Who is Inspecting Your Fire Doors?
Hopefuly by now, your organization has a program in place that includes fire door inventory, inspection and testing. However, recently some state survey agencies have been looking closely at who is conducting the required fire door inspections. In fact, a few health care organizations have been cited under K-761. So, who can inspect and test your fire doors?

The Life Safety Code® (Section 7.2.1.15.5) indicates that testing of fire door assemblies “shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subject to the testing.” The code language very specifically does not include the term “certified.” A person is not required to be certified or licensed to conduct fire door testing and inspection. Rather, a health care organization should be prepared to demonstrate how the individual(s) conducting their fire door inspection and testing is knowledgeable and experienced in the process. Documentation is often the best mechanism to accomplish this. Some best practices for establishing knowledge and competency include:

- Maintain on-site a copy of the fire door inspection and testing checklist found in NFPA 80.
- Document any training or education an individual has received specific to fire door inspection, testing, installation and/or repair.
- Outline the length of time an individual has been working with fire door assemblies.

You can purchase a copy of NFPA 80 online at [www.nfpa.org](http://www.nfpa.org).

How Telehealth Can Benefit Post-Acute Care
As patient preferences have evolved over the last decade, new forms of providing healthcare and home health services have continued to unfold. One popular trend is the rise of telehealth.

For most providers, telehealth can mean a lower cost of providing health service and for patients as it offers convenience and increased access to care.

A major component to a successful telehealth strategy and program is the ability to actively engage patients in their care. Across the healthcare ecosystem, patient and resident engagement is increasingly seen as a top strategic priority due to the opportunity to improve patient outcomes and maximize potential reimbursements. Home health agencies, in particular, are faced with some of the most significant changes in reimbursement and regulatory requirements, highlighting the importance of new, cost-effective strategies to remain competitive and profitable.
Engagement is a set of tools, processes, and actions that allow providers and residents/patients to communicate effectively to make informed decisions to improve outcomes. One common misconception is that patient engagement only happens in the home during home health visits; however, there are many opportunities for agencies and their staff to remain engaged with patients during the entirety of the episode of care and beyond. This is especially critical for skilled nursing providers tracking patients after they are discharged.

Telehealth is one way in which post-acute providers can engage patients in their care between home visits or after discharge. Similarly to how other industries have worked towards perfecting customer engagement, home health agencies in particular must follow their lead and capitalize on the benefits of engaging their consumers, or in this case, patients. If Uber or Safelite can check in before they show up, and follow up to see how your experience was after, why shouldn’t providers?

**What does telehealth look like for skilled nursing?**

Telehealth can be in reference to a remote biometric monitoring system, or can simply be provided via phone calls or SMS text messages offering educational and clinical resources between regularly scheduled home health visits or post-discharge from the SNF or home care agency. Many providers use telehealth services to communicate with patients to identify any potential issues such as low supply levels or challenges with obtaining or understanding medications.

There are two ways post-acute providers carry out this type of telehealth. The first being to employ staff members or call centers to perform outreach manually or they can also leverage automated calls or texts to perform the initial outreach and subsequently connect patients to someone who can resolve the issue. While manual outreach can feel more personalized, most providers are realizing the limitations in standardization, reporting, and call volumes. Automation, on the other hand, can be standardized and has the potential to reach out to 100% of patients on census. Depending on the goals of the agency or facility, manual or automated telehealth services should be explored by those looking to augment their patient engagement programs.

Engaging with patients between via telephone outreach can help providers address patient concerns before an adverse event occurs, such as a readmission. This can mean calls, texts, or other communication methods that prompt patients to answer questions about their status, including medication information, experience, scheduling, and more. Once patients answer, the care worker has the opportunity to proactively address any issues and ensure patients are on a successful road to recovery.

Being proactive in trying to solve issues could mean help with clinical activities such as ensuring the patient has all of their necessary medications and is adhering to instructions. It can also mean helping with non-clinical activities such as transportation challenges. When staff members are not in the home but are still able to provide clinical and non-clinical services, there is a decreased likelihood that the patient will experience an adverse event such as a readmission or re-hospitalization. This positive outcome is beneficial to the provider, the patient, and referral partners.

In addition to the outcomes benefit, when providers add meaningful and timely patient interactions between home health visits, there is an opportunity to improve the patient and their family’s perceptions of care. Showing concern for a patient’s well-being outside of home visits can reinforce positive interactions or even turnaround ones which are negative. Additionally, with telehealth programs, agency or facility staff can close the loop on potential concerns prior to the patient filling out HHCAHPS surveys, resulting in potentially higher scores.

**Telehealth can augment revenue**

By positively impacting both patient outcomes and satisfaction, agencies can be in a strong position to improve star ratings, increase referral volume. By employing proven telehealth strategies, agencies can drive better patient care at a lower overall cost. And with new payment programs, such as the Home Health Value-Based Purchasing Program (VBP) and the mandatory Patient Driven Grouping Model (PDGM), agencies who provide better care quality at a lower overall cost will likely see additional revenue gains.

Specifically with PDGM, starting in 2020, agencies will receive a higher reimbursement rate for referrals that come from hospitals or skilled nursing facilities compared to community referrals such as a physician’s office. With this in mind, agencies who align their goals with those of network partners, such as the hospital, will likely see a higher volume of
referrals, and therefore agency revenue. If an agency can show a positive impact on both readmission rates and patient satisfaction scores there is an increased likelihood that they will become a preferred partner. Additionally, agencies with higher 5-star quality rankings will also be well-positioned under changing regulations. For skilled nursing facilities, there is also immense benefit to proactively engaging patients with telehealth services. Similarly to what home health agencies are experiencing, SNFs also stand to benefit from showing referral sources that their care is helping to improve patient outcomes.

Patient engagement is at the forefront of healthcare policy and telehealth is one strategy that is both effective and cost-efficient. Whether you choose to invest in health IT that will meet all of your patient engagement needs or instruct staff members to manually engage with patients, implementing patient engagement programs will have a clear impact on your agency’s bottom line.

*Article authored by John Banks and reprinted out of McKnight’s.*

**Focus F-Tag – F868 QAA Committee**

This Regulatory Beat’s Focus F-Tag is F868 QAA Committee. This regulation has some new additions effective with Phase 3 (November 28, 2019) and a good deal of Interpretive Guidance was added when the RoPs were updated, so let’s take a look at what is required from providers.

Each nursing home must have a Quality Assessment and Assurance Committee that reports to the facility’s Governing Body. The QAA Committee must meet at least quarterly and be comprised of the Director of Nursing, the Medical Director (or designee) and three additional members of the facility. One of these three members must be the Administrator, the owner, a Board Member or someone else who holds a leadership role. Beginning in Phase 3, the facility’s Infection Preventionist must be part of the QAA Committee.

**Responsibilities of the QAA Committee**

The QAA Committee is responsible for identifying and responding to quality deficiencies that are identified in the facility. It is also responsible for reporting to the Governing Body regarding the implementation of the QAPI Program. Related to QAPI, the QAA Committee is also responsible for identifying which QAA activities, including Performance Improvement Projects (PIPs), will be conducted. As we also discussed in prior Focus F-Tag posts, the QAA Committee must also develop and implement corrective actions for an identified issue and conduct monitoring to ensure goals are reached or revisions are made to corrective actions (if needed).

The QAA Committee must meet at least quarterly, and more often as needed to fulfill its responsibilities when quality issues have been identified that need to be corrected.

**Responsibilities of the Medical Director**

The Interpretive Guidance (IG) has been expanded significantly to outline the requirements of the Medical Director’s participation on the QAA Committee. The Medical Director is required to participate on the Committee since his/her responsibility is for the overall medical care being provided by the facility and for ensuring that resident care policies are implemented appropriately. There needs to be evidence that the Medical Director has participated “meaningfully,” and according to the IG, this can include trend reporting related to medication regimen reviews and other medical oversight activities.

If the Medical Director chooses to use a designee, that person may not be someone who is already a member of the QAA Committee, and he/she must be familiar with the facility’s P&Ps and practices in order to be able to provide value to the Committee. If the Medical Director utilizes a designee, there needs to be evidence that the designee has provided information on the meeting to the Medical Director. The Medical Director must acknowledge receipt of this information. Remember there are options for the Medical Director’s participation in scheduled meeting, including via video or teleconferencing. When remote participation is done, a facility needs to ensure that there is documented evidence of the Medical Director’s participation included in the attendance record.
On survey, before the QAPI Plan/QAA review is conducted, surveyors will have identified and validated the presence of systemic issues in the facility, including repeat deficient practices and issues identified on survey that could be cited at a scope/severity of E or above. Your biggest fear should be that there is a quality issue/deficient practice that your QAA Committee is unaware of being identified during survey. There needs to be reliable communication and reporting systems established on how issues/concerns are brought to the attention of this committee and addressed. Such systems will help to avoid finding yourself responding to citations included on the CMS-2567 with a Plan of Correction.

---

**Trending Statistics**

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

**2018 Profile of Older Americans**

In the United States, the population age 65 and over numbered 50.9 million in 2017 (the most recent year for which data are available). They represented 15.6 percent of the population, more than one in every seven Americans. The number of older Americans increased by 13 million or 34 percent since 2007, compared to an increase of 4 percent for the under-65 population.

Between 2007 and 2017, the number of Americans age 45-64 (who will reach age 65 over the next two decades) increased by 9 percent and the number of Americans age 60 and over increased by 35 percent from 52.5 million to 70.8 million.

In 2017, among the population age 65 and over there were 28.3 million women and 22.6 million men, or a sex ratio of 125 women for every 100 men. At age 85 and over, this ratio increased to 184 women for every 100 men.

Since 1900, the percentage of Americans age 65 and over has more than tripled (from 4.1 percent in 1900 to 15.6 percent in 2017), and the number has increased over sixteen times (from 3.1 million to 50.9 million). The older population itself is increasingly older. In 2017, the 65-74 age group (29.7 million) was more than 13 times larger than in 1900 (2,186,767); the 75-84 group (14.7 million) was more than 19 times larger (771,369), and the 85+ group (6.5 million) was more than 52 times larger (122,362).

In 2017, persons reaching age 65 had an average life expectancy of an additional 19.5 years (20.6 years for females and 18.1 years for males). A child born in 2017 could expect to live 78.6 years, more than 30 years longer than a child born in 1900 (47.3 years). Much of this increase occurred because of reduced death rates for children and young adults. However, the period of 1990-2007 also has seen reduced death rates for the population age 65-84, especially for men–by 41.6 percent for men age 65-74 and by 29.5 percent for men age 75-84. Life expectancy at age 65 increased by only 2.5 years between 1900 and 1960, but has increased by 4.2 years from 1960 to 2007. Nonetheless, some research has raised concerns about future increases in life expectancy in the US compared to other high-income countries, primarily due to past smoking and current obesity levels, especially for women age 50 and over (National Research Council, 2011).

In 2017, 3.6 million persons celebrated their 65th birthday. Census estimates showed an annual net increase between 2016 and 2017 of 1.6 million in the number of persons age 65 and over.

Between 1980 and 2017, the centenarian population experienced a larger percentage increase than did the total population. There were 86,248 persons age 100 and over in 2017 (0.2 percent of the total age 65 and over population). This is more than double the 1980 figure of 32,194.

**Highlights of the Report**

- Over the past 10 years, the population age 65 and over increased from 37.8 million in 2007 to 50.9 million in 2017 (a 34 percent increase) and is projected to reach 94.7 million in 2060.
- Between 2007 and 2017 the population age 60 and over increased 35 percent from 52.5 million to 70.8 million.
The 85 and over population is projected to more than double from 6.5 million in 2017 to 14.4 million in 2040 (a 123 percent increase).

Racial and ethnic minority populations have increased from 7.2 million in 2007 (19 percent of the older adult population) to 11.8 million in 2017 (23 percent of older adults) and are projected to increase to 27.7 million in 2040 (34 percent of older adults).

The number of Americans age 45-64 – who will reach age 65 over the next two decades – increased by 9 percent between 2007 and 2017.

More than one in every seven, or 15.6 percent, of the population is an older American.

Persons reaching age 65 have an average life expectancy of an additional 19.5 years (20.6 years for females and 18.1 years for males).

There were 86,248 persons age 100 and over in 2017 (0.2 percent of the total age 65 and over population).

Older women outnumber older men at 28.3 million older women to 22.6 million older men.

In 2017, 23 percent of persons age 65 and over were members of racial or ethnic minority populations—9 percent were African-Americans (not Hispanic), 4 percent were Asian (not Hispanic), 0.5 percent were American Indian and Alaska Native (not Hispanic), 0.1 percent were Native Hawaiian/Pacific Islander (not Hispanic), and 0.8 percent of persons 65 and older identified themselves as being of two or more races. Persons of Hispanic origin (who may be of any race) represented 8 percent of the older population.

A larger percentage of older men are married as compared with older women—70 percent of men, 46 percent of women. In 2018, 32 percent older women were widows.

About 28 percent (14.3 million) of older persons lived alone (9.5 million women, 4.8 million men).

Among women age 75 and over, 44 percent lived alone.

The median income of older persons in 2017 was $32,654 for males and $19,180 for females. The real median income (after adjusting for inflation) of all households headed by older people increased by 1.1 percent (which was not statistically significant) between 2016 and 2017. Households containing families headed by persons age 65 and over reported a median income in 2017 of $61,946.

In 2017, 4,681,000 older adults (9.2 percent) were below the poverty level. This poverty rate is not statistically different from the poverty rate in 2016 (9.3 percent). In 2011, the U.S. Census Bureau released a new Supplemental Poverty Measure (SPM) which takes into account regional variations in living costs, noncash benefits received, and non-discretionary expenditures but does not replace the official poverty measure. In 2017, the SPM showed a poverty level for persons age 65 and over of 14.1 percent (almost 5 percentage points higher than the official rate of 9.2 percent). This increase is mainly due to including medical out-of-pocket expenses in the poverty calculations.

The need for caregiving increases with age. In January-June 2018, the percentage of older adults age 85 and over needing help with personal care (20 percent) was more than twice the percentage for adults ages 75–84 (9 percent) and five times the percentage for adults ages 65–74 (4 percent).

Among adults age 75 and over, 42 percent report the television is their first source of emergency information as compared with 31 percent for the total population. The percentage of older adults receiving information from the internet (9 percent) is much lower than for the total population (31 percent).

---

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

1) There were no new Federal [CMS Quality, Safety and Oversight Letters](https://www.cms.gov) (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 Statement on Quality of Care in America’s Nursing Home Facilities.** Improving safety and quality in America’s nursing homes is one of CMS’ top priorities. CMS welcomes the recent attention on nursing home quality of care that has amplified the important national dialogue. Administrator Verma began working on this issue at the beginning of her tenure in 2017.

CMS offers Americans a comprehensive, consumer-friendly quality hub, called Nursing Home Compare, which provides quality of care information for every nursing home that participates in Medicare and Medicaid. Nursing Home Compare includes an easy to understand overall star rating based on three factors: health inspections, staffing levels, and quality measures. The site also includes results of recent health inspections. In addition to this information, CMS will soon be posting a list of candidates for the Special Focus Facility (SFF) program. CMS urges all Americans to consult their physician, family, and Nursing Home Compare before choosing a nursing home for their loved ones.

Administrator Verma has made ensuring quality care in nursing facilities a priority and recently announced a five-part plan that focuses on strengthening requirements for nursing homes, working with states to enforce statutory and regulatory requirements, increasing transparency of nursing home performance, and promoting improved health outcomes for nursing home residents. CMS has already improved the way nursing homes are surveyed by implementing a robust, standardized survey process, strengthened the staffing requirements for nursing homes, updated the way nursing homes report their staffing to CMS, then targeting nursing homes with staffing problems for off-hours and weekend surveys; and we began to post all of the agency’s surveyor training online.

• **New Medicare Card: 75% of Claims Submitted with MBI.** Many providers are using the new Medicare Beneficiary Identifier (MBI) for Medicare transactions. For the week ending June 14, providers submitted 75% of fee-for-service claims with the MBI. Help protect your patient’s personal identity by using their MBI for Medicare business, including claims submission and eligibility transactions. Here is how you are using the MBI on claims:
  - Institutional: 75%
  - Professional: 76%
  - Durable Medical Equipment: 64%

Review the MLN Matters Article to learn about getting and using the MBI.

• **CMS Proposes to Update e-Prescribing Standards.** On June 17, CMS issued a proposed rule that would update the Part D e-prescribing program by adopting standards that ensure secure transmissions and expedite prior authorizations.

  “Improving patients’ access to prescription drugs is a top priority for CMS,” said CMS Administrator Seema Verma. “This proposed rule would reduce the time it takes for a patient to receive needed medications and ease the prescriber burden by giving clinicians the flexibility and choice to complete prior authorization transactions electronically.”

Under the proposed change, clinicians would be able to choose to complete prior authorizations online, reducing burden for providers through a more streamlined process for performing prior authorization for Part D prescriptions. Clinicians who select the electronic option will typically be able to satisfy the terms of a prior authorization in real time and before a prescription is transmitted to a pharmacy, so patients do not arrive at a pharmacy counter to find that their prescription cannot be filled.

The proposed rule would implement new prior authorization transaction standards for the Part D e-Prescribing program as required by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The proposed standards would begin in January 2021.

See the full text of this excerpted CMS Press Release (issued June 17).
**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 4 – 2017 and Quarter 3 – 2018 and reflects what will be published on LTCH Compare during the September 2019 refresh of the website. Providers have until July 10, 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.

Beginning with the September 2019 refresh, CMS will publicly display measure results on the LTCH Compare website for the Potentially Preventable 30-Day Post-Discharge Readmissions measure adopted for the LTCH Quality Reporting Program (QRP). CMS decided not to publish this measure in late 2018 to allow more testing to ensure it provides a reliable, accurate picture of provider performance on quality, in line with CMS’s Meaningful Measures Initiative to address high-priority areas for quality measurement with measures that will help improve outcomes while minimizing provider burden. We have since completed this additional testing and have refined the method for assigning providers to performance categories, in which their performance level is compared to the national rate. LTCH performance data for these measures will be included for the first time on this preview report.

CMS is additionally previewing the Discharge to Community (DTC) measure for the first time, using updated methodology for assigning categorical ratings to each provider based on their performance on this measure (better than, same as, or worse than the national average).

LTCHs can access their preview report by logging in to iQIES at https://iqies.cms.gov/. At the main screen, select Reports; then ‘My Reports’.

For more information:
- The LTCH data referenced in the above messaging, we invite you to view the LTCH Quality Public Reporting webpage and/or LTCH Compare.
- Potentially Preventable Readmissions measures, we invite you to view our related Fact Sheet and Q & A documents on the LTCH QRP Public Reporting webpage, under the Downloads section.
- The newly updated methodology used to assign categorical ratings to providers with respect to their performance on the DTC measure, as referenced above, we invite you to view our related Fact Sheet and Q & A documents on the LTCH QRP Public Reporting webpage, under the Downloads section.

**FY 2020 ICD-10-CM Diagnosis Code Updates.** The FY 2020 ICD-10-CM diagnosis code updates are available on the 2020 ICD-10-CM webpage.


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

- **MMWR: 2018-19 Flu Season Activity Update.** The 2018–19 flu season was moderate in severity with two consecutive waves of influenza A activity of similar magnitude during the season: A(H1N1) pdm09 predominated from October 2018 to mid-February 2019, and A(H3N2) activity increased from mid-February to mid-May. The latest MMWR summarizes activity this season and includes the vaccine viruses recommended for next season’s flu vaccines.

- **The Deadliest Flu: Discovery and Reconstruction of the 1918 Pandemic Virus.** The 100-year anniversary of the 1918 pandemic and the 10-year anniversary of the 2009 H1N1 pandemic provide an opportunity to reflect on the groundbreaking work that led to the discovery, sequencing and reconstruction of the 1918 pandemic flu
4) The **HHS Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE)** released their June 2019 The Express.

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

- HFS has released an updated notice in regard to Medicaid managed care billing requirements as a follow-up to the notice released June 3. The Illinois Medicaid Managed Care Organizations (MCOs), have developed a Comprehensive Billing Guide for Medical Assistance Program providers. This billing guide is designed to help providers who are contracted with the MCOs understand the general MCO billing requirements. MCOs have different policies and procedures related to billing. With this manual, the MCOs have created a single source of information for all claims regardless of provider type. The most recent update has published information in regard to billing for Supportive Living providers. The new guide is posted on the [IAMHP website](http://iamhp.org). The full notice can be read [HERE](http://iamhp.org).

- HFS posted **updated 2019 LTC Cost Report Files**. You may view the new files [here](http://iamhp.org).

- HFS has posted June 28, 2019 **Waiver Advisory Subcommittee Adult’s and Children’s Agenda**. To view these documents [click here](http://iamhp.org).

- HFS posted a provider notice regarding **Training on New ABE Partner Portal Functionality Report the Birth of a Newborn and Provider Requirements**. To view the notice [click here](http://iamhp.org).

- HFS posted a new **Provider Notice regarding Ordering, Referring, Prescribing - National Provider Identifier (NPI) Requirements - Delay in Implementation to October 1, 2019**. You may view the notice [here](http://iamhp.org).

- HFS posted a new **Provider Notice regarding Fiscal Year 2020 Expansion to Illinois DocAssist**. You may view the new notice [here](http://iamhp.org).

- HFS posted a new **Provider Notice regarding Correction to Hospital Outpatient Calculator Relative Weights**. You may view the new notice [here](http://iamhp.org).

- HFS posted a new **Public Notice regarding Substance Use Prevention and Recovery Provider Reimbursement**. You may view the new notice [here](http://iamhp.org).

- HFS posted a new **Public Notice regarding Mental Health Reimbursement Rates**. You may view the new notice [here](http://iamhp.org).

- HFS posted a new **Public Notice regarding Psychiatric Services Reimbursement Rates**. You may view the new notice [here](http://iamhp.org).

- HFS posted an **Updated Therapy Fee Schedule**. You may view the new fee schedule [here](http://iamhp.org).

- HFS posted a new **Provider Notice regarding Proposed Nursing Facility Reimbursement Rate Increase**. You may view the new notice [here](http://iamhp.org).

- HFS posted a new **Public Notice regarding REVISED Proposed ID/DD and MC/DD Reimbursement Rate Increase**. You may view the notice [here](http://iamhp.org).

- HFS posted a new **Public Notice titled Orthotics and Prosthetics Rates**. To view the notice [click here](http://iamhp.org).
HFS posted a new Public Notice titled **New Payment Methodology for Transportation Providers**. To view the notice click [here](#).

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

   - The schedule for **IDPH Town Hall Meetings** will be out shortly.

7) The **Illinois Department on Aging** is responsible for the **Consumer Choice Website**. The Illinois Department on Aging and the Office of the State Long-Term Care Ombudsman Program have developed a website for consumers to use when seeking a long term care facility. The website meets the requirement of the Illinois Act on the Aging 20 ILCS 105/1 (from Ch. 23, par. 6101) (c-5). The intent of the website is to provide consumers with information about facilities in their preferred area regarding medical care, services and treatment, special services and amenities, staffing, facility statistics and demographics, ownership and administration, safety and security, meals, nutrition, rooms, furnishings and equipment as well as family, volunteer and visitation provisions. The consumer will be able to filter their search based on location, needs, and preferences.

    Facilities licensed under the Nursing Home Care Act (210 ILCS 45/2-214), the MC/DD Act (210 ILCS 46/2-214), and the ID/DD Community Care Act (210 ILCS 47/2-214) are all **mandated** to complete the electronic questionnaire provided by the Office of the State Long-Term Care Ombudsman. The questionnaire must be updated annually or when changes occur within the facility. To find out how to access the Questionnaire, [click here](#). To view the Facility Letter the Ombudsman are handing to facilities, [click here](#).

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

   - **Providers Find Value in the AHCA/AHIMA ICD-10 Training.** Accurate ICD-10 coding and documentation are important to the success of your PDPM implementation. But with all of the work leading up to implementation, how can you fit gaining proficiency in the changes in the ICD-10 coding into your schedule. Hundreds of providers have found the answer in the self-paced online training offered by AHCA/AHIMA. Register now and be ready for PDPM on October 1.
      - Coder version
      - Non-coder version

    AHIMA and Nurse CE are available for the coder training and NAB and AHIMA CE are available for the non-coder training.

   - **Mark Parkinson Receives Top CEO Recognition.** We are excited to announce that AHCA/NCAL President & CEO Mark Parkinson has been named a 2019 Top CEO by *The Washington Post*!

    This honor comes as part of *The Post's* 2019 Top Workplace survey, in which the Association made the elite list of Washington, D.C. area employers for the fifth consecutive year. As part of the program, hundreds of employees in the Washington area were asked to rate the extent to which they have confidence in their company's leadership. He received the highest totals in the small-employer category for 2019.

    "This is a tremendous honor," said Parkinson. "It is rewarding to know that not only is the work you do helping people, but the staff is truly passionate about making a difference. That passion shows through the culture we've built and in both of these special recognitions. It is a pleasure to work alongside and lead this committed group of talented professionals every day."

    Selection as a Top Workplace is based solely on employee feedback gathered through an anonymous third-party survey administered by research partner Energage, LLC, which measured several aspects of workplace culture, including alignment, execution, and connection. This year's list honors more than 150 companies including government contractors, law firms, nonprofits, schools, and businesses.
Read more about Mark and his experience in *The Washington Post*'s article, "How the Top Workplaces winners became leaders in their industries." You can also visit *The Washington Post website* for more about this year's Top Workplaces and to see the full list of 2019 honorees, including AHCA/NCAL.

- **AHCA PDPM Academy Update – Live Webinar June 25, 2019 at 2:00pm – 3:30 pm CST** [PDPM Updates to the MDS-RAI Manual and the Potential Impact on CMS PDPM Quality Monitoring](#). As providers prepare for the October 1, 2019 hard transition from the Resource Utilization Groups, version four (RUG-IV) skilled nursing facility prospective payment system (SNF PPS) to the Patient Driven Payment Model (PDPM), it is important to monitor for updates from the Centers for Medicare and Medicaid Services (CMS) that impact PDPM Implementation. On May 20, CMS issued an early, preliminary release of the MDS 3.0 RAI Manual v1.17 that contains many updates including information related to PDPM. In addition, CMS conducted a two-day SNF Quality Reporting Program (QRP) Provider Training event on May 7-8 that included extensive discussions about the upcoming MDS changes, the alignment of PDPM with the SNF QRP, and how CMS intends to use MDS and SNF QRP data to monitor PDPM implementation.

This webinar will provide an overview of the significant changes to the MDS-RAI manual and specific MDS data elements and quality measures described in these recent CMS updates that will most likely be monitored by CMS. Providers are encouraged to view this webinar and the CMS resources provided as accurate MDS coding will be essential for provider success with PDPM implementation.

- **AHCA/NCAL Social Media Update** ([click here](#))

- **Recording of Webinar: AHCA PDPM Academy Monthly Live Webinars is Ready.** The archived recording of AHCA PDPM Academy Monthly Live Webinars is now ready for you to view at your convenience.
  - Once the page opens, click on the "View Archived Recording" button on the right-hand side of the page.
  - The presentation will open in a new window for you to view and hear the program.
  - Click on the Handout tab to download your copy of the handouts and other available materials.

  For questions or support, please email [ahca@commpartners.com](mailto:ahca@commpartners.com).

- **The Quality Initiative Quarterly Update** ([see attached](#))

- **ACHA PDPM Academy Weekly Update** – June 27 ([click here](#))

9) **This Month at Telligen.**

10) **The Cleveland Plain Dealer** reports that Some Question Whether Federal Government Should Regulate Assisted Living. The *Cleveland Plain Dealer* reports that some seek to re-evaluate the degree to which assisted living facilities are regulated by the federal government as the makeup of the resident population has changed over time and because Medicaid’s role in paying for care in assisted living is growing. For example, "thirty-eight states leave the amount of personnel needed to care for residents up to individual facility owners," which some believe may be insufficient. Rachel Reeves, a spokeswoman for the National Center for Assisted Living, said, "We believe that states are better equipped to help assisted-living centers adapt and customize the care needed. The states offer greater flexibility. They can see what is best for residents and deal with those issues."

11) **Skilled Nursing News** reports, Skilled Nursing Out-Of-Pocket Costs Growing Faster Than Inflation, Study Finds. *Skilled Nursing News* reports that a study examining data from 2005 to 2010 across eight states found "the out-of-pocket cost of receiving care in a nursing home has consistently grown faster than gains in consumer and medical care prices." The trend is "raising questions about the affordability for seniors without Medicaid coverage or long-term care insurance." The study was published in the journal *Medical Care Research and Review.*
12) Today's Geriatric Medicine reports, 10 Years After Alzheimer’s Report: Any Progress? A Forbes reporter with a family history of Alzheimer’s disease looks at what progress has been made since “A National Alzheimer’s Strategic Plan: The Report of the Alzheimer’s Study Group” was released 10 years ago. He discusses recent disappointments, doubts about the amyloid theory, the increasing importance of lifestyle changes as risk reduction factors, and the future of medications.

13) Provider Magazine reports, AHCA Denounces Trump Administration Proposal to Impose Tariffs on Health Care Products from China. Provider Magazine recently reported that the American Health Care Association “is denouncing a proposal from the Trump administration that would impose tariffs on Chinese-supplied critical health care products used in nursing facilities.” AHCA “is concerned that the proposed scope of List 4 under Section 301: China’s Acts, Policies, and Practices Related to Technology Transfer, Intellectual Property, and Innovation includes critical health care products used daily in nursing facilities, including wet wipes, drapes, underpads, and exam and surgeon gloves." Mark Parkinson, the president and CEO of AHCA, said in a statement, "The administration’s proposal to impose tariffs on critical health care products such as gloves and drapes will have a dramatic impact on the long term care profession. These products serve a vital role in providing safe, efficient care to our residents and are subject to strict FDA requirements and regulations--including a two-year review period."

14) McKnight’s reports:

- Investors Expect Steady Growing SNF Demand This Year, Study Finds. McKnight’s Long Term Care News reports that the results from the CBRE U.S. Health care Capital Markets’ Health care Real Estate Investor & Developer Survey indicate "some 73% of investors think demand for skilled nursing properties will either hold steady or increase over 2019," while last year investors "were split evenly over the idea of steady or shrinking demand." Meanwhile, only "10% of investors put skilled nursing facilities on their most-wanted list for 2019."

- CMS Delays Action on Repeal of Requirement That Medicaid Cover Non-Emergency Medical Transportation. McKnight’s Long Term Care News recently reported that CMS may be delaying action on the repeal of "a requirement that state Medicaid programs cover transportation for non-emergency medical care." Meanwhile, "a regulatory agenda included in the White House budget set a new deadline in late 2021 for a proposed rule allowing states to opt out of transportation coverage." An AHCA spokesperson "said the provider organization is aware of the new timeline but did not have any insight as to why CMS pushed back its plans." Moreover, "AHCA said Tuesday afternoon that it would withhold comment until a proposal is published."

15) Interesting Fact: A human eye can distinguish between approximately 10 million different colors.