZIP code levels
- Medicaid Opioid Prescribing Mapping Tool: An interactive, web-based resource that presents geographic comparisons at the state level

**New Medicare Card: Need an MBI for a Patient?** You can find the Medicare Beneficiary Identifier (MBI) on the remittance advice of a prior claim or from your Medicare Administrative Contractor’s portal (get access if you do...
not already have it). Update your system and use it on the claim. Still having problems? Review the one page Understanding the MBI Medicare Learning Network Educational Tool to learn about:
  - Alpha and numeric characters
  - Letters never used to avoid confusion

- **Putting our Rural Health Strategy into Action.** Approximately 60 million Americans or roughly 1 in 5 live in rural areas, with nearly every state having a rural county. CMS recognizes the significant obstacles faced by patients and providers in rural areas and places an unprecedented priority on improving the health of these Americans, including the introduction of the first **Rural Health Strategy.** In the last year, we took several steps to improve rural health:
  - Expanded access to telehealth and other virtual services across the Medicare program
  - Proposed to increase the wage index of rural and other low wage index hospitals through the **Inpatient Prospective Payment System (IPPS) proposed rule:** We are seeking input on several approaches for accomplishing this
  - Proposed to remove urban-to-rural hospital reclassifications from the calculation of the rural floor wage index value through the **IPPS proposed rule**
  - Announced the **CMS Primary Care First Initiative,** a new set of payment models for primary care practices and other providers; Seeking public comment on the Direct Contracting: Geographic Population-Based Payment model option
  - Developing a new innovative model for rural communities that will offer a pathway for stakeholder coalitions to invest collectively in increasing access and improving rural health care delivery

See the full text of this excerpted [CMS Blog](https://www.cms.gov/Blog/issued-May-8) (issued May 8).

- **Help Prevent Older Adult Falls: New Clinical Tools from the CDC.** The Centers for Disease Control and Prevention (CDC) released two new complimentary clinical tools to help health care providers reduce older adult falls:
  - **Coordinated Care Plan to Prevent Older Adult Falls:** Framework for implementing a Stopping Elderly Accidents, Deaths, and Injuries (STEADI)-based clinical fall prevention program
  - **STEADI: Evaluation Guide for Older Adult Clinical Fall Prevention Programs:** Key steps for measuring and reporting on the success of your program

Older adult falls are the leading cause of all fatal and nonfatal injuries among adults age 65 and over in the United States, accounting for over 3 million emergency department visits, 962,000 hospitalizations, and approximately 30,000 deaths in 2016. Help keep your older adult patients safe, independent, and STEADI. To learn more visit the [STEADI](https://www.cdc.gov/steadi/) webpage.

- **CMS Is Committed to Ensuring Safety and Quality in America’s Nursing Homes.** CMS is committed to ensuring safety and quality in America’s nursing homes. To make good on that commitment, CMS Administrator Seema Verma recently announced a five-part strategy in a blog, “**Ensuring Safety and Quality in Nursing Homes.**”

CMS has been actively addressing patient safety, improved oversight, stronger enforcement mechanisms, increased transparency, all while minimizing the administrative workload that keeps providers from seeing their patients. Administrator Verma has led the agency charge to issue new and innovative guidance that takes key steps and makes across-the-board improvements in healthcare safety and quality.

In case you missed any of these announcements or have interest in the important work taking place at CMS, we are highlighting recent activities. On April 24, Nursing Home Compare updates that were announced in the March 5 CMS [Press Release](https://www.cms.gov/Press-Release/Press-Releases/2019-03-05-CMS-Releases-Updated-Nursing-Home-Compare-Data) went live. You may also be interested in reading Administrator Seema Verma’s Blog “**Protecting the Health and Safety of all Americans.**”

- **Renewal of the HHCCN.** The Office of Management and Budget (OMB) has approved the Home Health Change of Care (HHCCN) Form, CMS-10280. Effective July 1, 2019, all Home Health Agencies (HHA) will be required to
use the renewed form with the expiration date of 4/30/2022 on the bottom. Please note that HHAs may continue to use the old form up until July 1, 2019 but we encourage HHAs to begin transitioning to the renewed form. There have been no changes made to the form. HHAs may find the form and the form instructions in the download section of the website here.

- **Laboratory Blood Counts: Provider Compliance Tips.** In 2017, the Medicare fee-for-service improper payment rate for blood counts was 19.2 percent with projected inaccurate payments of $56.6 million. Improper payments resulted from:
  - Insufficient documentation - 89 percent
  - Incorrect coding - 8.3 percent
  - No documentation - 2.7 percent
  - Prevent denials by reviewing the Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet, which details coverage and documentation requirements

- **Post-Acute Care QRPs: Reporting Requirements and Resources Call — Wednesday, June 5, 1 - 2:30 pm CST.** Register for Medicare Learning Network events. During this call, learn about reporting requirements and resources for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) and Skilled Nursing Facility (SNF) Quality Reporting Programs (QRPs). Topics:
  - Data submission requirements and deadlines
  - Annual Payment Update requirements
  - Reconsideration process
  - Reports

- **International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs).** A new MLN Matters Article MM11229 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) is available. Learn about updates and changes. A new MLN Matters Article MM11230 on Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program is available. Learn about system changes.

- **Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Reminder.** The Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Medicare Learning Network Educational Tool is available. Learn:
  - Billing information
  - Frequently asked questions
  - Codes
  - Descriptors

- **AMCC Lab Panel Claims Payment System Logic.** A new MLN Matters Article MM11248 on Re-implementation of the Automated Multi-Channel Chemistry (AMCC) Lab Panel Claims Payment System Logic is available. Learn about changes to editing within the claims processing system to enforce National Correct Coding Initiative guidance.

- **E/M Services of Teaching Physicians: Documentation.** A new MLN Matters Article MM11171 on Documentation of Evaluation and Management (E/M) Services of Teaching Physicians is available. Learn about the documentation policy change.

Implementation of the SNF Patient Driven Payment Model — Revised. A revised MLN Matters Article MM11152 on Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) is available. Learn about the required changes.

MLN Catalog May 2019 Edition. The MLN Catalog May 2019 Edition is available. Learn about:
  o Products and services you can download for free
  o Web-based training courses; some offer continuing education credits
  o Helpful links, tools and tips

Provider Compliance Tips for Nebulizers and Related Drugs — Revised. A revised Provider Compliance Tips for Nebulizers and Related Drugs Medicare Learning Network Fact Sheet is available. Learn about:
  o Coverage requirements
  o How to prevent claim denials
  o Documentation needed to submit a claim

Medicare Diabetes Prevention Program Expanded Model — Reminder. The Medicare Diabetes Prevention Program (MDPP) Expanded Model Medicare Learning Network Booklet is available. Learn to:
  o Become a Medicare-enrolled MDPP supplier
  o Help beneficiaries with prediabetes decrease diabetes risk
  o Look for an MDPP supplier

Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training Course — Revised. With Continuing Education Credit. A revised Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn about:
  o Billing requirements
  o Claims processing actions
  o How to identify aspects of paper and electronic claims

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


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

Report Summarizes Effectiveness of Drugs To Treat Osteoporosis. A new AHRQ-supported report summarizes the effects of long-term osteoporosis drug treatments in postmenopausal women aged 50 years and older and shows two therapies—alendronate and zoledronic acid—can reduce fracture risk. The evidence review also demonstrates that long-term bisphosphonate treatment beyond three to five years may reduce risk for vertebral fractures, but increases the risk for rare adverse events, such as osteonecrosis of the jaw and atypical femoral fracture. Based on nearly 50 studies from 1995 to 2018, the review also concludes that long-term hormone therapy reduces hip fracture risks but can lead to serious harms. Access the report and the abstract to an Annals of Internal Medicine article based on the review. This report was conducted in partnership with the NIH Office of Disease Prevention for the Pathways to Prevention workshop: Appropriate Use of Drug Therapies for Osteoporotic Fracture Prevention. An independent panel also developed a companion article to summarize gaps in knowledge and recommend areas for new research. A commentary piece accompanies both reports in the April 23 issue of Annals of Internal Medicine.

For Medicare Heart Failure Patients, Hospital Readmission Risks Are Highest Immediately Following Nursing Home Discharge. Patients with heart failure were more likely to go back to the hospital within two days of being discharged to their homes from a skilled nursing facility, but after that two-day period the chance of readmission declined considerably, a recent AHRQ-funded study found. In the study, published in the Journal of the American Medical Directors Association, researchers examined records of 67,500 Medicare patients 65
years and older who were hospitalized with heart failure 30 days after discharge from a nursing home in 2012-2015. Of them, 16,333 (24 percent) were readmitted within 30 days of discharge from the facility. But the readmission rate was at least twice as high in the first two days after discharge as in subsequent days. The results are meaningful because 1 in 5 Medicare patients has heart failure. Researchers suggested that further work should examine if current hospital discharge practices could be applied to the transition from nursing home to home. Access the abstract.

- AHRQ’s Hospital-Based Re-Engineered Discharge Program Adaptable to Skilled Nursing Facilities. An AHRQ-funded toolkit designed to improve the hospital discharge process can be adapted for use in skilled nursing facilities (SNFs), according to a study published in the Journal of Nursing Care Quality. Researchers tracked the implementation of AHRQ’s Re-Engineered Discharge (RED) toolkit over 18 months at four short-stay SNFs in the Midwest. They evaluated whether the RED toolkit could help involve family members and caregivers with patient-focused discharge plans; reconnect patients quickly to primary care providers; and educate patients at discharge about their health condition, medications and other chronic health needs. While staff capacity and corporate-level policies may limit adoption of some components, transitional care processes such as RED can be adapted for SNFs to improve discharges, researchers concluded. Access the abstract.

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

- HFS posted a new Public Notice regarding Proposed Changes in Methods and Standards for establishing Medical Assistance Payment Rates. You may view the notice here.

- HFS posted a new Public 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 The Medical Electronic Data Interchange (MEDI) System – Identifying Dual Eligible Beneficiaries Enrolled in HealthChoice Illinois Managed Long Term Services and Supports (MLTSS). You may view the new notice here.

- HFS posted a new Provider Notice regarding Medicare-Medicaid Alignment Initiative (MMAI) - Central Illinois Region Managed Care Update. You may view the new notice here.


- HFS posted a new Provider Notice regarding Advance Payment Requests Due to Financial Hardship. You may view the new notice here.

- HFS posted a new Provider Notice regarding An Overview of the Preadmission and Conversion Screenings Process for Potential Supportive Living Program Participants. You may view the new notice here.

- HFS posted a new Provider Notice regarding Long Term Care Admission Transaction Rejections without Notification. You may view the new notice here.

- HFS posted a new Provider Notice regarding Instructions to Long Term Care Providers for Locating the Redetermination Date of Medicaid Eligible Residents in the Medical Electronic Data Interchange (MEDI) System. You may view the new notice here.

6) The Illinois Department of Public Health (IDPH) reports:

- Schedule for IDPH Town Hall Meetings will be out shortly.
ePOC Update. 664 facilities have registered in ePOC out of 728 eligible facilities. That is 91 percent. We only have 64 facilities not registered. QA is reaching out to each facility each time they have a survey to encourage them to get registered so that we can send their SOD via ePOC.

Pam Winsel, Review and Certification Manager will be leaving IDPH. Pam’s last day is May 15. All ePOC questions should go to the facilities Reviewer.

Pam will be going to HFS. We wish her the best at her new position.

ePOC has speeded up the process; facilities are receiving SOD faster; we are getting POC quicker; facilities are getting approval/rejection of ePOC quicker. All of this is good, however, the good comes with a slight glitch. Sometimes we receive a POC from a facility and we have already accepted/rejected prior to the 10-day time period for the IDR. The IDR then comes after we have accepted/rejected the POC. If we make changes to the deficiencies due to the IDR or an administrative review then we must repost the survey per CMS, because the SOD is no longer accurate and the POC should match the SOD. Once we repost the survey the facility will get notification that there has been a change due to IDR. The facility will need to resubmit the POC even if we have already accepted/rejected the POC because of the modification due to IDR.

Overall, we have received very positive feedback from facilities regarding ePOC. Facilities have said they find it easy to use and that they like how fast everything moves. They like being able to see if POC are accepted or rejected so timely and they like not having to do an entire POC over when we only reject one deficiency.

If you are experiencing any problems, contact your IDPH Reviewer.

o Notice of Funding Opportunity for Infection Prevention Liaison Program. Please help us get the word out that there is a new Notice of Funding Opportunity (NOFO) posted for the Infection Prevention Liaison Program. Additional information is available here.
  o Click on “…browse a list of current funding opportunities”
  o Click on “Infection Prevention Liaison Program (formerly Healthcare Infection Control Assessment & Response Grant”)

Please note:
  o The deadline to apply is June 6, 2019
  o Interested applicants are REQUIRED to attend an information session: May 15, 2019 10:00am CST - or - May 28, 2019 1:00pm CST

See NOFO for call-in details.

A “pdf” of the opportunity announcement is attached to this email.

Any questions regarding this opportunity are to be directed to Ms. Chinyere Alu @ Chinyere.Alu@illinois.gov.

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

- AHCA PDPM Academy Weekly Update: May 9. In the AHCA PDPM Academy workshops we have emphasized that PDPM will no longer use 20 MDS items used to classify residents under RUG-IV related to Section G activities of daily living and Section O therapy minutes and days. This improved reference table tool indicates all the MDS elements that will be used by PDPM to classify each resident under the PT, OT, SLP, Nursing and NTA components that we previously provided in our high impact tables, and it now includes items currently used to classify residents under RUG-IV for comparison purposes. Click here to access.

- AHCA PDPM Academy Weekly Update: May 16. Live Webinar May 28, 2 p.m. - 3:30 p.m. CST. Add this live event to your calendar by going to your dashboard and locating the title, AHCA PDPM Academy Monthly Live
Webinars. Then under the contents tab, scroll to the May 28 webinar and click add to calendar. You can login 15 minutes before the start time.

An important feature of your PDPM Academy participation is access to monthly live 90-minute webinars on recently announced CMS information, AHCA PDPM training resources, and transition updates. These webinars will be held the last Tuesday of each month, 3:00 p.m. – 4:30 p.m. (Eastern). Access to the monthly calls will require a specific login for each individual. If you need assistance with your login information please email educate@ahca.org.

The webinars also include at least 30-minutes of question and answer. Additionally, the webinars will be recorded and FAQs and related materials posted with the video file. Please note we anticipate large participant numbers. If we are unable to respond to your question due to the number of participants, please direct questions to the pdpm@ahca.org email address. We incorporate questions submitted at the email address into our FAQ documents.

The recording of each live event will be accessible at this link, AHCA PDPM Academy Monthly Live Webinars.

- **How to Access Your PDPM Academy Resources.** To locate all AHCA PDPM Academy resources, please follow these 4 steps:
  - Go to AHCA PDPM academy web page at https://educate.ahcancal.org/pdpmacademy
  - Click the yellow “LOG IN” button on the left side of the page and enter your login information. (contact educate@ahca.org if you have any logon problems).
  - Click on the “MY DASHBOARD” button on the left side of the page
  - Scroll down to the “PACKAGES” near the bottom of the page and click on “AHCA PDPM Academy.”

Please contact educate@ahca.org for any assistance needed.

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

We've collected several stories from the past couple of weeks as well as drafted some sample posts for you to share on social media. Sharing the positive stories that happen every day in your buildings as well as the hardships you face are the only way to change the narrative about long term and post-acute care. We encourage you to join in.

We are excited to have several new subscribers to this email. Please help us spread the word! If you have an interested colleague or a suggestion for what to share on social media, please have them send an email at socialmedia@ahca.org so they can join in.

8) **Telligen reports:**
  - **This Month at Telligen.**

9) **Kaiser Health News** reports Nursing Home Compare Adds Ratings for Rehab Services. Kaiser Health News reports that "the federal government is shining a spotlight on the quality of rehabilitation care at nursing homes." Specifically, "Medicare’s Nursing Home Compare website now includes a ‘star rating’ (a composite measure of quality) for rehab services" and "breaks out 13 measures of the quality of rehab care, offering a more robust view of facilities’ performance." If a facility on the website "has an average or low quality score, Dr. David Gifford, a senior vice president at the American Health Care Association, a nursing home industry group, recommended that people look closely at various measures and try to figure out where the institution fell short."

10) The **New York Times** reports Analysis: Most Americans Who Will Need Long-Term Care In 2029 Will Not Be Able to Afford It. The New York Times reported a new analysis in Health Affairs determined that in a decade, "most middle-
income seniors will not be able to pay the rising costs of independent or assisted living." The analysis suggests the middle-income cohort in 2029 would need "access to about $25,000 to $74,000 a year in current dollars" for those aged 75 to 84. The analysis indicates nearly "14.4 million people will fall into the middle-income category, almost double the current number," and that while they are "less likely to experience poverty...80 percent of middle-income seniors will have less than $60,000 a year in income and assets," while the "estimated cost of assisted living plus out-of-pocket medical expenses will hit $62,000."

11) **Skilled Nursing News** reports that a webinar says some providers not ready for PDPM despite looming implementation. [Skilled Nursing News](https://www.skillednursingnews.com) reports a recent webinar from Minnesota-based consulting firm Health Dimensions Group (HDG) reviewing the fiscal 2020 SNF PPS proposed rule outlined the key takeaways providers should expect for implementation of the Patient-Driven Payment Model. Brian Ellsworth, vice president of public policy and payment transformation at HDG, said, "The biggest takeaway...is that PDPM is on track to be implemented on October 1," adding that "providers are in varying stages of readiness." HDG recommended that operators "look to changes that CMS made to the accountable care organization (ACO) and bundled payment programs," and that while some ACOs may depart, "the ones that remain will be looking for good partners."

12) **Axios** reports that long term care costs expected to “explode” in coming decades. The problem of "prohibitively expensive" long term care "is expected to explode in scope in the next couple of decades," Axios reports. The problem "is especially acute for the group of seniors that have incomes too high to qualify for Medicaid or subsidized housing, but too low to afford pricey long term care."

13) **Provider Magazine** reports that AHCA’s Ciolek: To Succeed Under PDPM, Providers Should Return to Daily Self-Assessments of Levels of Care. Daniel Ciolek, American Health Care Association associate VP, therapy advocacy, wrote in the May Issue of Provider Magazine that upcoming changes to Medicare reimbursement under PDPM should encourage providers to return to "go back to the future" of managing SNF resident level of care (LOC). While the RUGs system encouraged providers to track "minutes, days, and number of therapy disciplines involved in the resident’s care, with less focus on discussing skilled nursing needs," the switch to PDPM offers an opportunity to "blow the dust off the old daily Part A meetings playbook and self-assess whether they are adequately discussing the SNF LOC criteria like we did before RUGs were introduced in 1998."

14) **HealthDay** reports mental decline may be greater in seniors who engage in low-activity exercises than seniors who engage in high-activity exercises. HealthDay reports researchers "compared results of two sets of brain scans and tests measuring memory and thinking skills in 876 seniors" that "were done five years apart," and "found a greater mental decline for those who reported low-activity exercises, such as light walking and yoga, compared to those with high-activity levels and exercises like running and cardio workouts." The findings of the 876-participant study were published in Neurology.

15) **McKnight’s** reports:

- **Professor Mulls Ethical, Legal Issues of Nursing Home Cameras.** In an opinion piece for McKnight’s Long Term Care News, senior editor Elizabeth Newman writes that one "problem, according to Clara Berridge, Ph.D., an assistant professor of social work at the University of Washington, is nursing home cameras can raise more legal and moral issues than they solve." The professor "outlines three big ethical issues: The risk that in-room cameras pose to residents’ privacy and dignity, the risk of undermining care workers’ sense of being fiduciaries for residents, and the probable extension of camera use by facilities to monitor staff and residents." Newman concludes, "Ultimately, Berridge’s posing of questions convinced me that we haven’t thought enough about these cameras. Or maybe we have and realized, in this day and age, the concept of privacy seems quaint."

- **Study: Ransomware is Top Cyber Threat for Health Care Providers.** McKnight’s Long Term Care News reports that "ransomware attacks are the biggest data breach threat facing nursing facilities and other health care institutions, a new analysis finds." Such attacks "accounted for 68 out of 602 health care breaches over the past two years, a Bloomberg investigation concluded." According to Colin Zick, a health care attorney with
Foley Hoag, "training should focus on recognizing phishing attempts and resisting the urge to click on questionable hyperlinks." Experts also recommended "punishing employees who violate privacy laws, segmenting data to minimize ransomware attacks' reach, and conducting periodic disaster recovery tests."

- **Visual Monitors May Improve Turning Practices by Nursing Home Staff.** *McKnight’s Long Term Care News* reports a new study indicates that visual monitors which "cued staff to reposition nursing home residents every two hours led to more frequent turning." Researchers conducted the study at a 120-bed nursing home and "found use of the patient-monitoring system brought the facility closer to compliance with recommended two-hour turn rate, which could help prevent pressure ulcers." Researchers published the findings in the *Journal of Wound Ostomy & Continence Nursing.*

16) **Interesting Fact:** Memorial Day - The holiday was celebrated by “decorating” the graves of fallen soldiers with flowers, flags, and more, hence the name “Decoration Day.” Over time, it became known as Memorial Day.